STORIES OF CHANGE IN FOUR COUNTRIES

Building capacity for integrating mental health care within health services across humanitarian settings

World Health Organization

mhGAP

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Executive summary

Stories of change from four countries: Building capacity for integrating mental health care within health services across humanitarian settings advocates for the importance of building mental health care in humanitarian emergency settings by describing efforts to do this in four countries.

The report includes three sections, the first describing the importance of scaling up mental health care in emergency contexts, the second outlining case studies ("stories of change") to scale up the Mental Health Gap Action Programme (mhGAP) programme in four settings and the third describing lessons learned by stakeholders.

Section 1: Introduction

The first section of this report details the rationale for building capacity for integrating mental health services in primary and secondary general care settings in the context of humanitarian emergencies. Currently there are vast numbers of people in need of humanitarian assistance, many of whom experience considerable distress and impairment. A subset of these individuals also experience mental, neurological or substance use (MNS) conditions. However, services and supports for these individuals remain extremely scarce in many emergency contexts. Scalable approaches to providing mental health and psychosocial support (MHPSS), which should include approaches to integrating mental health in primary care settings, exist and have been developed to address these problems. The World Health Organization (WHO)'s mhGAP Intervention Guide (mhGAP-IG) and mhGAP Humanitarian Intervention Guide (mhGAP-HIG) are key tools for increasing access to mental health care in primary care settings. However, barriers to implementing these approaches, such as limited organizational capacity reported by certain humanitarian actors, have hindered their uptake. To address this issue, WHO and International Medical Corps (IMC) partnered to initiate the mhGAP-HIG capacity-building project in 2018.

Section 2: Stories of change

The second section of the report details stories of change in building mental health systems in four countries. Three of these contexts were conflict-affected regions, while a fourth was a setting where risks for emergencies are high and many development challenges persist.

Libya

Between 2011 and 2019, Libya's international ranking on the Human Development Index fell 43 places due to conflict, challenges in its governance system and associated humanitarian needs. The mental health system has struggled due to years of underdevelopment. However, a coalition of partners, including the Ministry of Health, the National Centre for Disease Control (NCDC) and WHO, have collaborated to strengthen the capacity of local mental health professionals and systems, to reduce stigma experienced by people with

mental health conditions and to coordinate effective mental health care activities, including implementation of mhGAP programmes. In 2019, supported by guidance and training through WHO and IMC's mhGAP-HIG capacity-building project, and in collaboration with government, the International Rescue Committee (IRC) and IMC began rolling out the mhGAP-HIG in selected areas of the country. These efforts have resulted in many important changes, including contextualization of mhGAP-HIG materials, increased workforce capacity, the development of mobile response teams, strengthened referral pathways between community providers and health system facilities, increased access to services for refugees and migrants, and new systems for monitoring service usage. In addition, internal agency changes have been achieved to improve the response capacities of the non-governmental agencies involved, including the addition of certain psychotropic medications to IRC's essential medications list. Linked to initiatives to strengthen the system in the country, such as the recent Strengthening the Coordination and Availability of Libyan Effective (SCALE) Mental Health Care in primary health care (PHC) services project, these efforts represent progress towards building a sustainable mental health system in Libya.

South Sudan

South Sudan began its statehood in 2011 as one of the least developed countries in the world, due to decades of intercommunal violence, civil war and political instability. The country faces many challenges in meeting the mental health and psychosocial needs of the estimated 2.5 million people who may be experiencing mental health conditions. In response, WHO has provided support to the South Sudan Ministry of Health and other stakeholders in building the mental health system. These efforts include strengthening coordination mechanisms across humanitarian actors, supporting the planning of MHPSS operations in the country and establishing an mhGAP operations team at the national level, while building workforce capacities to provide care for persons with MNS conditions at the level of primary care. These efforts have resulted in significant changes, including an update to the essential medications list for South Sudan and significant improvements in systems for capturing routine data on mental health conditions and service usage. As part of these efforts, the International Non-Governmental Organization (INGO) Medair, which was working in South Sudan, was invited to participate in the mhGAP-HIG capacity-building project run by WHO and IMC. With support from partners and WHO, Medair began implementation of mhGAP-HIG in Leer county in Western Upper Nile state while effectively addressing many challenges including difficulty in identifying qualified personnel, limited initial buy-in, social stigma and logistical challenges due to the county's remote location and poor infrastructure. Through these efforts, Medair has supported the development of a functional local mental health system linked with other national and regional structures.

> **THREE OF THESE CONTEXTS WERE CONFLICT-AFFECTED REGIONS, WHILE A FOURTH WAS A SETTING WHERE RISKS FOR EMERGENCIES ARE HIGH AND MANY DEVELOPMENT CHALLENGES PERSIST**

Ukraine

Ukraine has a mix of stable and humanitarian settings within its national borders. Many system-wide challenges, such as overly centralized mental health services, limited funding, social and practical barriers, and perceptions among some providers that mental health care can only be provided by those with highly specialized training and resources, have limited accessibility to mental health care for Ukrainians. As part of wider reform efforts focused on scaling up care at the primary level, the country's Ministry of Health, WHO and other partners have engaged in efforts to reform the mental health system to make it more accessible. These efforts include developing a consensus-based national concept for mental health services which heavily prioritizes mhGAP implementation, establishing an mhGAP operations team, adapting the mhGAP model to the Ukrainian context, and training PHC workers to provide basic care for persons with MNS conditions. More recently, international organizations working in the conflicted-affected eastern regions of the country, including IMC and Médicos del Mundo (MdM), have participated in mhGAP-HIG capacity-building. Initial implementation of mhGAP by these agencies has resulted in considerable impact, including strengthened referral links between rural villages and urban centres, increased appreciation for community-based mental health care by specialist providers and advanced capacities in rural health care facilities to care for MNS conditions at the PHC level. In the context of WHO's Special Initiative for Mental Health (SIMH), these advances potentially provide a key foundation for further shaping and reforming Ukraine's national mental health systems.

Belize

While it is currently not an emergency setting, Belize faces many challenges, such as high poverty rates, increased susceptibility to natural disasters and a growing influx of refugees and migrants fleeing violence and other hardships in Central and South American countries. The country's mental health system is particularly underfunded and as a result the workforce has been limited to a significant degree. Starting in the 1990s, the Ministry of Health, the Pan American Health Organization (PAHO), WHO and other partners have implemented a model of community-based care where most mental health services are provided by psychiatric nurse practitioners (PNPs) operating at district level. Yet despite the effectiveness of this system in scaling up care many gaps remain, including a hesitancy for mental health services to be offered by other providers, an overreliance on referral or medication and limitations in capacity across many facilities. To address these issues, the San Ignacio Community Hospital participated in the mhGAP-HIG capacity-building project. The hospital had no financial or administrative support by way of allocated professional time but was still able to achieve success in the project through didactic and on-the-job training, and ultimately it succeeded in increasing access to services for persons with MNS conditions.

Section 3: Lessons learned

Despite many variations and unique challenges in each of the contexts described, numerous similarities in the stories and the factors that contributed to success can be identified. These lessons are highlighted here and discussed further in the report.

1. **Programmatic support** can be key to initiating change in contexts where there are many competing priorities and resources are limited. In each of the four cases, WHO contributed technical support to various stakeholders and collaborated on moving mental health initiatives forward, both through mhGAP implementation and through wider policy support, capacity-building, coordination and other system strengthening actions.

2. **Providing formal recognition for training** of health-care providers can be crucial to ensuring mhGAP uptake. In each of the cases described in this report, efforts by stakeholders to ensure that training was recognized were crucial to increasing uptake and buy-in for the project.

3. **Emphasizing wider system development and sustainability** is crucial for ensuring that an mhGAP project is successful and lasting. WHO emphasized system strengthening and sustainability throughout efforts in the countries selected. This long-term view was also transferred to other participants in mhGAP-HIG capacity-building projects.

4. **Advocacy and awareness raising are critical** to ensuring that stakeholders are supportive of implementing a project and that community members are able to access the services provided. This includes generating buy-in from both local communities and affected persons as well as from local, regional and national governmental authorities. Cultivating local champions who can lead these efforts can be crucial to success.

5. **Establishing working relationships** can also lead to greater collaboration and trust among partners, which is essential for timely and effective implementation. This lesson was demonstrated in varied ways in each of the case studies, where prior working relationships and trust between stakeholders were key to advancing priorities.

6. **Engaging coordination mechanisms,** such as MHPSS technical working groups (if in place), contributes to project success. In three of the four cases, coordination was helpful given the number of actors involved and the threat of duplication and inefficient use of resources without coordination.

7. **Adaptation of materials, training structures or service provision approaches** is vital to ensuring that contextual needs are met within the limits of local resources. This may be particularly true in settings that have fewer human resources available or limited administrative support.

8. **Engaging both general practitioners and specialists can increase confidence and help to build the mental health system.** By demonstrating the usefulness of mhGAP at the primary and secondary general care levels, systems can be strengthened by building confidence and familiarity across levels of care.

Introduction

Background

The world is facing an unprecedented range of emergencies. At the end of 2020, there were 235 million people in need of humanitarian assistance across the world *(1)* and nearly 80 million people had been forcibly displaced from their homes due to warfare and conflict *(2)*, the highest numbers since the Second World War. Adding to the urgency of these circumstances is the fact that many of those affected are living in countries or territories severely affected by food insecurity and malnutrition, where opportunities for education, employment or economic advancement are scarce and where health systems are fragile and often cannot provide many of even the most essential services.

Each of these considerable adversities has been badly exacerbated by the global impact of COVID-19. The pandemic has triggered the deepest global recession since the 1930s, has massively strained and stressed health services in every country, has greatly worsened food insecurity and has highlighted the deep social inequalities that leave many people vulnerable around the world, particularly in emergency settings. In reaction to these complex adversities, many people surviving in humanitarian settings experience considerable distress and impairment, and some may go on to develop mental health conditions. Meanwhile, those with pre-existing mental health conditions may experience a worsening of their condition and are at risk of neglect, abandonment, abuse and lack of access to support. A recent meta-analysis indicated that one in five persons exposed to conflict in the last 10 years experiences some form of mental health condition *(3)*. This figure is particularly concerning because, in humanitarian contexts, health systems can be quickly overwhelmed and may struggle to address competing demands. Access to specialists is often extremely limited and medication supply chains may become significantly disrupted. Moreover, limited human and financial resources, poor governance, stigma and cultural factors can present further barriers to maintaining a health system that includes mental health services. As a result, mental health needs risk being overlooked almost entirely in many humanitarian settings.

