Speeches and background information related to the symposium:

“Mental Health Consequences of Conflict on Children”
With a special focus on children in the Central African Republic

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1. Presentation of Fracarita International

Target groups?

Fracarita International focuses on children, youth and adults in the South who are confronted with three very specific problems:

- **Disability**: physical, cognitive, mental, sensory, emotional, developmental or social disabilities
- **Mental suffering and disorder**: need for psycho-social counselling, psychiatric care and care of addicts
- **Lack of educational and vocational opportunities**

That’s why our NGO concentrates its activities in three different fields:

- **mental health care**
- **care for people with a disability**
- **education and training**

In addition to these three sectors, the NGO is also frequently involved in emergency aid and care for refugees, street children, HIV-patients or elderly, but only in very specific cases.
What?

The international NGO for development cooperation of the Brothers of Charity.

Mission?

Fracarita International wishes to dedicate itself to the challenge of improving the living conditions of the most vulnerable people. It is our mission to increase the quality of life of these people. To this end, we wish to focus on two core values:

- their personal rehabilitation as unique human being
- their social reintegration in society as active members of their community

In order to increase the quality of life for these people, we want to mobilize people and financial means in the North and set up, develop and support initiatives in the South together with local Brothers of Charity and other partners. Capacity building in the field of personal rehabilitation and social reintegration of our target groups is therefore crucial to us.

Fracarita International has a special consultative status in the Economic and Social Council (ECOSOC) of the United Nations.
Fracarita International supports more than 100 projects in 19 countries in Latin America, Africa and Asia: schools, psychiatric centres, centres for people with a disability, vocational training centres, etc. Learn more about these projects on our website and discover how you can help us to increase their impact.

The NGO fully promotes the application of the UN resolutions regarding human rights without any form of discrimination such as that on the basis of functional impairment, race, colour, gender, language, religion, tradition, political or other opinions, national, ethnic or social origin, legal or social status, age, property or birth.

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2. Profile of the Congregation of the Brothers of Charity

How it all began

On 28 December 1807, Father Peter Joseph Triest gathered a few young men to take on the care of some elderly people in a Ghent hospice. In this town, just as in many others in these regions at that time, the care for the poor, the sick and the aged was at a low ebb. Triest wanted to change this situation, and therefore he founded no less than four religious congregations. Our story is about one of them – the Brothers of Charity. In 1807, they were still called the “Hospital Brothers of St Vincent”.

The first brothers took their religious vows in 1811. That which started quite small in 1807, gradually developed into an international congregation with houses in 25 countries. From a small seed a big three would grow; one that is still bearing good fruit. We would like to invite you to listen to the story that is still being written today.

A founder

Peter Joseph Triest was born in Brussels in 1760. He took holy orders in an agitated time. One political regime replaced another in quick succession; the Roman Catholic Church was going through hard times during the French Revolution. From 1797 till 1802, the nonjuring Father Triest had to live in hiding and administer the sacraments in secret. Yet, this period in his life was fruitful in that his inner drive to help his fellow man matured. Moved by Jesus’ words, “In truth I tell you, in so far as you did this to one of the least of these brothers of mine, you did it to me” (Mt. 25:40), he dedicated himself to the poorest. “I am to give you my example, my teaching and my service” was how he formulated his mission in life.

Having been appointed parish priest in Lovendegem in 1803, he founded his first congregation, the Sisters of Charity of Jesus and Mary, a few months after his arrival. They would take on the care of poor and abandoned children in the parish.

In 1806, he was made a member of the Commission of Civil Hospices in Ghent, where his pastoral care would really blossom. Care for the elderly poor, the mentally ill, foundlings – all of these people, the least privileged of society in those days, were the object of his loving attention. In 1807, he founded the Brothers of Charity to take on the care for the poor elderly and the mentally ill. In 1825, he established the Brothers of St John of God for domiciliary care of the poor sick; and in 1835, a year before his death, he concluded his founding work by instituting the Sisters of the Childhood of Jesus, who were meant to care for foundlings.

These 30 years, during which Triest helped organise poor relief in Ghent, were truly revolutionary. Freeing the mentally ill from their chains and the crypts at Gerard the Devil’s Castle was certainly one of his most memorable deeds. It was his vision to approach all people and bring them God’s message of deliverance by giving them a sign of love, and he did so successfully. Peter Joseph Triest, meanwhile honoured as Canon of St Bavo’s Cathedral in Ghent, died in 1836. His dying words, “Give and it shall be given unto you”, are a poignant summary of his life, which was one gift.

With a vision

Canon Peter Joseph Triest was not just a man of charitable works; he had a clear vision and was an inspired leader. Many people were moved to go out to the poor and the humble through his spirit of love. He was anxious not to exclude anyone so that they all would hear God’s message of love. This was expressed in his great respect for every fellow man and his preferential love for the less privileged.

Starting from a basic attitude of love; he offered people expert help and tried to improve the material environment. An able organiser, he considered his leadership as a supreme way of rendering service.

Father Triest was totally committed to his neighbour’s enhancement, to the improvement of the quality of life. Underlying his action was his conviction that all people are children of God who have been saved and meant to live in the light of the resurrection.

“Bringing food to these people, offering them a bed, nursing their wounds... is that not making the sun shine for them, is that not creating a new earth? Is that not resurrecting them and drawing them from the jaws of death?” was one of his memorable phrases.

A vision for today

Spirituality is something that should always be reshaped. The seed, which our founder Father Triest sowed, has developed through many generations of brothers after him. Today, brothers and staff members are working together moved by the same spirit.

A basic attitude of love still is the foundation, and preferential love for the less privileged is still being cultivated. Our care for the poor today is expressed in our special attention for those people who fall through society’s cracks: people from the Fourth
World, persons with AIDS, persons with an addiction, young people who have gone astray. But also in the care for the mentally ill, persons with disabilities, and in the education of young people, the Brothers of Charity remain present to bring the culture of charity. Guaranteeing Christian-inspired care and support continues to be an important on-going task. Expertise and professionalism, attention to proper material surroundings, supported by adequate structures; these are the aspects of our basic attitude of love. Our deepest inspiration and our motivation are drawn from the Gospel and Christ’s Message of Love. Only God’s love enables us to love our neighbour with unconditional respect and warm humanity.

3. Call for psychosocial support to traumatized children in the Central African Republic

At the occasion of World Mental Health Day on 10 October, Fracarita International and Unicef organised an international symposium on the impact of armed conflict on the mental health and psychosocial well-being of children. Particular attention was given to the current precarious situation in the Central African Republic.

Mental health consequences of conflict on children Terrible violence as a result of armed conflict continues to have a negative impact on children and their families in many areas of the world. Children have been killed, and continue to be directly targeted by violence, including rape, torture and mutilation. The impact on the mental health of these children is often devastating. In the Central African Republic alone, more than 2 million children are suffering the consequences of the crisis that erupted last year. The impact on their mental health and psychosocial well-being is enormous. The consequences of this crisis on the health and social services in the country too is immense, adding to the vulnerability of these children who may not have access to the support services they need. In order to review the impact of conflict on the well-being of children and to share experiences on good practices to address their post-traumatic stress disorders, Fracarita International and Unicef organised a symposium at the Church Centre in New York. Participants to this World Mental Health Day event included Leila Zerrougui, Special Representative of the UN Secretary-General for Children and Armed Conflict, Ted Chaiban, Director Programme Division UNICEF, Jacob Kumaresan, Executive Director WHO Office at the United Nations, Omar Hilale, Permanent Representative of the Kingdom of Morocco to the United Nations and Bro. René Stockman, President of Fracarita International.

Fracarita International: providing mental health care to vulnerable people since 1815 Fracarita International is the NGO for development cooperation of the congregation of the Brothers of Charity. It is specialized in the provision of professional mental health care to vulnerable people. The founder of the congregation, Canon Peter Joseph Triest, started mental health care in Belgium in 1815. This means that the congregation has acquired extensive knowledge and has gained vast experience in mental health care over the years. Fracarita international shares this expertise with nearly 30 local services for mental health care in Latin America, Sub-Saharan Africa and Asia and provides psychiatric care in these regions to thousands of vulnerable people, including children.

Psychiatric care for traumatized children in the Central African Republic At the symposium in New York, Bro. René Stockman, president of Fracarita International, announced that his organization has the ambition to extend its mental health care services to the Central African Republic (CAR), where it already runs a social service in a detention centre in the capital Bangui. The programme for mental health care in CAR will adopt a similar approach as the Neuropsychiatric Hospital of the Brothers of Charity in Ndera, Rwanda, that has a separate ward for child psychiatry. This unit was set up in the aftermath of the Rwandan genocide, when many Rwandans were severely traumatized, including children. At Ndera, children and their parents receive psycho-education to empower the whole family to deal with the mental health condition of the child in an optimal way and to teach the parents some specific parenting skills. The hospital also provides individual and group counselling to the children, so that they understand that they are not alone in their struggle to overcome their trauma and can find strength in each other’s stories.
4. Speeches at the occasion of the Symposium in New York

4.1. Ambassador Bénédicte Frankinet

In her opening speech at the Symposium on the Consequences of conflict on the Mental Health of Children the Permanent Representative of the Kingdom of Belgium, Ambassador Bénédicte Frankinet, briefly presents the work of Fracarita International in fighting the stigma associated to mental health disorders and in restoring the dignity of patients. She also draws the attention of participants on the consequences of conflict on Children.

Mme Special Representative,
Dear Colleagues,
The Permanent Representatives of the Kingdom of Morocco and of the Central African Republic,
Mr. Executive Director of WHO in NY,
Ms. Bissell,
Mr. Chaiban of UNICEF,
Brother René Stockman,

My only function today is to welcome all participants to this event on the Mental Health Consequences of Conflict on Children and I do this with great pleasure.

This is a joint event between the UN family represented by Leila ZERROUGI, the Special Representative of the Secretary-General for Children in armed conflict, UNICEF and WHO on the one hand and by a Belgian NGO, Fracarita, on the other hand.

Fracarita has been active since many years in a variety of countries to promote greater attention for mental disorders, to fight the stigma associated with them, and to restore the dignity of the persons affected by these disorders and protect their human rights.

As we all know, the traumas of conflict, especially in children, can affect entire lives. As an illustration you will hear some of the panelists focusing on the consequences of the conflict in the Central African Republic. But the perspective is broader and this will be highlighted through the various interventions.

I am happy to give back the floor to our moderator.
4.2. Remarks by SRSG Leila Zerrougui

The Special Representative of the UN Secretary General for Children and Armed Conflict, Ms. Leila Zerrougui, states that extreme violence can affect a whole generation of children exposed both directly and indirectly and that the consequences of armed conflicts on them are long lasting and difficult to fully address. Nevertheless actions are needed to give to the children in conflict a fair chance at a peaceful and productive future.

Thank you Belgium for organizing the event and thank you Morocco, UNICEF, WHO and Fracarita for participating to share experience, knowledge and recommendations.

When my Office was created in 1997, the world had just woken to the horrible reality of children in conflict – both as victims and, sometimes, perpetrators of violations against children. Since that time, we have wizened to the fact that children often bear the brunt of conflict- they are maimed, tortured and killed in their homes and schools or exposed to the horrors of sexual violence, they are abducted or recruited and used by armed forces and groups. Sadly, these are themes and images we deal with almost daily. Indeed, today the large majority of armed conflicts are intra-state in nature and civilians, especially children, find themselves at the centre of these conflicts. But now, some 17 years after the creation of my mandate, we are discussing the true price that children and childhood pay during conflict. We have realized that the price children pay is much greater, much deeper and much more concerning than we had thought.

We know that extreme violence can affect a whole generation of children exposed both directly, as child soldiers or physical victims of guns and bombs, and indirectly as witness to acts of violence affecting their families and communities. We know this and we know that doing nothing to assist these children and their caregivers has a real cost for the future.

The consequences of armed conflicts on children’s mental health are long lasting and difficult to fully address. In a recent discussion on the issue of child soldiers, a government representative of a country recovering from conflict admitted that they are facing more difficulties reintegrating ex-child soldiers than adult combatants. These children had only known war and found it more difficult than adults to adjust to a peaceful environment.

Children whose lives have been turned upside down by conflict are faced with huge obstacles in trying to reclaim degrees of normality. Their exposure to extreme violence has left some of them with lasting traumatic impact such as violent outbursts, lack of trust in others, and inability to socialize.

Do these children have family support and will their families accept them back? In many cases, children have become orphans during the time of the conflict and in some cases, children who had been associated with armed groups are not always welcomed back. These children have missed out on years of education and do not have civilian professional skills. Capacity of community to provide education opportunities or income opportunities is most often very limited.

In my work as SRSG for Children and Armed Conflict, one priority is to have children released from armed groups, be it state or non-state actors. Once this arduous political phase is on track, one main challenge is the re-integration of children into their communities. By all accounts this re-integration is a long and costly process. The need for and provision of psycho-social support is thankfully now accepted dogma by practitioners such as UNICEF and NGOs. However, we need to push for a better understanding and acceptance by the international community for the need to provide support for mental health services to affected children and communities if we want them to have a fair chance at a peaceful and productive future.

Central African Republic

- I travelled to CAR in December of last year, just after the country descended into violence and witnessed myself the consequences for children. Killing, Maiming, Displacement. Anti-Balaka and Seleka victimized children and used children to victimize others.
- The fabric of affected societies has been torn (ethnic and sectarian strife). Absence of the state in light of an overwhelmingly young population. NGOs and the UN are seeking to fill the gaps and have a large role to play in assisting CAR to recover. DPKO Mission is now there with Child Protection Capacity

“We have realized that the price children pay is much greater, much deeper and much more concerning than we had thought.”

“We need to push for a better understanding and acceptance by the international community for the need to provide support for mental health services to affected children”
Major Challenges

- Major lack of service capacity in CAR. Need to work with NGOs and Community Based Organizations and Communities themselves to bring relief but also build local capacity.
- More resources must be made available for psycho-social and mental health support.
- How do we use religious and community leaders to assist healing when some may have exacerbated that very violence?
- What role for accountability/ truth telling in post sectarian violence? How can psycho-social work also bring communities together after ethnic and sectarian strife?

I hope that this modest contribution to the discussion will help in our common agenda in raising awareness on the needs of children in general and those affected by conflict in particular.