Fortunately, suffering can be reduced and mental health and psychosocial well-being can be addressed through varied forms of mental health and psychosocial support (MHPSS), which can be effective, low-cost and low-intensity, and thus potentially scalable. The Sphere standards and the Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings both underline that humanitarian assistance should address mental health and psychosocial issues through intersectoral actions, which may include informal and community-led supports, as well as more formal mental health services integrated within wider health systems (see Figure 1).

> SUFFERING CAN BE REDUCED AND MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING CAN BE ADDRESSED THROUGH VARIED FORMS OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Mental health care by mental health specialists (psychiatric nurses, psychologists, psychiatrists, etc.)

Specialized services

Basic mental health care by primary health care doctors or social and livelihood programmes for survivors of gender-based violence

Focused (person-to-person/group) non-specialized supports

Activating social networks. Supportive child-friendly spaces. Communal traditional supports

Strengthening community and family supports

Advocacy for basic services that are safe, socially appropriate and protect dignity

Social considerations in basic services and security

Figure 1. MHPSS intervention pyramid (adapted from IASC Guidelines, 2007)

Both these sets of guidelines outline the essential importance of making basic clinical mental health care available at every health-care facility and complementing these services with a range of other MHPSS response activities, including those that strengthen community supports. However, to date, many health systems in countries and regions afflicted by emergencies do not prioritize or integrate mental health care, and many international organizations do not regularly address mental health needs through humanitarian health programming.

To address these gaps, the World Health Organization (WHO) and the United Nations High Commissioner for Refugees (UNHCR) published the Mental Health Gap Action Programme (mhGAP) Humanitarian Intervention Guide (mhGAP-HIG) in 2015, based on evidence-based guidelines (*4*). This practical tool, adapted from the mhGAP Intervention Guide (mhGAP-IG), supports health-care providers in assessing and offering first-line management of mental, neurological and substance use (MNS) conditions in humanitarian emergencies. However, to date, uptake and implementation of the tool has not reached its full potential. According to global assessments, international agencies report a considerable need for further capacity development to implement the tool in their humanitarian health activities (*5*).

In response, WHO and International Medical Corps (IMC) initiated the **mhGAP-HIG capacity-building project** in late 2018. Using recently released mhGAP-HIG training materials, the mhGAP Operations Manual and IMC's Global Toolkit for integrating mental health into general health care in humanitarian settings, WHO and IMC engaged 16 international non-governmental organizations (INGOs) to support agencies in scaling up the delivery of mental health services. This project included in-person training in mhGAP-HIG implementation and clinical guidance; follow-up support, including provision of technical guidance, clinical supervision and knowledge exchange; and careful evaluation, including feedback on training and documentation of case studies.

The purpose of this report

This report partially assesses the impact of the mhGAP-HIG capacity-building project on individual programmes and at the organizational level through case studies that describe the work of agencies in four unique and complex settings. Through interviews with staff of participating organizations, feedback from persons benefiting and organizational monitoring and evaluation (M&E) data, the case studies demonstrate the extent to which mhGAP-HIG capacity-building has led to improved quality and quantity of programming and highlight lessons learned through stories of change. These stories are discussed within the larger context of work by INGOs in each country, supported by WHO, to strengthen the mental health system and scale up evidence- and community-based services over time.

Stories of change

"Stories of change" is an approach to describing key factors that lead to a policy or system change through narrative descriptions of a programme or initiative (6). Stories of change follow a process of data gathering, reflection and writing. Data collection can involve both document review and key stakeholder interviews with those involved in the change. During interviews, stakeholders identify an important change and work backwards to describe the factors that played a role in that change. One of the purposes of stories of change is to provide an accessible review of how critical changes can be achieved in complex settings. In the current project, stories of change were collected through document reviews, semi-structured interviews and checklists completed by key project stakeholders.

Source: WHO

Libya
Mobilizing mental health providers to meet the needs of conflict-affected Libya

Belize
Championing change at the local level

Source: WHO Libya

Source: WHO Sudan

Ukraine
Under construction: reforming mental health care in Ukraine

South Sudan
Building a mental health system in the world's youngest country

Source: WHO

Stories of change: mhGAP-HIG capacity-building in four countries

Libya

Mobilizing mental health providers to meet the needs of conflict-affected Libya

Children participating in a national mental health awareness campaign in Libya. Source: WHO.

Background

Libya is located in northern Africa on the Mediterranean Sea coast. Bordered by six other countries to the west, south and east, it is home to a population of approximately seven million people (*7*). Prior to 2011, Libya had been governed by the regime of Colonel Muammur Gaddafi for a period of 42 years. In February 2011 uprisings began in Benghazi and eastern Libya, and isolated demonstrations rapidly escalated into conflict between government forces and armed groups. Since the fall of the Gaddafi regime, the country has experienced years of war, with numerous administrations and political rivals claiming legitimacy and authority, and an influx of armed groups attempting to capitalize on gaps in power. As a result of this instability, the social, economic, physical and mental welfare of the country's population has been gravely affected. For instance, since the conflict began, Libya's ranking on UNDP's Human Development Index has seen the biggest fall of any country globally, sliding from 67th place in 2010 to 110th in 2019. By the end of 2020, 1.3 million people were in need of humanitarian assistance due to both the

conflict and the COVID-19 pandemic. Approximately 40% of people in need are women and girls, and 60% are boys and men; this gender imbalance is due to the fact that 93% of migrants are male. An estimated 35% of people in need are children *(8)*. Due to the protracted nature of the conflict, hundreds of thousands of people have been displaced. Moreover, serious risks to the civilian population are often reported, including unlawful killings, torture, sexual violence, forced labour, extortion and arbitrary detention. At the end of 2020, nearly 600 000 people faced critical problems in living conditions, including substandard shelter and lack of access to basic services, while over 800 000 faced critical problems related to their physical and mental well-being *(9)*.

In part due to the lack of a unified and functional government, public services in Libya, including the health care system, have been significantly disrupted, with a number of hospitals and PHC services destroyed or out of service. According to an October 2019 joint needs analysis for the health sector, more than one in five of the 1145 PHC facilities and 88 hospitals assessed across 85 Libyan municipalities was closed. In the context of COVID-19, these issues have resulted in a severe lack of access. Only 40% of communities in Libya have access to child health and emergency services, only 35% to general clinical services and only 15–20% to reproductive health care and noncommunicable and communicable disease services. Meanwhile approximately 80% of refugees and migrants in the country report serious issues in access, due to costs. In health-care facilities that remain open, medicines, equipment and staff to provide many critical services are lacking *(10)*. Likewise, many facilities have inadequate health information systems, which are largely outdated and poorly functioning, and only a few report to the disease Early Warning and Response System (EWARS), which severely limits rapid response to disease alerts and outbreaks, including of COVID-19.

> **BY THE END OF 2020, 1.3 MILLION PEOPLE IN LIBYA WERE IN NEED OF HUMANITARIAN ASSISTANCE DUE TO BOTH THE CONFLICT AND THE COVID-19 PANDEMIC**

Unfortunately, the situation is also dire in terms of access to mental health care. Based on WHO estimates for conflict settings, it is likely that one in 10 Libyans is in need of mental health care for moderate–severe mental disorders. This equates to around 700 000 people, of whom more than 100 000 are in need of humanitarian assistance. In addition, rates of illicit drug use have been rising since 2011. According to the Libyan Anti-Narcotics Authority, there are approximately 21 000 illicit drug users in Libya, of whom between 4600 and 9800 are injecting drugs. However, there is no centre in Libya to manage substance use disorders, and human resources with this capacity are very limited. These issues are particularly concerning given the fact that Libya has the highest reported prevalence of HIV among injection drug users in the region, with prevalence rates estimated to be as high as 87% *(11)*. According to reports from Tripoli Central Hospital and Tripoli Medical Center, more than 1700 new clinical cases of HIV were documented between 2014 and 2018, and intravenous drug injection remained the most common mode of transmission.

The mental health system in Libya has struggled to meet these many needs, largely due to limited development over time. An assessment of MHPSS services conducted in 2017 stated that "mental health is a chronically neglected field in the country with many longstanding problems that predate the conflict that started in 2011, including underdeveloped community and specialized services, shortage of qualified workforce, lack of facilities, social stigma towards people with

mental illness and funding marginalization" *(12)*. Also conducted in 2017, a Service Availability and Readiness Assessment (SARA) by WHO indicated that mental health care was provided at only six hospitals, one clinic and four PHC facilities across the whole of the country. Later, in 2019, a complementary mapping of private health-care facilities conducted by WHO showed that mental health services were also very limited in private settings, particularly for persons with serious conditions. Unfortunately, Libya has also struggled to maintain the services that have been established. Two psychiatric hospitals, each with approximately 200 beds, were established in the 1990s and are located in Tripoli and Benghazi. However, staffing capacity and stock-outs of psychotropic medication have severely affected the functioning of these hospitals.

WHO staff providing support to a PHC facility in Janzour. Source: WHO.

Mental health policies and capacity for services are also lacking. The country does not have a stand-alone policy or plan for mental health nor a plan or policy for managing drug use, and training for a mental health workforce is very limited. Training of psychologists in Libya is largely constrained to degrees at bachelor level and generally does not include clinical training. Physicians and nurses previously received on-the-job training in mental health hospitals but, with reduced operations in these hospitals, such training has been largely unavailable. General health care doctors are often expected to act also as specialists, despite having received no formal training in mental health. As a result, care for mental health conditions in the Libyan health system is heavily focused on the prescription of medications, but this is frequently hindered by medication shortages, high costs and procurement restrictions. A WHO study of the health policy context in Libya indicated that only 1% of the country's PHC facilities had psychiatric medications available.