4.3. Statement of H. E. Mr. Omar Hilale, Ambassador, Permanent Representative of Morocco to the United Nations

The Permanent Representative of Morocco, Ambassador Omar Hilale, shows how children in armed conflict are denied the protection promised to them in the Convention on the Rights for the Child and how they are brutally uprooted and exposed to danger and insecurity and are affected by other painful experiences. He invites the participants to join the UN Secretary General in his call for an immediate end to targeting of innocent children and civilians and to provide children in armed conflict with emergency assistance, long-term support and education.

At the outset, let me thank the Farcarita International and the Mission of Belgium for organizing this timely symposium on a crucial subject which is the impact of armed conflict on the mental health and psychological well-being of affected populations, as well as for inviting me to speak on this event.

Today, the 10th of October, the world is celebrating the « The Mental Health Day », which provides an opportunity to raise awareness of mental health issues around the world, mobilize efforts in support of mental health, and take stock of the achievements and challenges that lie ahead to make mental health care a reality for people worldwide.

Unfortunately, reports make disturbing and often shocking reading of the situations of children on the ground, revealing the heartrending reality of children’s involvement in more than 30 armed conflicts around the world, and provide an alarming description of the cruelty and abuses that children have suffered, and still do.

Millions of children are caught up in conflicts in which they are not merely bystanders, but targets.

Some fall victim to a general onslaught against civilians. Others die as part of a calculated genocide.

Reports also say that in the past decade, at least 2 million children have been killed in armed conflicts, and more than 6 million have been seriously injured or permanently disabled, and countless others have been forced to witness or even to take part in horrifying acts of violence.

The proportion of war victims who are civilians has leapt in recent decades from 5 per cent to over 90 per cent and at least half of these are children.

Just as shocking, thousands of young people are cynically exploited as combatants, or cowardly and without heart, slaughtered, raped, and maimed; or otherwise exploited as soldiers and exposed to extreme brutality.

As a result, says the report, children are being denied the protection promised them in the Convention on the Rights of the Child. « War violates every right of a child -the right to life, the right to be with family and community, the right to health, the right to the development of the personality, and the right to be nurtured and protected. »

Coupled with the rapid social change which often precedes or accompanies war, armed conflict leads to a breakdown in the family support systems, which is so essential to a child’s survival and development. Other forms of protection also slip away, particularly government and community support systems.

In a number of cases children have been deliberately exposed to horrific scenes to harden them to violence. Some have even been forced to commit atrocities against their own families as a way of severing all ties with their communities.

These children are in need of special attention. At a crucial and vulnerable time in their lives, these children are brutally uprooted and exposed to danger and insecurity.

Thousands of children die each year as a direct result of armed violence - from knives, bullets, bombs and land-mines.

Millions more die from the indirect consequences of warfare - as a result of the disruption in food supplies and the destruction of health services, water systems and sanitation.

But beyond the physical dangers, children involved in armed conflicts also suffer lasting psychosocial damage - as a result of the loss of their families, for example, or of exposure to violence or witnessing scenes of murders.

“Children involved in armed conflicts also suffer lasting psychosocial damage”
Children are also affected by other painful experiences. Armed conflict fragments communities and breaks down trust among people, undermining the very foundation of children’s lives.

In such distressing experiences, different children will respond in different ways. Some will recover but many others may suffer permanent damage.

These grave violations against children demand an immediate response.

In this framework, we join the Secretary General in his call for an immediate end to the targeting of innocent children and civilians, including the use of weapons that cause indiscriminate and disproportionate harm.

Those involved in conflicts and those who have influence over them have an obligation to do everything possible to protect children from violence - violence that is not of children’s making, and in which they should play no part.

Emergency assistance should address the health needs of children and the importance of building on community resources: helping close family members as well as school teachers and other community workers to provide children with the long-term support they need.

Education plays a major role. It affords children a sense of security and continuity even when they are surrounded by chaos engendered by armed conflict. Therefore, schools should be kept open as long as possible.

Keeping children in class is particularly important for adolescents who are at risk of being recruited into armed forces, prostitution or drug abuse. One of the best ways to protect older children is to involve them actively in community activities, including their own personal development programs.

4.4. Speech of Madam Ambroisine Kpongo, Permanent Representative of the Central African Republic to the United Nations

La nouvelle Représentante Permanente de la République Centrafricaine auprès des Nations Unies, Madame Ambroisine Kpongo, souligne d’abord l’impact dramatique de la crise que vit son pays sur la santé mentale des enfants. Elle énumère ensuite les actions entreprises par le gouvernement centrafricain, avec l’appui de l’UNICEF et d’autres partenaires, pour accompagner les enfants traumatisés sur le plan socio-psychologique et pour prendre en charge ceux qui sont sortis des forces et groupes armés. Elle termine en dressant le tableau de ce qui reste à améliorer et en remerciant les organisateurs du Symposium et les ONG actives dans son pays.

Distingusés Invités

Mesdames, Messieurs,

Je voudrais avant tout vous remercier pour l’invitation que vous avez bien voulu m’adresser en vue de prendre part à ce Symposium, à l’occasion de la journée mondiale de la Santé mentale, et c’est à juste titre que l’accent est mis sur ‘les conséquences des conflits sur la Santé Mentale des enfants).

En effet, la crise militaro-politique qui a ébranlé et qui continue d’ailleurs d’ébranler la République Centrafricaine, a eu un impact grave sur la santé mentale des enfants. Qu’il s’agisse des enfants soldats ou d’autres enfants, les séquelles et les conséquences psychologiques sont importantes et je dirai même dramatiques.

La fracture sociale due au déplacement massif de la population se fait sentir sur la santé des enfants, car l’accès aux soins est rendu particulièrement difficile à cause de cette mobilité incessante et de la destruction des infrastructures sanitaires.

Le Gouvernement Centrafricain, avec l’appui de l’UNICEF et des Médecins Sans Frontières, organise des consultations gratuites pour les enfants dans différents sites et dans deux hôpitaux à Bangui.

Les actions sont :

- Mise en place d’un sous cluster protection avec élaboration des termes de référence et plan d’action
- Constitution d’une base de données pour les enfants séparés et non accompagnés et une autre pour ceux associés aux forces et groupes armés
Elaboration d’un plan de renforcement des capacités des acteurs (associations et ONGs) pour la prise en charge des enfants

Résultats

- 255 personnels des ONG, agents de l’État formés sur la protection de l’enfant
- 8 sur les 12 préfectures ciblées sont couvertes par le Mécanisme de surveillance sur les violations graves commises à l’encontre des enfants.
- 556 enfants séparés et non accompagnés réunifiés sur les 2000 ciblés sont réunis avec leur famille.
- 1.660 survivants du VBG dont des femmes, filles et garçons ont accès aux services holistiques (soins médicaux, soutien socio-psychologique, protection juridique) grâce à l’opérationnalisation de 19 centres d’écoute.
- 56.448 enfants ont bénéficié du soutien socio-éducatif et récréatif et la formation professionnelle.
- 1.511 enfants des 3.000 enfants visés dont 421 filles et 1090 garçons sont sortis des forces et groupes armés, pris en charge par divers partenaires (ONG nationales, internationales et Ministère en charge d’action sociale).

Qu’en est-il des enfants vivant dans les autres préfectures non ciblées que compte la République Centrafricaine ? Il m’est difficile de vous décrire dans quelle situation ils vivent, sans soins et même privés de toute condition adéquate d’apprentissage et d’instruction. L’avenir d’une nation se construit sur la formation intellectuelle et socioprofessionnelle de ses enfants.

Domaines à améliorer

A l’issue de l’évaluation des activités, certaines recommandations principales ont été formulées dont :

- Poursuivre la sensibilisation des groupes armés en RCA pour décourager la pratique du recrutement/ utilisation des enfants.
- Améliorer la couverture des besoins en relançant les activités de protection dans les préfectures/ sous-préfectures affectées par le conflit mais où il y a très peu de partenaires.
- Relancer le mécanisme étatique de coordination de la protection de l’enfant.
- Renforcer le partenariat avec le secteur de l’éducation en offrant une deuxième chance aux enfants pour faciliter la réintégration des enfants sortis des groupes armés.
- Renforcer la structure de prise en charge socio-psychologique sur le plan national.

Les efforts déployés sur le plan socio-psychologique pour accompagner ces enfants traumatisés viennent encore d’être mis à rude épreuve par les événements qui ont encore secoué Bangui ces dernier jours, avec des maisons incendiées ou détruites, occasionnant le déplacement des populations des quartiers touchés par ces violences. Ces derniers événements mettent en cause l’Accord de cessation des hostilités signé à Brazzaville le 23 Juillet dernier.

Je voudrais exprimer ma reconnaissance à l’Organisation Fraca International, pour les activités qu’elle mène à Bangui et pour avoir organisé ce symposium. Mes remerciements sont également adressés à toutes les ONG opérant sur le terrain dans des conditions d’insécurité notoires et extrêmement difficiles.

Je vous remercie

4.5. Mr Ted Chaiban, UNICEF

The representative of the UNICEF, Mr Ted Chaiban, elaborates key elements of psychosocial support to children in armed conflicts areas and specially explains how his organization responds to the needs of children in the Central African Republic.

- Thank you for inviting me today to join this distinguished panel. This is a timely issue and topic. Trends in the nature of armed conflicts and disasters are increasing both the scale and scope of protection issues affecting children and women in humanitarian contexts. After a decade of decline in the number of armed conflicts, since 2010 there has been an escalation in armed conflict globally. By 2012, more people were refugees (15.4 million) and internally displaced (28.8 million) than at any time since 1994. Nearly half of these people are children.
- In my brief remarks I will focus on three key points. First, let me elaborate the key elements of psychosocial support (PSS) programming, which aim to:
  o Reconnect children with family members, friends and neighbours;
  o Foster social connections and interactions, including in situations where children are separated from their family or community of origin;
  o Normalize daily life; including creating safe spaces for learning, play and recreation;
  o Promote a sense of competence and restoration of control over one’s life;
  o Build on and encourage children’s and community’s innate resilience to crisis, and;
  o Provide for identifying, referring and treating children with severe mental disorders.
- Globally, UNICEF reaches some 2.5 million children annually through these safe spaces which are often called Child Friendly Spaces. It is also estimated that over 3.6 million children are reached annually through Temporary Learning Spaces (TLS), which focus on learning and psychosocial support.

- Second, I would like to speak specifically to the context in the Central African Republic and areas of support. **Over 2.3 million children in CAR are affected by the conflict.** Thousands of them have either witnessed atrocities directly or have been affected by violence in an indirect way. An estimated 10,000 children are associated with armed groups, forces and militias in the country. Children have been killed, injured or raped or have been witnessed violence in some form or the other.

- In responding to the crisis in CAR to-date, we have reached nearly 100,000 children through Child Friendly Spaces (CFS) and Temporary Learning Spaces (TLS). Some 300,000 children were reached through the provision of recreation kits. Nearly 2000 children to-date were released from armed forces and supported with reintegration. **Community based networks are being supported to sensitize community members in the northern part of the country on the prevention of violence, child recruitment, and other forms of abuse against children. UNICEF also works with and through communities to build awareness and understanding of children’s protection needs and rights, including the prevention of violence.**

- Third, I would like to elaborate more broadly on the four main strategies UNICEF employs globally in responding to humanitarian crises to protect and promote children’s psychological and social well-being in emergencies.

1) **Supporting centre-based psychosocial activities for children:** This includes providing children with opportunities for safe and stimulating activities that are appropriate for their age and culture, such as sports, play and games, as well as activities that develop children’s life skills and coping mechanisms.

2) **Helping parents and other community members to better support children:** This involves parent support programmes and work with adolescent, youth and women support groups.

3) **Ensuring access to professional help for children and families with more severe psychological or psychosocial problems:** These can include behavioral problems in children, parental depression or anxiety, or abuse of drugs or alcohol, along with severe mental disorders such as post-traumatic stress disorder or schizophrenia. UNICEF generally refers these cases to specialized services.

4) **Coordinating mental health and psychosocial support:** UNICEF supports coordination at country levels and provides leadership to the Inter-agency Standing Committee Reference Group on Mental Health and Psychosocial Support (MHPSS) and is currently one of the co-chairs.

- Finally, I would like to reflect a little more on my opening comments which noted the increasing scale and scope of protection issues affecting children and women in humanitarian contexts, particularly what that means for both our ‘development’ and ‘emergency’ work. The number of ongoing conflicts around the world, notably the Middle East, has drawn the attention of the global community to a whole generation of children experiencing violence on a day to day basis with terrible consequences for their overall wellbeing. It also raise concern on the impact of conflict on children in terms of influencing their overall outlook and the way in which they relate to the external world in the long term.

- I was in CAR early this year and I remember coming under fire while visiting villages. We had to take refuge in a mud hut. When I along with other colleagues were eventually transported from the scene in UN armoured cars, I remember thinking about children in that neighbourhood who had nowhere to go and who would live on to experience violence on a daily basis. ‘Before Iraq, before Syria, before Ebola, there was CAR’, there was the protracted crisis in CAR.

Thank you.

4.6. **WHO Mental Health Action Plan 2013-2020**, by Dr Jacob Kumaresan, Executive Director WHO Office at the UN, New York

The WHO Mental Health Action Plan 2013-2020 gives a general overview on Mental Health: definition, people affected with mental disorders, the consequences of these disorders on the society, and the barriers to overcome to increase the availability of mental health services. The Action Plan also sets the objectives to reach until 2020 and the guiding principles.

Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Mental health, like other aspects of health, can be affected by a range of socioeconomic factors that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach. Mental well-being is a fundamental component of WHO’s definition of health. **Good mental health enables people to realize their potential, cope with the normal stresses of life, work productively, and contribute to**
Mental health matters, but the world has a long way to go to achieve it. Many unfortunate trends must be reversed—neglect of mental health services and care, and abuses of human rights and discrimination against people with mental disorders and psychosocial disabilities. Strong links exist between mental disorders and other chronic diseases, not only with respect to their causes and consequences, but also in terms of their prevention and management.

Around 20% of the world’s children and adolescents have mental disorders or problems. About half of mental disorders begin before the age of 14. Similar types of disorders are being reported across cultures. Neurodevelopmental disorders are among the leading causes of worldwide disability in young people. Yet, regions of the world with the highest percentage of population under the age of 19 have the poorest level of mental health resources. Most low- and middle-income countries have only one child psychiatrist for every 1 to 4 million people.

Mental and substance use disorders are the leading cause of disability worldwide. About 23% of all years lost because of disability is caused by mental and substance use disorders.

Over 800 000 people die due to suicide every year and suicide is the second leading cause of death in 15-29-year-olds. There are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide. 75% of suicides occur in low- and middle-income countries. Mental disorders and harmful use of alcohol contribute to many suicides around the world. Early identification and effective management are key to ensuring that people receive the care they need.