In response to the major gaps between the mental health and psychosocial needs created by the conflict and other adversities and the availability of accessible mental health services, WHO has actively supported the Ministry of Health, NGO partners and other stakeholders through long-term collaboration and technical support. Among many other efforts in system-building, a major focus has been on implementation of WHO's mhGAP programme in facilities across the country, which has been bolstered by achievements in policy development and strategic planning, coordination, system strengthening and expansion of the professional workforce. What follows is a story of change that describes the work of WHO and partners to implement mhGAP operations over time, focusing also on the International Rescue Committee (IRC)'s recent implementation of mhGAP-HIG, supported by WHO, while placing these efforts within the context of wider system strengthening in Libya.

Actions and results

Over time, WHO has worked closely with the Ministry of Health to increase the number of specialized mental health professionals in Libya, from a baseline of 11 in 2011 to 42 in 2019. This was facilitated by the Ministry of Health mental health department and also by the **establishment of a mental health unit in the National Center for Disease Control (NCDC),** which is responsible for policy guidance and system-wide recommendations and which has played an important role in mental health system strengthening in Libya since its inception. **WHO has closely supported the NCDC through ongoing capacity-building, guidance and partnership** over time as well as via WHO

scholarships that have allowed NCDC staff to receive international education in mental health and human rights through programmes in India and Portugal.[1] WHO and the NCDC have further advanced capacity-building for mental health professionals in Libya through the Arab Board of Psychiatry, which conducted exams for the first time in the country in 2014. WHO has also supported the advancement of other national training programmes providing longer-term capacity-building for PHC workers. As a result of these efforts, a mental health outpatient unit was established in Misrata Hospital and mental health care services were made available at Al Aswak clinic in Misrata and strengthened in Al Thanwya clinic. Misrata now has five professionals working in mental health care while Al Thanwya has three, compared with one each in 2011. In addition to expanding services, WHO, the Ministry of Health and NCDC have **established an MHPSS technical working group at the national level** to further coordinate humanitarian MHPSS response efforts. This coordination group continues to be supported by WHO and other international partners through the Dutch Surge Support (DSS) mechanism,[2] with an MHPSS coordinator deployed to support the group in September 2020. Over time, stakeholders have also focused on **promoting mental health and combating stigma through the development of mental health awareness packages**, including short radio dramas, posters and leaflets and a national campaign that was launched to raise awareness of mental health and the rights of people with mental health conditions.

However, despite these achievements, there is still **only one specialized mental health professional for every 300 000 people** in Libya, and only five cities, fewer than 12% across the country, are able to offer mental health services. As a result, the Ministry of Health and WHO continue to focus efforts on scaling up services for affected Libyans, in collaboration with many partners. One complementary approach to further scaling up mental health services is to **train and mentor staff of INGOs working in Libya to implement mental health programming through mhGAP-HIG**. IRC has been working to provide a wide range of services as part of its humanitarian

IRC national staff at a training session in Kyiv, Ukraine. Source: WHO.

response. As a result, its global public health and MHPSS focal points and staff working at the national level were invited to participate in WHO and IMC's mhGAP-HIG capacity-building project. IRC's global focal point for MHPSS and its national MHPSS focal point both participated in mhGAP-HIG training and both were also supported with follow-up mentorship, which included regular technical support calls and a field visit. Previous investments in local human resources had also established a strong foundation for IRC's implementation of mhGAP-HIG. Both the IRC national focal point and another lead IRC project staff member working in Libya had previously been trained by WHO as mhGAP supervisors and had received WHO scholarships for further education and training in mental health integration in primary care provision and in human rights.

In mid-2019 IMC and IRC, with support from WHO and in partnership with the government, began planning to roll out mhGAP projects across Libya. This began with efforts to ensure coordination and to raise awareness and support. Stakeholder engagement meetings were held between the

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[1] For more information, please see: https://www.who.int/mental_health/policy/Training_in_Mental_Health.pdf
[2] For more information, please see: https://english.rvo.nl/subsidies-programmes/mental-health-and-psychosocial-support-humanitarian-emergencies-dss-mhpss

Ministry of Health, the NCDC, international organizations and national health and protection sector actors. Within the government, barriers were initially created by frequent administrative turnover, **lack of priority for mental health for some actors** and other challenges stemming from uncertainty and stability of the governance system. However, thanks to previous and continued advocacy efforts, IRC and IMC's mhGAP-HIG project moved forward, eventually with support from the Ministry of Health. As part of initial planning, IRC and the Ministry of Health decided to address the **costs of health care**, particularly for migrants and refugees,

IRC global MPHSS focal point attending mhGAP-HIG training in Kyiv. Source: WHO.

which had traditionally been a **major barrier to access**. In order to address this concern, IRC trained mobile teams, comprised of trained local professionals, to support facilities at the primary care level while also **donating equipment, medications and other resources** to scale up capacity. In return, facility directors and local authorities reduced costs to migrants and refugees in order to increase access to services. Meanwhile, IMC coordinated with the Ministry of Health to engage in training Ministry of Health staff as mhGAP supervisors and trainers.

Once the coordination and planning for service scale-up had taken place, actors set to work on **contextualizing the mhGAP-HIG modules**. IRC completed a contextualization workshop in December 2019 in partnership with the Ministry of Health, health facilities and other implementing agencies. The **mhGAP Operations Manual and IMC toolkit for integrating mental health into general health care were also adapted** by IRC with support from WHO and IMC to fit its programming approach. These adaptations were key at an organizational level to ensure readiness and capacity to further implement mhGAP programming both within Libya and in other settings globally. Next, **trainings were held to scale up services**. IMC's trainings focused on increasing capacity among Ministry of Health staff, while IRC focused on training staff who would serve as service providers in mobile response teams across the country. IRC also trained local psychologists and psychiatrists in mhGAP supervision and administration. Once training was completed, **mobile units were dispatched and began rotating to fill gaps** across various municipalities where services were limited or non-existent. In total, IRC and IMC have trained 28 non-specialist professional health workers who provide services across 20 PHC centres. Additionally, five national trainers/supervisors have been trained to support these workers and engage in regular supervision. To date, providers and service users have reported **increased confidence in providing basic mental health care at the general health care** level and an **increased awareness of the importance of mental health and psychosocial well-being**.

Health systems strengthening has also been a focus of these INGO projects, in line with WHO and mhGAP priorities and principles. For instance, referral pathways have been very limited in Libya and generally uncommon or often disrupted for mental health services. As part of their work, IMC and IRC recruited volunteer community outreach workers, many of whom were themselves migrants or refugees, to raise awareness among these communities. Within the PHC facilities, internal referral pathways among mhGAP-trained staff, medical staff and integrated protection staff were also established to build a communicating system. Meanwhile, WHO supported psychiatric units in general hospitals to serve as referral centres. However, other external referral pathways outside of primary care settings for mental health care or psychological interventions have remained limited.

People waiting to access a health facility in Libya.
Source: WHO / Blink Media – Nada Harib

Implementing mhGAP also required increasing the **availability of psychotropic medications** for those in need. Initially, there were **major barriers to procuring these medications**. This issue was raised by IRC staff during a technical support call with WHO, which supported IRC actors by providing **information and guidance on procedures that allow for the procurement of psychotropic medications** by agencies providing humanitarian assistance during emergencies. This included references to WHO's International Emergency Health Kit and to procedures accepted by the International Narcotics Control Board (INCB). With this support, IRC staff were able to successfully advocate for the **addition of certain psychotropic medications to their organization's essential medications list**. As a result of this significant change, IRC has been able to coordinate the procurement of medications with the Libyan Ministry of Health. This change has also been extremely useful across IRC's projects in other countries. However, the Libyan **essential drugs list remains outdated**, with its most recent update being in 2005. As a result, **procurement of certain medications is still strictly regulated** and prequalification requirements for manufacturers have not yet been revised to meet the current context. Ongoing advocacy efforts are needed to address this barrier to the system's efficiency.

Another major barrier to the provision of services was the **lack of strong health information and administrative systems**. During mhGAP-HIG implementation, Ministry of Health staff trained under IMC struggled to track consultations due to the lack of a formal system for doing this. In response, stakeholders have begun **developing tools to improve service monitoring at health facilities**. For instance, IRC began implementing a **client tracing tool** across facilities it supported in order to ensure continuity of care for service users. This change has the potential for scale-up within the health system to strengthen information and monitoring of mental health care usage.

Despite the many challenges faced, these mhGAP-HIG capacity-building efforts have translated into considerable provision of care for persons with MNS conditions at the primary level. Between January and December 2020, a total of 1044 service users received mhGAP services from IRC-trained providers. Additionally, in response to initial **disruptions in services caused by the COVID-19 pandemic** (see trends in Figure 2), mhGAP-HIG-trained providers have **transitioned to providing care via remote consultations**. To facilitate this process, dedicated phone numbers are distributed by outreach workers to persons identified in the community. This adaptation allows for continued access in the long-term context of the pandemic.

" DESPITE THE MANY CHALLENGES FACED, THESE MHGAP-HIG CAPACITY-BUILDING EFFORTS HAVE TRANSLATED INTO CONSIDERABLE PROVISION OF CARE FOR PERSONS WITH MNS CONDITIONS AT THE PRIMARY LEVEL
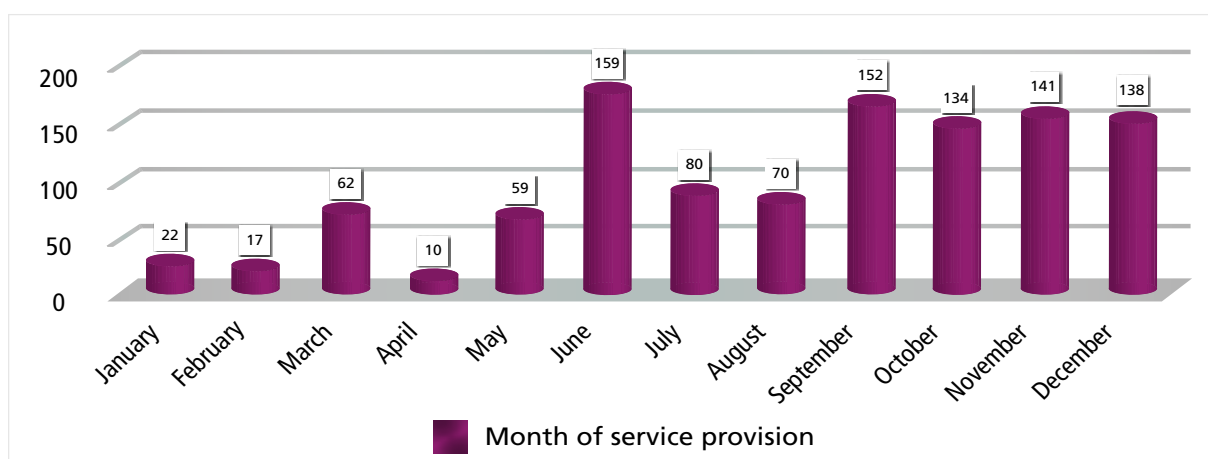
Figure 2. Persons receiving care for MNS conditions in 2020, by month

Conclusions

The indications are that mhGAP-HIG training efforts have built upon many years of efforts to strengthen Libya's mental health system. Many Ministry of Health and NCDC staff and Libyan professionals have trained as trainers and supervisors in mhGAP and now retain capacity to further scale up the programme. Meanwhile, medical doctors and general health-care staff working at Ministry of Health facilities are now implementing mhGAP programmes, including the mhGAP-HIG, and are reporting increasing confidence in their ability to provide basic management services for MNS conditions. Referral linkages have been created within and across targeted health facilities and to larger psychiatric units in the country. Furthermore, health information systems have been supported through newly created tracing tools, with the potential to scale up, and advocacy is ongoing to change drug lists and update restrictions on the procurement of medication. All of these successes contribute to sustainability. However, difficulties remain in reaching the long-term goal of a comprehensively functioning mental health system. For instance, NGO actors have expressed concerns about the sustainability of the mhGAP-HIG project due to the fragile state of the country's governance system. These issues of uncertainty and insecurity continue to present challenges for long-term sustainable change.

Despite these challenges, WHO, the Ministry of Health, the NCDC and other partners continue to strive for system strengthening. For instance, in May 2020 the Strengthening the Coordination and Availability of Libyan Effective (SCALE) Mental Health Care in PHC Services project was initiated to further strengthen community-based mental health care in the country. The SCALE project aims to expand the services available in three geographic regions and will rely on Libyan leaders and professionals previously trained and supported by WHO. Through SCALE, WHO and partners will support the activation of MHPSS subnational coordination groups and will establish a national scientific committee for mental health within the NCDC. The project will also build local capacities through local, regional and international trainings, leadership courses and seminars and workshops on integrating mental health within PHC, followed by on-the-job mentoring. Non-specialized staff working in general health-care facilities will also be trained in mhGAP through a cascade training model (training of trainers followed by roll-out of training and on-the-job mentoring), and essential supplies, including psychotropic medications, will be provided for general health-care facilities to scale up mhGAP services in regions that have not yet been reached. Finally, WHO and its partners will also work to further improve the promotion of mental health and prevention of mental disorders by integrating MHPSS services in schools and by further establishing referral systems between health services and community structures. This project represents one of many intended to strengthen and build the Libyan mental health system.

Building a mental health system in the world's youngest country

Leer county, South Sudan. Source: Medair.

Background

The Republic of South Sudan gained independence in 2011, making it the world's youngest country at that time. However, due to decades of intercommunal violence, civil war and political instability both before and after independence, it has begun its statehood as one of the least developed countries in the world. According to the World Bank, the poverty rate in South Sudan increased from 50.6% in 2009 to 82.3% in 2016, growing at an average annual rate of 13.38%. In 2019, the country ranked 186th out of 189 countries in the Human Development Index Report _(13)_. As a result, its population face considerable challenges. According to the South Sudan Humanitarian Needs Overview 2020, approximately 7.5 million people were reported to be in need of humanitarian assistance, equating to nearly two in three of the country's population of 11.7 million _(14)._ About 1.5 million people have been internally displaced and 2.2 million have sought refuge in neighbouring countries. Meanwhile, South Sudan has received an estimated 300 000 refugees from the Democratic Republic of Congo, Sudan, Ethiopia and the Central African Republic. The country remains in a critical period of unprecedented severe food insecurity, with 6.4 million people considered food-insecure and with malnutrition rates of 16%, exceeding the global emergency threshold. As of 2019, nearly two thirds of the population were struggling with a convergence of high levels of need in the areas of water, sanitation and hygiene, protection and education, 44% were at serious risk of communicable and noncommunicable diseases and 40% had no access to PHC services. In the context of the global COVID-19 pandemic, these needs have become even more severe.

Historically, the country's health-care system has struggled to meet these challenges. According to a 2018 assessment, the General and Specific Service Availability and Readiness scores for most indicators on a SARA survey were far below the WHO recommended minimum thresholds. For

Internally displaced persons camp in South Sudan.
Source: WHO/ Bimpa

example, the General Service Readiness score (the overall capacity of the health system to provide health services) was only 37%. As a result, health service delivery, including case management and infection prevention and control, remains highly fragmented and continues to face enormous challenges in terms of access, with only 44% of the population living within a 5 km radius of a health facility. It is estimated that over 30% of public health facilities across the country are non-operational. Out-of-pocket expenditure on health is estimated at 54% and per capita expenditure on health in 2016 was estimated at US$ 34, which is well below the minimum of US$ 84 recommended by WHO.

As a result of the protracted conflict, mental health problems affect a large portion of the population, with an estimated 2.5 million people experiencing mental health conditions. However, mental health services remain particularly limited in South Sudan's already fragile health system. The Ministry of Health recommended the integration of management, care and follow-up for persons affected by mental health conditions in PHC and general hospitals as part of the country's Basic Package of Health and Nutrition Services (BPHNS) 2017–2022. However, implementation has been limited by many challenges. As of 2017, there was fewer than one mental health worker of any kind for every 100 000 persons, with even fewer mental health professionals (0.03 psychiatrists, 0.26 psychologists and 0.02 mental health nurses).[1]

> **AS A RESULT OF THE PROTRACTED CONFLICT, MENTAL HEALTH PROBLEMS AFFECT A LARGE PORTION OF THE POPULATION, WITH AN ESTIMATED 2.5 MILLION PEOPLE EXPERIENCING MENTAL HEALTH CONDITIONS**

Leer county in Western Upper Nile state, one of many counties in South Sudan struggling with these challenges, has a population of approximately 76 000, nearly 70% of whom were in need of humanitarian assistance as of December 2020 (15). In 2017, the county faced a severe humanitarian crisis after famine was declared in the region. Before it was able to recover from this, it was plagued by an upsurge of violence accompanied by the increasing presence of armed groups. The targeted killing of civilians, numerous instances of sexual violence, widespread destruction of housing and many other forms of conflict have been reported in recent years. As a result, there are numerous constraints on women, men and children living in the area, and access to services and necessary humanitarian aid has been severely limited. Additionally, Leer county is located in a rural area, nearly 400 km from Juba, the capital city, where most health and mental health services are centralized. In rainy seasons, travel to and from the area becomes nearly impossible. Limited

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[1] Rates per 100 000. From: Mental Health Atlas 2017. Geneva: World Health Organization; 2017 (https://www.who.int/mental_health/evidence/atlas/profiles-2017/SS.pdf?ua=1, accessed 9 September, 2021)

internet and unreliable communications infrastructure also present significant logistical challenges in the area. Prior to 2019, MHPSS services were limited to basic support and did not include integrated mental health care in primary or general health services, nor access to psychotropic medications for those in need. In response, the INGO Medair began working in Leer county to provide a range of humanitarian supports, including the implementation of WHO's mhGAP-HIG to increase access to mental health services in general health care and to build and strengthen the local mental health system. This effort represents the most recent of many projects to integrate mental health care across the country by the Government of South Sudan, WHO and other partners. The following story of change highlights Medair's work in Leer county while placing these efforts within the larger context of changes brought about by WHO and its partners through mhGAP operations and system strengthening in the country.

WHO staff visit to mhGAP clinic with MHPSS TWG coordinator, CP AoR coordinator and IMC MHPSS officer. Source: WHO.

Actions and results

Since shortly after South Sudan's independence in 2011, WHO has provided support to the Ministry of Health and other stakeholders to build the country's mental health system. One of the key issues faced has been **difficulty in coordinating MHPSS response activities across the many responding agencies and the large geographical spread** of those in need. As part of its co-chairing role in the Inter-Agency Standing Committee (IASC) Reference Group on MHPSS in Emergency Settings, **WHO has provided ongoing technical support and guidance both remotely and via multiple country missions to strengthen coordination mechanisms** and MHPSS technical working groups (TWGs). It recently facilitated funding for a consultant to strengthen coordination, deployed through the DSS mechanism in February 2020. Over time, these support efforts have also entailed multiple workshops on building capacity, expanding operational approaches and developing policy, and have focused on bringing together multiple diverse MHPSS stakeholders in the Ministry of Health and other government sectors, along with UN agencies and NGOs. Already, these efforts have led to **significant changes in the country's mental health system**. For instance, WHO's advocacy and collaboration with the Ministry of Health has led to a **revision of the South Sudan essential medicines list to include medications for mental health conditions** at the PHC level. Following on from this, WHO has provided funding to ensure procurement of psychiatric medications for the first time for many in South Sudan. This change has been crucial for the practical integration of mental health care in primary care settings and has led to significant increases in access to needed care. With WHO's support, Ministry of Health actors have also **revised the country's District Health Information Software (DHIS2) to capture routine data on mental health conditions**, which has been crucial for monitoring progress and tracking impacts.