War and disasters have a large impact on mental health and psychosocial well-being.

Fact 5
Mental disorders are important risk factors for other diseases, as well as unintentional and intentional injury. Mental disorders increase the risk of getting ill from other diseases such as HIV, cardiovascular disease, diabetes, and vice-versa.

Fact 6
Stigma and discrimination against patients and families prevent people from seeking mental health care. Misunderstanding and stigma surrounding mental ill health are widespread. Despite the existence of effective treatments for mental disorders, there is a belief that they are untreatable or that people with mental disorders are difficult, not intelligent, or incapable of making decisions. This stigma can lead to abuse, rejection and isolation and exclude people from health care or support. Within the health system, people are too often treated in institutions which resemble human warehouses rather than places of healing.

Fact 7
Human rights violations of people with mental and psychosocial disability are routinely reported in most countries. These include physical restraint, seclusion and denial of basic needs and privacy. Few countries have a legal framework that adequately protects the rights of people with mental disorders.

Fact 8
Globally, there is huge inequity in the distribution of skilled human resources for mental health. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are among the main barriers to providing treatment and care in low- and middle-income countries. Low-income countries have 0.05 psychiatrists and 0.42 nurses per 100 000 people. The rate of psychiatrists in high income countries is 170 times greater and for nurses is 70 times greater.

Fact 9
There are 5 key barriers to increasing mental health services availability. In order to increase the availability of mental health services, there are 5 key barriers that need to be overcome: the absence of mental health from the public health agenda and the implications for funding; the current organization of mental health services; lack of integration within primary care; inadequate human resources for mental health; and lack of public mental health leadership.

Fact 10
Financial resources to increase services are relatively modest. Governments, donors and groups representing mental health service users and their families need to work together to increase mental health services, especially in low- and middle-income countries. The financial resources needed are relatively modest: US$ 2 per capita per year in low-income countries and US$ 3-4 in lower middle-income countries.
The challenge for countries is therefore not simply to scale up existing health services, but also to transform health systems by implementing evidence-based approaches for integrated, effective, and efficient care for mental disorders and other chronic diseases.

The Global Mental Health Action Plan of WHO 2013-2020 has the following objectives:
1. to strengthen effective leadership and governance for mental health;
2. to provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
3. to implement strategies for promotion and prevention in mental health;
4. to strengthen information systems, evidence and research for mental health.

Following six cross-cutting principles and approaches in the Global Mental Health Action Plan:

Universal health coverage: Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

Human rights: Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

Evidence-based practice: Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.

Life course approach: Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.

Empowerment of persons with mental disorders and psychosocial disabilities: Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

Multisectorial approach: a comprehensive and coordinated response for mental health requires partnerships with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well the private sector, as appropriate to the country situation.

4.7. The contribution of the Brothers of Charity to the Mental Health Care in Africa, by Bro. Dr René Stockman, Superior General of the Brothers of Charity and President of Fracarita International

In his speech Brother Dr René Stockman went through the history of Post-traumatic Stress Disorders (PTSD), explained the meaning of the disorders, their symptoms and the adapted therapy. He based his comments on the experience of the Brothers of Charity in Central Africa. At the end of his speech he revealed the plan of Fracarita International to start a Centre for Children and adolescents with post-traumatic stress disorders in the Capital city of the Central African Republic.

Excellences,
Distinguished Guests,
Ladies and Gentlemen,
It is a real honour for me as general superior of the Brothers of Charity and chairman of Fracarita International to be present here in order to share our experiences in the field of mental health care worldwide, with the focus on our development of initiatives in Africa and today with a special focus on the treatment of children and adolescents with post-traumatic stress disorders.

The Brothers of Charity are present in Africa in the fields of education, mental health and the care for people with a disability in the following countries: Central African Republic, Ivory Coast, Democratic Republic of Congo, Zambia, South Africa, Ethiopia, Kenya, Rwanda, Burundi and Tanzania.

From the late 60s of the previous century onwards, the Brothers of Charity were involved in the development of mental health care in the Great Lakes region of Central Africa. It started in 1967 with the creation of the first and only psychiatric hospital in Rwanda, Caraes Ndera, followed by the Kamenge Neuropsychiatric Hospital in Bujumbura, Burundi in 1980. Following the genocide in Rwanda in 1994, several centres were established in the Kivu region of DRC in Bukavu, Goma, Shabunda and Uvira, and in the Kigoma region of Tanzania with Kasaka and Marumba.
In Rwanda, we set up a new centre in Butare, and two new centres were recently started in Burundi: in Gitega and in Ngozi. At the same time, efforts were made to decentralise the services by empowering the general hospitals and the health centres with more specialised staff in the field of mental health. In Kigali, Rwanda we opened a special unit for PTSD and substance abuse called the ‘Icyizere Psychotherapeutic Centre’, and we created special wards for children and adolescents.

Every time we start with a new initiative, we follow our own strategy.

We start with the care for chronic psychiatric patients with attention for community-based rehabilitation.

We start with training of local staff.

In many places there are no trained workers in mental health care, so training is becoming really a key-activity from the beginning.

This training is organised by our international NGO Fracarita International and based on exchange programs on the international level.

As a next step we try to give information about psychiatric disorders and mental health care because on so many places there is still a huge taboo and stigma on psychiatric patients.

I can refer that yesterday we could give our Dr Guislain Award here in New York. With this award we like to focus on initiatives worldwide which try to put down the stigma on mental disorders in a successful way.

We name this award: ‘Breaking the chains of stigma’.

Gradually, when we have more specialised manpower, we can start with the treatment of more acute psychiatric patients and also start with the decentralisation of our care.

Finally, we keep an openness of specific needs in the field of mental health. We can think here on drug-abuse, but also on post-traumatic stress disorders.

During the past 45 years that we have been active in these regions, we have been constantly confronted with post-traumatic stress disorders, because of the weak political situation of these regions and the ethnic problems that are constantly present, especially in Rwanda and Burundi.

Victims of the genocides, veterans, child soldiers, refugees and victims of sexual abuse are our centres’ clients, and gradually, we have developed a more adapted treatment for these victims.

Today, we are being asked to start an initiative in the Central African Republic, where recently a severe war situation has displaced so many inhabitants and where we are confronted with a very severe situation of children and adolescents who have currently lost all perspectives in their lives.

Let us now go deeper into these post-traumatic stress disorders.

Post-traumatic stress disorders were first mentioned in history – without using the term as such – in the beginning of the 19th century when French psychiatrist Philippe Pinel gave a description of traumatic neuroses in his work ‘Traité pour l’humanisation du traitement des aliénés’.

During the second part of the 19th century, there was an increase of interest, and both in France and in England they studied the post-traumatic reactions linked to railway accidents. In 1884, Herman Oppenheim, a German neurologist, brought them together under the name ‘traumatic neuroses’.

During the 20th century, interest continued to grow, particularly among psychologists like Sigmund Freud, Pierre Janet, and others, and they started the first psychotherapeutic treatments of mainly old traumas, by means of hypnosis and psychoanalysis.

During the Russo-Japanese War of 1904-1905, it was the first time that they took a special interest in traumatic situations, linked to situations of war.