In addition, much of WHO's support has involved building local capacity while strengthening the mental health system. Through long-term support and relationship-building, WHO, the Ministry of Health and other stakeholders developed **a plan for MHPSS response operations in the country**. Building on the BPHNS 2017–2022 recommendation for mental health care integration, mhGAP was identified as a central component of this plan. As a result, in 2017 WHO held an **mhGAP-HIG adaptation workshop with participants from the Ministry of Health and key national and international NGOs.** The workshop involved both general capacity-building and focused training

Medair MHPSS staff and other participants at the Kyiv mhGAP-HIG training. Source: Medair.

sessions with locally recruited professionals who would serve as mhGAP supervisors. Thereafter, WHO continued to advance the roll-out of mhGAP by **establishing an mhGAP operations team at the national level** and facilitating funding for its workplan. The team comprised a psychiatrist from the Ministry of Health, two national psychiatrists working at the University of Juba, an international consultant and representatives from WHO and from INGOs, including a psychiatrist from IMC and the coordinator for the country's MHPSS TWG chaired by the International Organization for Migration (IOM). Together, the team developed a costed six-month operations plan for assessment, selection of trainees, training of supervisors and service providers, supervision, development and printing of implementation tools, and supply of psychotropic medication. Thereafter, two mhGAP-HIG trainings were held for national South Sudanese health workers – one for new trainees and the second as a refresher for previously trained providers. A total of 52 local health workers from 17 health facilities and the national Ministry of Health received training and follow-up supervision from four WHO-trained and supported national mhGAP supervisors. Facilities were also supplied with patient recording forms, including forms for assessment, referral and suicide assessment. By the end of 2019, a total of 11 of the 17 heath facilities targeted were implementing mhGAP-HIG, more than double the number available the year before.

However, despite these successes, many counties in South Sudan still have little to no service availability and employ an extremely limited workforce relative to the population's needs. Therefore, in order to further expand local service availability, WHO engaged INGOs working in the country as participants in its global mhGAP-HIG capacity-building project. Among those participating was the INGO Medair, which was working primarily in Leer county. Medair staff, including its global senior MHPSS advisor and a senior health advisor, participated in a training held in Kyiv, Ukraine, and

Medair staff during an MHPSS supervision exercise in Leer county. Source: Medair.

thereafter received mentoring and technical support consultations from WHO that guided planning and development of the Medair programme in Leer county. To begin its project, Medair coordinated with the Ministry of Health to conduct a **needs assessment and situational analysis**. The needs assessment identified **significant need for MHPSS** due to frequent stressors and many individuals potentially experiencing mental health conditions without corresponding care or support. However, the assessment also identified **clear gaps in the availability of mental health services** beyond informal mechanisms of support, including a complete lack of formal mental health services for people with serious mental health conditions.

Thanks to its participation and training in mhGAP, and with support from WHO, Medair was well prepared to implement mhGAP-HIG in response to the needs and gaps identified. However,

advocacy and awareness raising were needed to create support for the programme among local stakeholders. In Leer county, many stakeholders were sceptical of the notion that mental health care could be provided by non-specialized providers, and governmental and local authorities did not initially see mental health as a priority. However, Medair's previous implementation of other health and WASH activities in Leer county had led to the establishment of strong local partnerships with the Ministry of Health and name recognition among many stakeholders. Additionally, the backing of WHO and the national MHPSS TWG

Medair professional staff in South Sudan. Source: Medair.

in Juba was useful in creating further buy-in. These **relationships were leveraged to create support for mhGAP-HIG implementation**. As a result, Medair was able to collaborate with national and local Ministry of Health staff, the Leer county health director and other local administrators and authorities to engage religious leaders, health system partners and community-based networks to raise awareness and to roll out mhGAP-HIG services in two clinics, a primary health care unit (PHCU) and a primary health care centre (PHCC).

Implementation of local capacity-building on the mhGAP-HIG by Medair began towards the end of 2019. However, due to the remote rural nature of the area, **identifying qualified personnel to receive the training presented a unique challenge**. After consultation with local stakeholders, the Ministry of Health and WHO, Medair responded to this challenge by adapting the mhGAP-HIG training approach to allow community health workers with limited experience to also receive an **adapted and simplified version of mhGAP-HIG training**. To ensure quality service provision, **Medair, with support and approval from the Ministry of Health, also developed an apprenticeship system** whereby trainees with limited backgrounds would be paired with more experienced providers to gain experience and know-how.
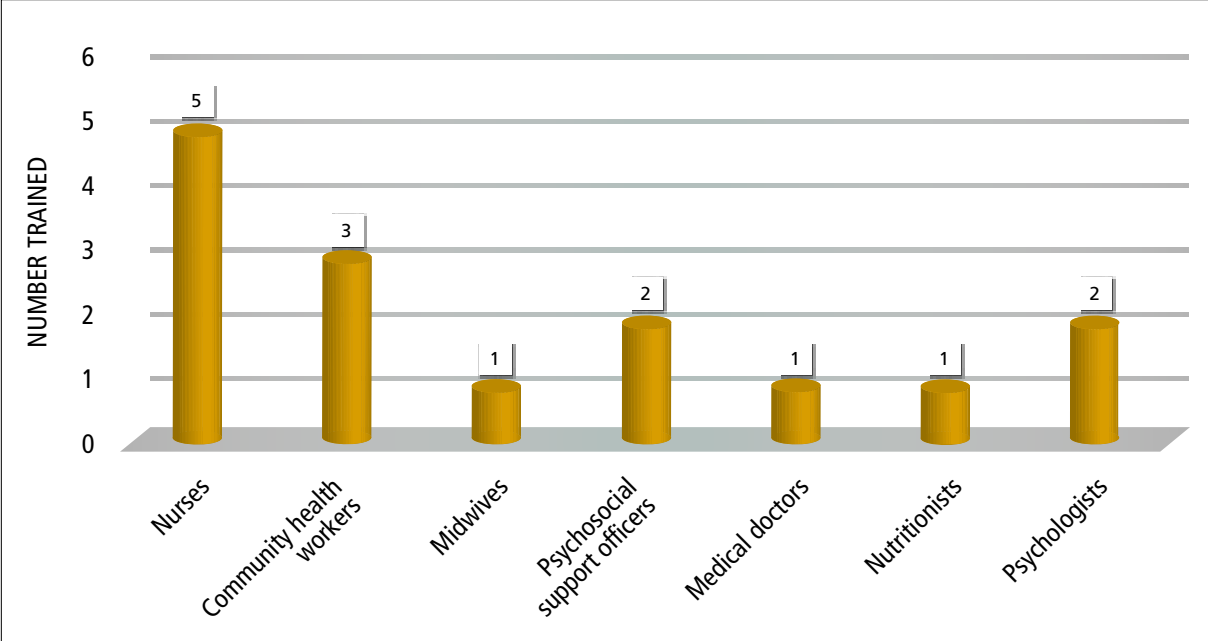

Figure 3. mhGAP-HIG capacity-building summary, Leer county

In total, 15 health-care providers received training on the mhGAP-HIG from Medair across the two facilities. These included two local professionals working as MHPSS project managers for Medair were trained in mhGAP-HIG supervision (see Figure 3). However, **logistical and communication challenges have presented barriers to providing consistent supervision** to newly trained supervisors and providers. Limited access due to poor roadways that are often severely affected by rain and other weather, inadequate telecommunications and dependency on often unreliable satellite communications are all factors that have hindered supervision. Medair has focused on expanding supervision considerably when access does allow, but **innovative and creative solutions are needed** to ensure reliable access for newly trained providers.

In addition to developing local mental health workforce capacities, an important focus of WHO's capacity-building project was ensuring that participating agencies were also well positioned to **develop the wider mental health system**. Medair's mhGAP-HIG project has accordingly emphasized strengthening of the wider health system in Leer county and linking with other national efforts. To do this, Medair established a **layered MHPSS system** by ensuring that mhGAP-HIG services at the two PHC facilities were complemented by psychosocial services provided through peer-to-peer support groups and by multisectoral community-based staff offering psychological first aid and basic psychosocial support to community members. In addition, **local community actors were effectively engaged to raise awareness** about the mental health supports available and thus to create an

South Sudan MHPSS TWG meeting. Source: WHO.

effective referral system. These efforts have resulted in nearly 35% of patients served by mhGAP-HIG providers coming from outside of Medair's catchment area, **many of them referred by community workers, religious leaders or local authorities**. However, despite the local successes of this new system, the referral process has faced **barriers to reaching higher levels of care**. More specialized mental health services remain difficult to access because such services are limited generally and are centralized in Juba, a long way from the project sites. Nevertheless, project implementers learned that **people with many conditions could receive services successfully in Leer county through the mhGAP-HIG programme**. Another challenge faced in developing the local system was addressing **disruptions in continuity of care** caused by frequent movement among the many displaced persons served by the project. To improve continuity, Medair and its partners engaged with community networks to ensure follow-up and resupply of medications, when necessary, and developed **customized patient and drug registries** that include **individualized patient tracking cards**. This adaptation has allowed for much higher levels of continuity in care for those in the county displaced by conflict. To fully implement the mhGAP-HIG and expand the capacity of the health system, Medair also established a medication supply chain by procuring medication internationally from Nairobi, Kenya. Since the initiation of the programme, there have been no stock-outs, even with the many logistical challenges faced, which has led to a substantial change in making procurement consistent. Nonetheless, further changes are needed at the system level to increase efficiency in this area.

Despite significant disruptions experienced due to the COVID-19 pandemic, Medair's capacity-building efforts have translated into quality mental health care for a considerable number of people in Leer county. Between February and May 2020, 203 persons accessed and received care for MNS conditions through providers trained in mhGAP-HIG (see Figure 4). Also, because the project emphasized building the capacity of local providers and professionals, sustainability has been prioritized from the beginning.