By the end of last century, especially in the 1980s, following the traumatic situation of many Vietnam veterans, the DSM-III introduced it as ‘Post-Traumatic Stress Disorder’, also known by its acronym ‘PTSD’.

Post-traumatic stress disorder is a condition that is caused by being exposed to a traumatic event resulting in feelings of fear, distress, and horror. The disorder manifests itself in a persistent re-experiencing of the traumatic event, avoidance of stimuli associated with the trauma and a general numbing of responsiveness.
Post-traumatic stress disorder is also defined as a psychological defence strategy, a kind of mental anaesthesia produced to protect the individual from the awful memory of an event that has provoked fear, panic, distress, and horror.

The person who develops post-traumatic stress disorder might be the victim of the event. He or she might be a witness to an accident involving a loved one or to a catastrophe involving multiple victims. It does not just affect the victims of such events for that matter, it can also affect secondary victims.

The trauma is therefore a significant emotional shock, generally linked to a situation in which a person or a group of people have felt their lives to be in danger, which affects a person's mental balance.

According to this definition, the traumatogenic situation occurs in a massive and abrupt way. It is out of the ordinary, exceptional, and severe, and draws people into a spiral of violence. Think of natural disasters, epidemics, and acts of war.

We can distinguish 4 types of trauma.

4 TYPES OF TRAUMA

- Unique trauma
- Repeated trauma
- Violent events during a long period
- Ongoing trauma

Type 1 trauma: Unique trauma

A unique traumatic event with a distinct beginning and a clear ending. This type of trauma is induced by an acute, non-abusive stress agent.

Examples: assault, fire, natural disaster.

This trauma can have long-term consequences.

Type 2 trauma: Repeated trauma

The event reoccurred, it was constantly present or it threatened to repeat itself continually during a long period of time.

Examples: intra-familial violence, political violence, acts of war, sexual abuse, torture, etc.

Type 3 trauma: Violent events during a long period

Multiple overwhelming and violent events present during a long period of time. These are induced by a chronic or abusive stress agent.

Examples: prisoner-of-war and concentration camps, torture, forced sexual exploitation, intra-familial violence and sexual abuse.

Type 4 trauma: On-going trauma

Currently on-going trauma, happening in the present.

Examples: kidnapping, acts of war, deadly epidemics, famine, etc.

Trauma linked to armed conflict.

War is a menacing situation for every single person. It raises vital issues with regard to people's physical integrity, the preservation of their property, the integrity of the national territory, the country's economic and political autonomy, etc.

In this context, precise attacks and threats will jeopardise a person's life and mental balance.

Traumatic factors include:

- Death threats, injuries, suffering, torture, violence, witnessing the deaths of others, witnessing the suffering of others, witnessing destruction.

If you would bring together different studies on PTSD, the following traumatic events could be indicated:
According to the World report on violence and health, war is ranked 11th on the list of the leading causes of death in Africa in 2000, which represents 1.6% of all deaths on the continent.

The immediate effects of violence first result in physical injuries and death, reaching enormous proportions in the local population, even on a national level. In Rwanda, more than one million people were massacred in just 100 days, which is close to ten thousand people who were murdered every day.

In total, the wars in Africa are responsible for more than half of all conflict-related deaths all over the world. Over the course of the year 2000, 167,000 of the 310,000 deaths, which is close to 54% of all people having succumb to war injuries all over the world, were reported in Africa alone.

In addition to the numerous deaths and people injured, some of whom are disabled for the rest of their lives, survivors find themselves in an physical and psychosocial environment that is not theirs, often hostile and harmful to their health.

Also, we must not forget about all transmissible infectious diseases linked to situations of war.

Physical and emotional scars can result from physical and psychological torture, rape and sexual assault, often committed during times of civil wars.

A specific situation is the displacement of a population as a consequence of war. Indirect consequences of collective violence particularly include the massive displacement of populations.

The annual report of the Office of the United Nations High Commissioner for Refugees entitled 'Global Trends' points out that there are 11.4 million refugees and 26 million internally displaced persons all over the world.

It is established that massive displacement of civil populations constitutes as one of the major consequences of collective violence today.

It is for these groups that both in Tanzania and Congo, the BOC started to work in refugee camps, with a special attention for education programs, health care programs and of course with a special attention to mental health care.
With regard to mental health, multiple studies indicate that internally displaced persons constitute a category of very vulnerable individuals. On average, they have more symptoms of post-traumatic stress.

Symptoms

We speak of post-traumatic stress syndrome when the symptoms last for more than one month.

Therapy is necessary as:
- 30% of the people suffering from post-traumatic stress run the risk of developing depression;
- 25% develop anxiety disorders (panic attacks, obsessive-compulsive disorder, general anxiety, phobias, etc.);
- 50% abuse alcohol, medication or drugs, or develop a number of avoidance behaviours linked to the trauma.

In our experience, we have several groups of post-war victims with mental problems in the countries of Central Africa where we are present: veterans, victims of the genocide in Rwanda and Burundi, child soldiers, displaced persons, both inside and outside of the country, living in camps.

In these countries, 30% of the veterans have physical disabilities and 5% have symptoms of PTSD.

For them, we developed activities on 2 levels:
- on an individual psychological level, with narrative therapy, interpersonal therapy and sociotherapy;
- on a social collective level, where personal stories are used in educational programmes.

A special group are the child soldiers.

A certain number of factors lead to the recruitment of child soldiers. For some, particularly orphans and children who were separated from their families, it is about a calculated choice for survival, a way to earn a living, to protect themselves, and in some cases, to seek revenge. Children and adolescents are also actively being recruited by leaders of armed groups by means of ideological or political incentives. Children of the DRC can be soldiers, bandits, sex slaves, spies or cooks.

The effects of the trauma stem from the children’s exposure to situations that put their lives in danger, such as combat, death and injuries of soldiers, sexual violence, and torture. The children also see other children that are killed or injured.

As a form of therapy, these children are brought to rehabilitation centres where they receive psychological support and where they have the occasion to regain their childhood by being in contact with other children and the staff. At these centres, we work on identification, family research and reunion, family mediation, medical care, teaching them how to read and write, civic education, and reintegration. Several counselling and therapy techniques are used, including active listening, artistic therapy, theatre and dance, sports, and preparing for an active life.

In 1994, Rwanda experienced the genocide, which left the population with high levels of anxiety. Almost a third of its population has one or more symptoms of post-traumatic stress disorder and other related disorders. Some are using alcohol and other substances in order to forget the horrible experiences they had and to calm down their anxiety. Two thirds of all patients who are admitted to our centres in Rwanda with substance-induced mental illnesses have previously had either emotional disturbances or symptoms of PTSD.

In order to take care of these patients in a better way, a special centre was created in Kigali in 2004: the Icyizere Psychotherapeutic Centre, with a special mission of offering comprehensive care to patients suffering from PTSD and related disturbances.

A film will be shown and you find this film also on a stick.
In our further planning, we’d like to start with an initiative in the Central African Republic, where after the severe war situation, no less than 2 million children are suffering the consequences of the crisis that erupted last year.

For them, we plan to start with a centre for children and adolescents with post-traumatic stress disorders in the capital Bangui.

As Brothers of Charity, we are already active in the prisons of Bangui in developing social and pastoral services. Part of our activity is the care for psychiatric patients in these prisons.

This new initiative can only be realised through collaboration. Collaboration between Fracarita International, Unicef, King Baudouin Foundation, the local government, the catholic church and others.

Let us end with some images of the lifesituation of people in Bangui.

Many are living in refugee camps. Many lost their houses, and these destructions are still going on!

We see refugees living in the streets.
And of course also psychiatric patients are running around without any kind of care or treatment.

Conclusion

Respected audience,

For more than 200 years, as Brothers of Charity, we try to develop concrete answers to needs in the field of mental health. 200 years ago we liberated the psychiatric patients who were in chains in Ghent – Belgium. ‘To break the chains’ became a red file through our activities. Again and again we have to fight against the huge stigma that is linked to psychiatric disorders. We have to break the chains of stigma. And once again we are confronted with new situations where vulnerable persons are becoming the first victims. We cannot describe the suffering of all these people, children, adolescents and adults who are today the victims of severe war situations in Africa. The post-traumatic stress disorder is a heavy burden and is at the origin of many other mental and physical troubles. Only with an adapted treatment and care we can help these people to regain their place in the society. We cannot close our ears and our eyes for the cry of so many today in the Central African Republic. We hope we can give them a helping hand with charity and professional care.
5. Biography of the speakers

5.1 Biography of Bénédicte Frankinet, Permanent Representative of Belgium

(Based on information provided by the UN Protocol and Liaison Service)

Bénédicte Frankinet, the new Permanent Representative of Belgium to the United Nations, presented her credentials to UN Secretary-General Ban Ki-moon on March 13th, 2013.

Before her appointment, Ms. Frankinet was Ambassador to Israel since 2008, after she previously served as Director for the United Nations at the Ministry of Foreign Affairs in Brussels from 2003.

From 1999 to 2003, Ms. Frankinet was Ambassador to Zimbabwe, accredited also to Mozambique, Malawi and Zambia. Between 1994 and 1999, she served as Counselor, then Deputy Head of Mission at her country’s Embassy in Paris.

In 1992, Ms. Frankinet was an adviser in the private office of the Minister for Foreign Affairs, and from 1988 to 1992, she was First Secretary at Belgium’s Permanent Representation to the European Communities in Brussels.

She served a previous stint, between 1983 and 1988, at the New York Permanent Mission as First Secretary, and was an attaché in Brasilia from 1979 to 1983.

Ms. Frankinet holds degrees in political science, social science and journalism from the Free University of Brussels.

Born on 23 July 1951, she is married and has two children.
Ms. Leila Zerrougui is the Special Representative of the Secretary-General and Armed Conflict since July 2012.

Ms. Zerrougui had been the Deputy Special Representative of the Secretary-General and Deputy Head of the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO), where, since 2008, she spearheaded the Mission’s efforts in strengthening the rule of law and protection of civilians.

As a legal expert in human rights and the administration of justice, Ms. Zerrougui has had a distinguished career in the strengthening of the rule of law and in championing strategies and actions for the protection of vulnerable groups, especially women and children.

Ms. Zerrougui was a member of the Working Group on Arbitrary Detention under the United Nations Human Rights Council from 2001, and served as the Working Group’s Chairperson-Rapporteur from 2003 until May 2008. She had previously served as an expert member of a number of working groups and committees under the Commission on Human Rights.

Prior to her international engagements, Ms. Zerrougui has had a longstanding career in the Algerian judiciary and in 2000, was appointed to the Algerian Supreme Court. She served as a juvenile judge and judge of first instance from 1980 to 1986, and as appeal court judge from 1986 to 1997. From 1998 to 2000, Ms. Zerrougui served as legal adviser to the Cabinet of the Ministry of Justice.

Ms. Zerrougui graduated from the Ecole Nationale d’Administration (Algiers) in 1980. Since 1993, she has held various academic positions at law schools in Algeria, and was associate professor of the Ecole Supérieure de la Magistrature (Algiers). She has published extensively on the administration of justice and human rights.

Ms. Zerrougui was born in 1956 in Souk-Ahras, Algeria.
Source: United Nations
Omar Hilale (Arabic: عمر هلال; born 1 January 1951 in Agadir) is a Moroccan career diplomat. He is the current Morocco's Permanent Representative to the United Nations in New York, after he was appointed in this position on 14 April 2014, replacing Mohammed Loulichki. He previously was the permanent representative of Morocco to the UN in Geneva.\(^2\)

Hilale is a graduate of the Mohammed V University in Rabat where he obtained a bachelor in political science in 1974. He served in many diplomatic posts such as Ambassador in Singapore, New Zealand, Australia and Indonesia, between 1996 and 2001. He was the General Secretary of the Ministry of Foreign Affairs and Cooperation between 2005 and 2008. In November 2008 he became representative of Morocco to the UN in Geneva.

Source: Wikipedia, the free encyclopedia
La nouvelle Représentante permanente de la République centrafricaine auprès des Nations Unies, Mme Ambroisine Kpongo, a présenté aujourd'hui ses lettres de créance au Secrétaire général de l'ONU, M. Ban Ki-moon.

Mme Kpongo a été Ministre déléguée aux affaires étrangères de janvier 2009 à avril 2011, après avoir été Directrice générale des affaires politiques de juillet 2000 à janvier 2009 au Ministère des affaires étrangères.


Mme Kpongo est titulaire d’un diplôme en relations internationales qu’elle a obtenu à l’Université libre de Bruxelles (ULB) en 1980.

Elle est née le 11 novembre 1951 en République centrafricaine.
5.5 Biography of Mr. Ted Chaiban

Ted Chaiban, Director, Programme Division (PD), New York: Mr Chaiban has had a distinguished career at UNICEF, serving in a number of leadership positions in New York, East Africa, Middle East and South Asia. In his previous role as Director, Office of the Emergency Programmes (EMOPS), Mr Chaiban has been dynamic and effective in supporting timely, streamlined and reliable responses to the growing number and scope of humanitarian emergencies around the world, while further strengthening UNICEF’s collaboration with UN and other partners. Prior to this, Mr Chaiban provided strong leadership as Representative in countries with large and complex programmes such as Ethiopia, Sudan and Sri Lanka.
5.6 Biography of Dr Jacob Kumaresan, Executive Director of World Health Organization office at the United Nations in New York

Jacob Kumaresan, MD, DrPH is currently Executive Director, WHO Office at the United Nations in New York. Earlier he was Director at World Health Organization Centre for Health Development in Kobe, Japan from 2008-2011 and president of the International Trachoma Initiative, a non-profit organization dedicated to eliminating the leading cause of preventable blindness from 2003-2007. He joined World Health Organization headquarters in Geneva 1992, where he eventually headed the Stop TB Partnership expanding efforts to meet the global targets to control tuberculosis. He has widespread public health experience and worked with the governments of Zimbabwe and Botswana during 1980s.
5.7 Brother Réne Stockman, PhD, General Superior of the Congregation of the Brothers of Charity and President of Fracarita International

Brother Réne P. E. Stockman f. c. was born on May 13, 1954 in Assenede (Belgium). He is General Superior of the Congregation of the Brothers of Charity and has an enormous experience in Mental Health.

He joined the Congregation in 1972, studied medical and social sciences, management of hospitals and has a doctors degree he obtained at the Catholic University of Louvain (Belgium) in 1986.