	Total	Persons with epilepsy	Persons with psychosis	Persons with depression	Persons at risk of suicide	Persons with intellectual disabilities
Total	203	171	22	8	1	1
Female	137	127	7	3	0	0
Male	66	44	15	5	1	1
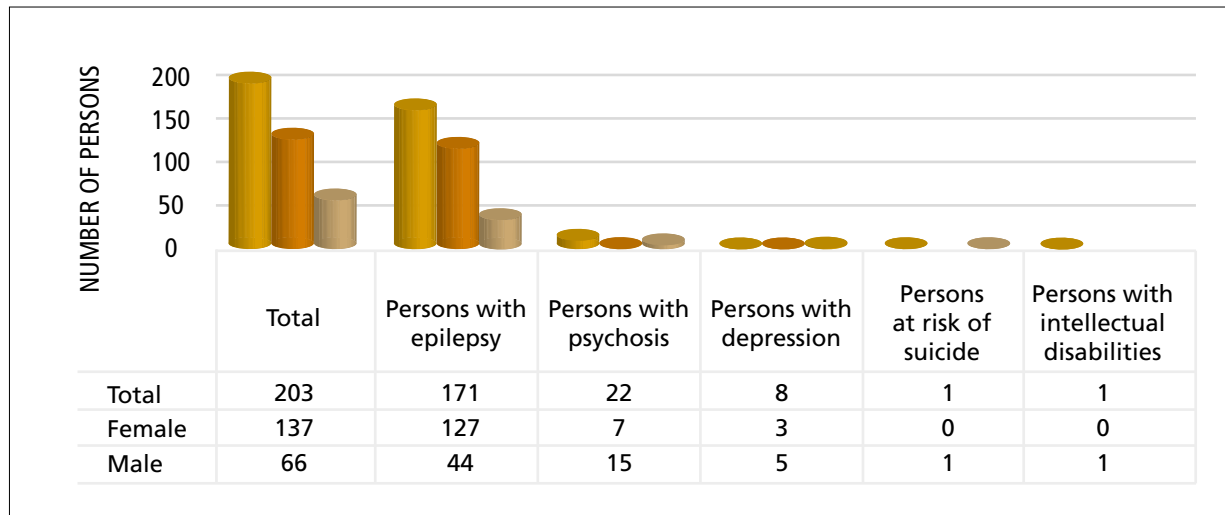
Figure 4. Persons receiving care for MNS conditions, Leer county, February–May 2020

Conclusions

There is no doubt that the progress made in scaling up mental health care in South Sudan over time has been substantial. Local communities have enhanced their awareness of mental health needs and have begun to see mental health as a priority; providers have been trained to provide quality mental health care; and functional mental health system linkages have been established and strengthened in many areas through locally trained providers. The country is also seeing many other promising changes in the mental health system. For instance, the Ministry of Health has been planning the development of a national mental health strategy with support from WHO, the first of its kind in South Sudan. This plan will undoubtedly build upon the major changes in the availability of services, the inclusion of mental health conditions in the essential drug list and the health information system, and the advanced coordination capacity supported by WHO. While more work remains to be done, these crucial steps offer much cause for optimism and hope for further change in one of the most complex and challenging humanitarian settings in the world.

Under construction: reforming mental health care in Ukraine

WHO staff support visit to Kramatorsk Donetsk oblast. Source: WHO.

Background

Ukraine is home to approximately 42 million people, the majority of whom live in major urban areas, including the cities of Kyiv, Kharkiv, Donetsk and Odessa. The Eastern European country has undergone many periods of economic, social and political instability, both before and after gaining independence following the collapse of the Soviet Union in 1991. In 2014, during the "Revolution of Dignity", a series of protests eventually led to a change of presidential administration. During the unrest, Russian military forces took control of strategic positions and infrastructure in the long-disputed Crimea region of Ukraine. Meanwhile, separatist demonstrations in the Donbass area escalated into full-scale conflict between the Ukrainian government and other armed groups. Now in its sixth year, the conflict has left nearly 3.4 million people in need of humanitarian assistance, including nearly 1.4 million internally displaced persons (IDPs) (*16*). The situation has become dire for many people, particularly those living in the conflicted-affected eastern region. An estimated 1.8 million people are in critical need of water supply, 2.2 million are in need of critical assistance to address untenable living conditions and 2.8 million are struggling with serious problems related to physical and mental well-being.

Unfortunately, many pre-existing system-wide challenges, combined with the effects of the armed conflict, present issues for accessing quality health and mental health care. Ukraine has historically operated a centralized mental health system, with services primarily located in large hospitals in urban centres and with services such as mental health care being viewed as highly specialized. The functioning of this system is hindered by the fact that the government spends just 2.5% of its health budget on mental health. Moreover, a recent World Bank assessment indicated that nearly 90% of funding for mental health has traditionally been allocated to psychiatric hospitals (*17*). The focus on specialized services is also reflected in the mental health workforce, which relies heavily on psychiatrists, many of whom work in these centralized hospitals. As a result, community-level services for mental health have historically been limited and have focused in particular on referral to more specialized care. Common issues for many centralized health systems, including the

system in Ukraine, have included establishing effective coordination of care and referral pathways and ensuring continuity. A recent study of the Ukrainian mental health system indicated that assessment and identification of common mental disorders in primary care were rare, and that practitioners tended to refer for mental health care only in cases where inpatient treatment was necessary. The study also concluded that there was a significant lack of communication between providers and significant fragmentation of care as a result (17). In addition to these issues in the mental health system, many people with mental health conditions living in Ukraine face a number of social and practical

Adapted mhGAP training materials, translated into Ukrainian. Source: MdM.

barriers to accessing needed services. These include fear of psychiatric interventions, which has roots in the historical use of psychiatry as a means of punishment, stigma and shame attached to mental health problems, fear of discrimination for "having a record" of a mental health diagnosis, lack of awareness, lack of trust, high out-of-pocket health expenses and geographic restrictions to access. These barriers present unfortunate challenges given the fact that return on investment analyses have indicated a return of US $2 in productivity and economic output gained for every US $1 spent on evidence-based mental health care in Ukraine (17).

> **UKRAINE HAS HISTORICALLY OPERATED A HIGHLY SPECIALIZED AND CENTRALIZED MENTAL HEALTH SYSTEM, WITH SERVICES PRIMARILY LOCATED IN LARGE HOSPITALS IN URBAN CENTRES**

Despite these challenges, a number of changes in the health system have been initiated and realized over the past decade that offer hope of improving the availability of community-based mental health services in the country. A major emphasis of these changes has been the government's adoption of a health reform package, which has included a transition to focusing on and modernizing care provided at the PHC level, as well as a massive focus on decentralizing various health services across the country. Mental health reform has been included in overall reform of the health system, and while additional allocation of financing for mental health has not materialized, the reforms do appear to promise a more efficient and potentially sustainable mental health system. In addition to major reforms, many international organizations and UN agencies, such as WHO, the World Bank and many INGOs, have been active across Ukraine and in response to the conflict in the east. Though the quality of services and adherence to international standards have been variable across some of the organizations providing mental health interventions (17), many have been active in improving the mental health system. To help coordinate these efforts and build capacities, several of these INGOs were invited to participate in WHO's mhGAP-HIG capacity-building project. What follows is a story of change describing the work of two of these organizations, IMC and Médicos del Mundo (MdM), which places their work in conflict-affected Eastern Ukraine in the context of the longer-term mental health reform efforts across the country made by WHO, the Ministry of Health and other partners.

Adapted mhGAP materials. Source: MdM.

Actions and results

Recognizing the **need for reform of the mental health system as part of general health care reform**, WHO and national stakeholders had begun conceptualizing an overhaul of the Ukrainian mental health system. In 2017, a **national concept note for mental health development for the period 2017–2030 was adopted** to align provider perspectives and create a shared vision for reform. The first phase of overall health care reform in Ukraine began in 2018 and focused on the scale-up of services at the primary care level. As a result, there was significant interest from the Ministry of Health and other stakeholders in implementing WHO's mhGAP programme. Following initial discussions, consultations and advocacy by WHO, **support for mhGAP implementation was established** and initial implementation was aligned in time with the first phase of reform at the primary care level. Due in large part to advocacy efforts and the success of this collaboration, buy-in also translated into **training hours spent on mhGAP being included in professional vocational training credits** and counted towards continuous professional development requirements. This change has been essential in increasing the feasibility of the reform and ensuring that providers are supported professionally in allocating precious time to training.

In October 2018, a first mhGAP planning and adaptation workshop was organized by the Ministry of Health and WHO, which marked the beginning of the national roll-out of mhGAP implementation. During the workshop, a road map for the integration of mhGAP into national health care provision was developed and the parts of the mhGAP Intervention Guide (mhGAP-IG) that **required adaptation for the context were identified by national stakeholders**. To share information and experience, align approaches, develop common monitoring indicators and coordinate capacity-building activities among the partners, **WHO supported the Ministry of Health in assembling an mhGAP Operations Group** at the national level and in coordinating the many stakeholders who would be implementing mhGAP. This group also developed the Common mhGAP Implementation Framework with minimum standards for mhGAP implementation, which have been essential in terms both of coordination and quality assurance. Nationally, the standards agreed on implementation of the mhGAP-IG were informed by ongoing reform of the health-care system and the need for a unified approach that would be general enough to serve both people affected by the conflict and those living throughout the rest of the country. The framework envisaged a blended model of mhGAP through the inclusion of stress-specific conditions from the mhGAP-HIG modules, such as PTSD, Acute Stress and Grief, for partners working primarily in conflict-affected areas. WHO provided support to partners throughout the planning and implementation of mhGAP by translating and adapting assessment and training tools, creating a blended model of the mhGAP-IG 2.0 and the mhGAP-HIG based on stakeholder feedback,[1] establishing a knowledge exchange platform and providing supervision to mhGAP master trainers, together with other technical guidance along the way.

The first training of national trainers on the blended mhGAP model was held in early 2019 and produced 35 national master trainers, including trainers from MdM. Following these initial

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[1] The Ukrainian version of the mhGAP-IG can be found here: https://apps.who.int/iris/bitstream/handle/10665/334239/WHO-EURO-2020-37299-37299-55107-ukr.pdf?sequence=1&isAllowed=y

Staff of MdM and other actors participating in a WHO mapping workshop. Source: WHO.

trainings, WHO began embedding and testing the service model developed in the implementation framework by delivering capacity-building activities to PHC facilities in Eastern Ukraine. The results from this effort demonstrated that PHC workers could effectively identify emotional distress and provide basic management and support for mental and substance use conditions. Over 120 PHC workers were intensively trained by WHO on the integrated management of MNS conditions and supported after the training through regular supervision and site visits in Donetsk oblast (region) during 2019. Initial results and lessons learned were shared with partners to further inform the mhGAP implementation process.