Brother Réne Stockman began his professional activities in 1976 as Nursing manager of the Health Care department at the Saint-Julian Psychiatric Institute that later became the Dr Guislain Psychiatric Centre. From 1982 until 1988, he served as General Director of the Dr Guislain Psychiatric Centre. In 1988, he was appointed General Manager of all Psychiatric Centres and all Institutes for people with a Mental Disability of the Brothers of Charity in Belgium, a position he held until 1994. During this period, he was also member of the Provincial Council of the Belgian Province of the Brothers of Charity. In 1994, he was appointed Provincial Superior of the Belgian Province of the Brothers of Charity. He held the position until 2000 when he was elected General Superior of the Congregation of the Brothers of Charity for a six-year term. He was reelected to this post in 2006 and 2012. He resides in Rome.

In 1980 Brother Réne Stockman was appointed Director of the Institute for Psychiatric Nursing Guislain, in Gent (Belgium). He combined this function with that of lecturer at the same institute until 1988, but continued to teach there until 2000. In 1986 he founded the Museum Dr Guislain in Gent and is since then its curator. In 2011 he founded Fracarita International as an international NGO for development cooperation of the Brothers of Charity and is since then its President.

Brother Réne Stockman also served as managing director of several organizations that don’t belong to the Brothers of Charity and as lecturer at several Health Institutes in Belgium such as the Medical School, Catholic University of Louvain. He is now visiting lecturer at the Kigali Health Institute in Rwanda, the Catholic University of America, Washington (USA) and the Lateran Pontifical University, Rome (Italy).

On 29 January 2013, Brother Réne Stockman was made Commander in the Order of Leopold (Belgium).

He has published on religious and social-economic issues.
6. Fracarita International and the Central African Republic (CAR)

At the request of the local bishops, our Congregation has been involved in this Central African Republic (CAR) for several years now. Following a few exploratory visits in 2003, 2005, and 2007, the General Council decided to start a community of Brothers in Capital city, Bangui.

Mission

The archdiocese of Bangui has charged the Brothers of Charity with chaplain work in the Bangui prisons (Ngaragba men’s prison and Bimbo women’s prison). The Brothers of Charity will also work with other organisations and religious workgroups that focus on helping prisoners in order to achieve harmonious relief work on a pastoral level, preparation of sacraments, health care, hygiene, and human rights. The Central African government has asked the Brothers of Charity to make sure that the situation of the inmates improves by developing adapted activities such as socio-cultural activities, sports, educational activities, vocational guidance, literacy projects, civil and agro pastoral education.

Two football teams within the Ngaragba prison

Fracarita International, the international NGO for development cooperation of the Brothers of Charity, recently opened an office in Bangui to coordinate the projects of the Congregation in the CAR.
7. Dr. Guislain Award: Breaking the chains of stigma

Fracarita International celebrates each year the World Mental Health Day on October 10th. At this occasion it organises activities in the Psychiatric Centres and other institutes of the Brothers of Charity worldwide. The aim is to inform people about mental health and sensitize the public about mental illness in order to break the chains of stigma associated with them.

Fracarita International and the Dr Guislain Museum, which also belongs to the Brothers of Charity, work tirelessly together to stand up for the rights of patients worldwide and to help improve their social position. In this regard, the Dr Guislain Museum initiated 'the Dr Guislain Award' in 2012 with the support from Janssen Research & Development, LLC ("Janssen") to honour an individual, project or organization that has made an exceptional contribution to reducing the stigma associated with mental illness. Since then, the Museum organises every year an award ceremony. For more information, please click here and visit our website (www.fracarita-international.org).

Winner Dr. Guislain Award 2014: Robin Hammond
New York, 09/10/2014

On the 9th of October Robin Hammond, a documentary photographer and filmmaker, has been selected as the 2014 winner of the Dr. Guislain "Breaking the Chains of Stigma" Award for his striking photojournalism that exposes the mistreatment of mentally ill people in African nations in crisis. The award winner receives a $50,000 prize that must be used toward further work to reduce societal stigma about mental health and disorders of the brain. Hammond’s body of work will be honored today at a ceremony in New York City.

"The Dr. Guislain Award is proud to honor the work of advocates like Mr. Hammond who have illuminated the fight against stigma related to mental illness," said Siri Hustvedt, jury member of the Dr. Guislain Award selection committee and internationally known author of twelve books, including an account of her own neurological illness. "Through the power of photography, Hammond has raised crucial awareness of the challenges faced by people with mental illness in countries were mental health care is under-resourced or nonexistent."

For people with mental disability in war, in displaced populations, in regions wracked by corruption, life is dire. I didn’t know this before January 2011. While covering a story for a newspaper I found a section of a prison in South Sudan where the inmates were naked and shackled to the floor: they had mental disabilities. They had committed no crime.

I had never thought about the long term consequences of disasters. We cover wars, famines, natural disasters, and displacements of people on the continent. Once the peace treaty is signed, the emergency food relief delivered, the flood waters have receded, we leave. For the media the story is finished. The suffering is not. Deep psychological scars remain, and when the dust settles, the facilities and staff to support the mentally disabled often no longer exist.

Discovering the incarcerated mentally ill in South Sudan started me on a journey to investigate other troubled regions. Over the course of three years, in ten different African countries, I documented the mental health impact of crises. In countries in war, in refugee camps, in mental health facilities in regions sucked dry by corruption, and in countries with dysfunctional health systems, I discovered a population confined to the dark corners of churches, chained to rusted hospital beds, kept behind bars in filthy prisons.

At the heart of the issue is overwhelming stigma attached to mental illness. It means that many people living with these disabilities are not seen, their voices are not heard. It is not that they do not have the ability to advocate for themselves, it is that they are not allowed to, after-all, they are ‘crazy’. Because of this, the enormity of the problem is hidden. The World Health Organization says one in three Somalis will suffer a mental illness in their lifetime. In countries in crisis stigma results in an entire section of communities at best, overlooked by their own society, at worst, the victims of severe maltreatment.

My photography project 'CONDEMNED' endeavours to bring the neglect and abuse they suffer to light, to advocate on their behalf, to give them the voice they have been denied. Statistics become faces, people have names, the de-humanised become human.

Precedents exist of attitudes, practices, and policies being affected by art and media movements. Aids, famine, Blood Diamonds, the Vietnam War, even slavery - campaigns have inspired enormous change.

This initiative is just as ambitious: to create a movement to raise awareness and end the stigma infecting all parties from the smallest African village, right up to the World Health Organisation.

With the help of The Dr. Guislain Award I will be able to make the light on this issue shine brightly. With still and moving images I will document those working, with little or no support, on mental health in African countries in crisis. These humble ambassadors of hope will provide an avenue for change countering the scenes of horror I present in my earlier work. They
will feature in an awareness raising campaign that will spearhead a giant leap towards influencing public opinion and targeting policy makers. With the help of The Dr. Guislain Award I will drag this issue out of the darkness - no longer will ignorance be an alibi for inaction.

I left South Sudan in January 2011 with a prison cell full of innocent people weighing heavily on my mind. The hardest part of making this work is knowing that three years later, most of them are still there.

With the aid of this award we can free them from their shackles. It may take time, and it will certainly take work, but I believe that once people see, they will care, and when they care, they will act to break, one link at a time, the chains of stigma.
Psychiatric home care for a young patient by the team of the Comisión de Salud Mental de Ayacucho (COSMA) in Peru, a mental health care centre of the Brothers of Charity in the Andes.

Websites:

www.fracarita-international.org
www.unicef.org
www.who.int
www.un.org