In mid-2019, a global capacity-building training workshop on the mhGAP-HIG, intended for INGOs and also including national project leaders working in Ukraine from MdM and IMC, was held in Kyiv. To further support INGOs working to implement mhGAP in Ukraine, WHO also held several workshops following the Kyiv training, including one for master mhGAP supervisors and another on mapping WHO technical packages used by partners in Ukraine. Holding these trainings in the country was beneficial in ensuring widespread participation by local actors and in bringing increased attention and awareness to the situation. These workshops were followed up with regular mentorship, technical support calls and field visits. As a result of all these efforts, strong capacity was further established among INGO actors to implement a comprehensive and contextualized model of mhGAP.

Accordingly, several INGOs supported by WHO and coordinated with the Ministry of Health, including MdM and IMC, began rolling out mhGAP in Eastern Ukraine towards the end of 2019. To begin, IMC and MdM targeted the conflict-affected Donetsk and Luhansk oblasts. **Needs assessment and situational analyses revealed high levels of distress among people affected by the conflict** and also strong desire from health-care staff for capacity-building on basic care for MNS conditions. Situation analyses also indicated that implementation of mhGAP, including the procurement of necessary medications, would be feasible in the target areas. Thereafter, implementation of mhGAP by IMC and MdM was coordinated through the Ministry of Health and the national-level mhGAP Operations Group. In preparation for IMC and MdM's efforts in Eastern Ukraine, meetings were also held with local medical and administrative staff to generate further buy-in for their programmes. Additionally, **representatives of the local departments of health were engaged to raise awareness and generate support for mhGAP**. Generally, local Ministry of Health and health department staff were quite supportive of mhGAP implementation in the area and appreciated its alignment with larger health reforms in Ukraine and its link with ongoing work by WHO and other partners in the region. However, **instability in the Ministry of Health, including the lack of a mental health-specific department, has also at times slowed progress**. In reaction to these issues, actors have continued to advocate for giving mental health greater priority in the governmental health agenda, while also emphasizing a **grassroots approach to raising awareness.** In doing this, WHO, MdM and IMC have focused considerable effort on conveying the value of mhGAP to primary and general health-care staff, nurses, doctors and psychologists and psychiatrists working in Eastern Ukraine. This approach has been complemented by **peer-to-peer advocacy following training in mhGAP**, with previously trained participants highlighting to colleagues the value of the programme and its practical applications. Fortunately, medical staff and health-care workers have largely been receptive to these efforts.

Following initial planning and preparation, IMC and MdM conducted trainings for providers in Eastern Ukraine with support and guidance from WHO. These trainings have focused on local primary health facilities, referred to as first aid points (FAPs). FAP facilities are typically staffed by a single doctor working with one or two nurses and are available in most villages in the Donetsk and Luhansk oblasts. However, as many as 35% of these facilities have been damaged by the conflict *(18)*. Prior to COVID-19, several trainings had been planned; however, the **pandemic massively disrupted these plans**, and due to limited and unstable internet connections, online provision has not been feasible. Nonetheless, both IMC and MdM were able to implement trainings in the region prior to the disruption caused by the pandemic. **IMC completed a four-day training** in December 2019, before subsequent delays. Meanwhile, **MdM initiated training following a phased approach and involving a series of two-day trainings** that would cover the various modules over a longer period of time, while embedding elements of case discussions on conditions previously covered. MdM's approach was designed both to meet the need for comprehensive and quality training and to address the time limitations of PHC workers in the region. In total, IMC has trained seven non-specialist health-care providers and six specialists on the blended mhGAP modules (see Figure 5), while MdM has trained 12 general practice family doctors in providing mhGAP and two supervisors in mhGAP supervision.

In order to further strengthen the mental health system and build on capacity, **psychiatrists and psychologists were also invited** to participate in these initial trainings. The purpose of their involvement was to establish **stronger referral links from rural villages to city centres**, where services have historically been centralized, by demonstrating the possibility of providing mental health care in less specialized general health-care settings. This effort also resulted in the benefit of strengthening personal connections between community-based FAP staff and specialized providers and has led to **a real change in the way that many specialists in Ukraine view community-based mental health care**.

Building on initial trainings, MdM and IMC have also both ensured that trainees receive regular supervision following training, including **live observations and online supervision sessions**. Meanwhile, project implementers have engaged in mentoring and technical support calls with WHO staff and have also been supported through field visits. Overall, initial reactions to the capacity-building efforts have been highly positive. All providers have reported an **improved ability to communicate with their patients and an increased focus on person-centred care**. Additionally, providers have described increased value for and confidence in mental health care.
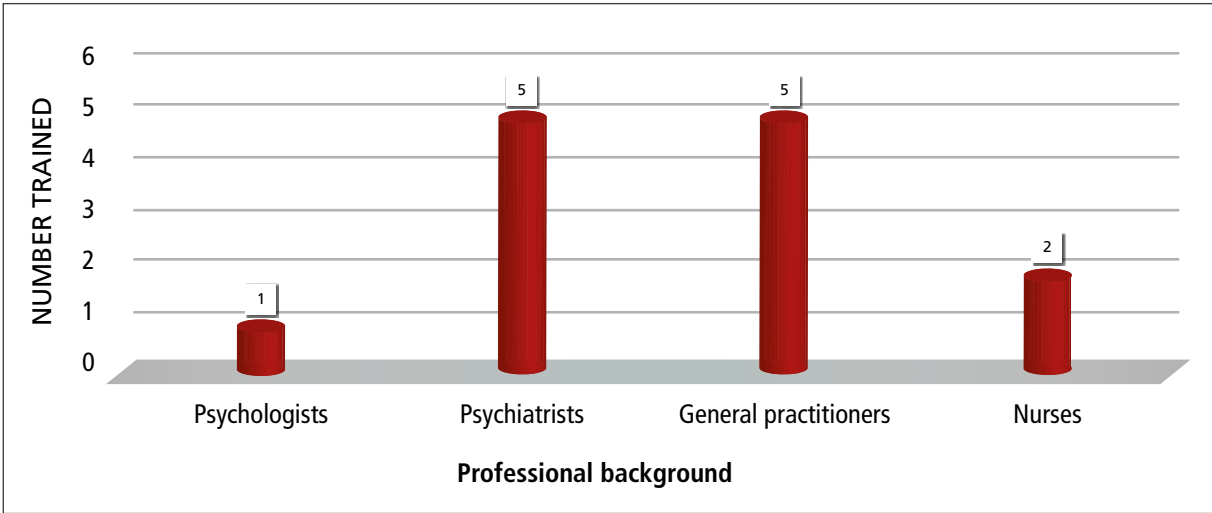

Figure 5. Summary of capacity-building on mhGAP-IG/HIG blended model in Ukraine

General practitioners have also reported **increased confidence in managing MNS conditions**, while psychiatrists and more specialized workers have reported **learning that these services can be managed at general non-specialized levels**. This learning has led to **better-functioning referral pathways** through personal links and the building of confidence between FAP staff and specialists working in larger hospitals. In the first five months after training, the initial cohort of practitioners trained by IMC recorded the provision of mental health services to 99 people who had sought medical care at FAPs. Meanwhile, two months after completing the training, MdM's trained family doctors reported providing services to 21 people with mental health conditions.

> *"Before participating, I was aware of the emotional part of life, but it was not something I considered much [in practice]. It was considered to be the private part of the patient's life. Now with training, I've started to slow myself down and talk more with the patient. I've noticed very clearly how powerful this support can be for someone."*
>
> Family doctor trained in mhGAP, Donetska oblast, Ukraine

Conclusions

Taken together, efforts by MdM and IMC to scale up the integration of mental health care into general health care in conflict-affected areas of Ukraine have already demonstrated success in strengthening the mental health system. Many local PHC providers have gained crucial awareness of mental health and have already begun to identify and treat mental health conditions in their daily practice, while persons experiencing mental health conditions are receiving the essential care they need in many facilities across Ukraine. Bearing in mind that no system-level change can happen instantly, the progress made to date through the mhGAP-HIG project and previous mhGAP operations has been significant. Levels of service coverage have increased, a national consensus has been reached on a vision for mental health care development, effective coordination is ongoing and policy changes have been put in place to incentivize increasing mental health capacity. However, more work is needed to ensure that these successes are sustainable over time and can be scaled up across the country.

WHO and the Government of Ukraine remain committed to converting these recent successes and increased attention into longer-term sustainable change. This is why Ukraine was selected by WHO to participate in the Special Initiative for Mental Health (SIMH) 2019–2023. Launched in 2018, the SIMH aims to bring quality, affordable and rights-based mental health care to 100 million more people across the world, including the people of Ukraine, by strengthening mental health policy and scaling up quality services in both community-based general health care and specialist settings. In Ukraine, this initiative will build upon efforts to strengthen local capacity for community-based mental health care while further expanding and rolling out the mhGAP implementation framework, which, among many other actions, remains central to the country's priorities moving forward. As evidence of the key role that mhGAP will play in this project, 55 PHC workers have been trained on mhGAP in Ukraine since September 2020 as part of the initial implementation of the SIMH. These workers have begun to bring mental health services to 82 000 more people as a result.[1] While the work is far from over, commitment from the government, WHO and many other stakeholders holds real promise for the creation of a sustainable mental health system in Ukraine.

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[1] The full story of initial SIMH implementation, as of January 2021, is available here: https://www.who.int/news-room/feature-stories/detail/country-in-focus-early-implementation-in-ukraine

Championing change at the local level

San Ignacio Community Hospital. Source: Belize Ministry of Health.

Background

Belize is situated south of the Yucatan Peninsula in Central America. It is home to a population of approximately 400 000 people and is comparable with many of the Caribbean island states in terms of development, culture and historical background. Though the country is not currently a humanitarian context, unlike the others discussed in this report, people living there face a number of significant risks to their health, mental health and well-being. Belize is susceptible to natural hazards and faces many risks from hurricanes, floods and tropical storms due to its geographical location. Events of this kind can result in considerable impacts on health and mental health and, due to its limited development context, could take a major toll on the country's population. Over 41% of Belizeans live at or below the poverty line, with 15.8% considered to be extremely poor (19). In 2019, the country ranked 103rd on the Human Development Index (out of 189 countries), placing it below the average in terms of many important development indicators (13). Moreover, in recent years it has become host to an increasing number of migrants and refugees fleeing conflict and violence in neighbouring and other countries in Central and South America (20). These groups face additional challenges and are further susceptible to risks posed by any crisis in the country. Unfortunately, the global COVID-19 pandemic has starkly demonstrated this reality, with significant impacts on both the health and economic well-being of many people in Belize.

As part of health reforms carried out in the late 1990s, the Belize Ministry of Health organized health care provision into four regional areas, headed by regional health managers, with six administrative health districts in total and two public hospitals per region. All regional hospitals are located in urban areas, with the rural population served by a network of health clinics, health posts and mobile health units. A major challenge faced by the country's health system has been a limited health-care workforce, with most professionals concentrated in urban areas, particularly Belize City. The country has no medical facility where physicians are trained, although some categories of nurses, laboratory technicians, pharmacists and social workers are trained at the University of Belize. Furthermore, many health-care workers who are trained in Belize leave for employment in neighbouring countries. Additionally, the health system relies heavily on public financing, with the Ministry of Health receiving approximately 11.0% of the national budget in 2017 (21).

The mental health-care system in the country has historically faced many of these same challenges and in the past has relied heavily on an institutional model of care. However, beginning in the 1990s, the Belize Ministry of Health, with technical and financial support and guidance from the Pan American Health Organization (PAHO/WHO) and other partners, introduced a series of initiatives to move towards community-based models of care and to meet the need for an expanded mental health workforce. Chief among these was the initiation of a programme in which psychiatric nurse practitioners (PNPs) operating at the district level (one per hospital) were trained to integrate mental health care within their diverse health responsibilities, which include clinical caseloads, home visits and community outreach. The first cohort of nurses received training and mentorship in 1991. In 2004, a second cohort was trained, and a third in 2015. PNPs also receive close supervision and frequent consultations with the two psychiatrists in the country who review the most difficult cases. The establishment of the PNP system has vastly increased access to mental health care in Belize. Over time, the role of the PNPs has consistently evolved to include independent assessment of patients, initiation of selected treatments, prescription of psychotropic medications and psychotherapy, and consultation with local health and social agencies. In line with these expanding roles, annual workshops are also organized and sponsored by the Ministry of Health, with support from PAHO/WHO, to provide skills refreshers and to update training.

> **A MAJOR CHALLENGE FACED BY THE COUNTRY'S HEALTH SYSTEM HAS BEEN A LIMITED HEALTH-CARE WORKFORCE, WITH MOST PROFESSIONALS CONCENTRATED IN URBAN AREAS**

The PNP service provision model has coincided with many other efforts to shift towards community-based mental health care and to integrate mental health at the primary care level in Belize, with support from PAHO/WHO. Efforts to advance this shift have included workshops for general practitioners, public health nurses, midwives and other community health workers in mental health care and psychosocial support. These projects have also led to the establishment of a mental health advisory board to provide guidance on the direction of the mental health system; mobile psychiatric units that now provide access to rural villages with the highest levels of need; and the strengthening of referral systems to ensure continuity of care for persons with mental health conditions. The first national mental health policy was also drafted with support from PAHO/WHO and coincided with the establishment of a mental health unit within the Ministry of Health and a dedicated mental health budget. These efforts also resulted in the integration for the first time of mental health indicators into the national Belize Health Information System (BHIS), a comprehensive health information system that includes electronic health records for patients, and the establishment of a suicide alert system to improve the detection of suicide attempts and to provide timely support. As part of the trend towards community-based care, the Ministry of Health has also shifted further towards deinstitutionalization by closing the country's psychiatric hospital and launching a new community treatment programme in which former inpatients of the institution are visited regularly by staff.

Taken together, the community mental health programme in Belize, initiated by the Ministry of Health and supported by PAHO/WHO, has resulted in massive changes in the country's mental health system. However, despite the many successes over time, the sustainability of these efforts has been challenged by a number of factors. First, mental health care in Belize remains underfunded. Additionally, the PNP system has struggled with the heavy burden of care for nurses. Nearly 90%

of mental health services in the country are provided by these few PNPs, in addition to their other roles and responsibilities, and an increasing number of nurses leaving the country to seek new economic and other opportunities has resulted in workforce shortages *(20).*

In response to these growing challenges, local actors have begun working to strengthen the system. In the town of San Ignacio, the medical chief of staff of the San Ignacio Community Hospital sought capacity-building through WHO's mhGAP-HIG project in order to build the local mental health system in the Cayo district and to better serve persons with current MNS conditions. What follows is a story of change brought about at the local level through this project and the implementation of mhGAP-HIG in San Ignacio Community Hospital.

Actions and results

San Ignacio is a town in Cayo district in the Western health region of Belize, located on the banks of the Macal River. The town provides many health services to inhabitants of the surrounding rural countryside, including mental health services. However, San Ignacio presents a microcosm of the challenges faced by the larger mental health system in Belize. One psychiatric nurse is tasked with the majority of the mental health care provided by the San Ignacio Community Hospital, which serves a population of nearly 55 000, an increasing number of whom are migrants and refugees escaping violence and economic turmoil in other countries. As a result, capacity for mental health services has been limited historically.

Additionally, due to the **increasing time demands** on health-care staff in San Ignacio and other regions in Belize, **capacity-building has been a logistical challenge**. Despite intentions within the Ministry of Health to increase training for general health-care staff in mental health care, finances, limited capacity and competing priorities have prevented these intentions from being realized. As a result, **medication or referral were often the only forms of mental health care** available to many practitioners working in San Ignacio. However, after participating in WHO's mhGAP-HIG capacity-building training, the medical chief of staff at San Ignacio Community Hospital was committed to implementing the approach. Despite operating with no budget, no allocated professional time and limited training in mental health as a general practitioner, this individual championed the effort to respond to the limited availability of mental health services by implementing the mhGAP-HIG.

To advance this plan, the medical chief of staff engaged the deputy regional manager for the Belize Ministry of Health by **advocating for the value of integrating the mhGAP training**. Additionally, within the hospital itself, meetings were held with the nurse-in-charge, medical officers and general practitioners to advocate for the value of increasing capacity to manage MNS conditions. These discussions were advanced by **arguing for the value of sharing responsibilities** and reducing the number of admissions, repeat visits and overall burden on the system. Although neither formal support nor financing were made available, health authorities were supportive of the programme, which increased the hospital's ability to begin implementation.

Given the **lack of resources invested** in the project, the intention was to **build a case study of success to advocate for financing** to support scale-up within other hospitals across the region and the country. To this end, the medical chief of staff at the hospital was trained as a trainer and supervisor during mhGAP-HIG training held by WHO and IMC in the summer of 2019. Thereafter, he received follow-up mentorship and guidance from WHO staff. Ultimately, the mhGAP-HIG training model was adapted for implementation in **a series of weekend sessions** that would be followed by live observational training in the hospital. This approach was necessary given that **no formal support in the form of allotted time for training was available** for the project

or participants. Nonetheless, two junior general physicians expressed interest in the training and **committed time outside of work** to build their capacity. These **physicians had only partially completed the training** when the COVID-19 pandemic drastically impacted their workloads and required them to spend much of their time in the field responding to the emergency. Nonetheless, **learning has continued through observation**, when possible, along with **experiential application of the modules covered**. Furthermore, competency has been continually assessed through supervision and in-person observations.

Despite the disruptions caused by COVID-19, participants have reported **significant changes in their perspective** on mental health care and their confidence in supporting people who present with MNS conditions. Prior to the training, participants reported a belief that the only solutions available were to refer patients presenting with potential mental health-related concerns or to prescribe medication or placebos.

> *"mhGAP has given us the confidence that mental health concerns are just as important and can be treated in more than one way. We can provide the support that is needed at the general health care level to reduce system burden and distress."*
>
> Medical doctor, San Ignacio Community Hospital

This change in perspective has **translated into a change in the services provided**. Between January and June 2020, patient tracking data indicated that the two trainees had identified 19 persons experiencing MNS conditions and provided basic interventions according to mhGAP-HIG modules. This is in comparison with a total of 28 such diagnoses for the entire year previously, the majority of which were immediately referred to the hospital's psychiatric nurse or sent home with medication or placebos. Importantly, the mhGAP model of care also seems to fit well with attitudes toward mental health in Belize generally. One of the trainees stated: "It is very important for mental health care to have the opportunity to see someone as a primary care doctor, where you may not have that stigma attached."

Conclusions

Though the programme remains only partially implemented on a small scale, the efforts of San Ignacio Community Hospital to scale up the mental health system have been truly admirable. Nonetheless, even before the COVID-19 pandemic, much greater formal support was needed to build the mental health system in the Cayo region and across Belize as a whole. Fortunately, there is a plan to continue advocating for this scale-up, using concrete results from the San Ignacio Community Hospital to show the value of the mhGAP-HIG nationwide. To some, this plan may seem ambitious, if not impossible, without budgeting, formal administrative support and dedicated professional time to carry it out. However, the implementation of the mhGAP-HIG in San Ignacio has proved that an essential ingredient in successful capacity-building may be a local advocate willing to go above and beyond their formal role to champion the effort.

Discussion and lessons learned

Source: Source: WHO/ Karen Reidy

The case studies presented in this report describe a number of useful approaches to integrating mental health care within general health services and strengthening mental health systems in humanitarian and under-resourced contexts. Each of these projects was unique in terms of both its setting and the various challenges experienced. Each case also demonstrated successful changes in mental health systems and shared a few common themes:

1. Each story involved actors working in low- or middle-income countries, three out of four of which have been significantly affected by ongoing conflict, where mental health policies and systems have been less developed and under-prioritized historically.

2. Each story reviewed the work of an organization which participated in WHO's mhGAP-HIG capacity-building project, which included ongoing technical support and mentoring.

3. Each story placed recent efforts by mhGAP-HIG participants in the context of long-term efforts by national governments, WHO and other partners to strengthen the mental health system through multiple approaches, including mhGAP operations. This support set the stage for successful implementation of the mhGAP-HIG in the stories described.

In reviewing the four stories, key factors can also be identified that led to success. The identification of these components can serve as lessons learned to inspire future implementers, including both decision-makers and humanitarian response or development agencies. While it is not possible to determine the exact role and relative weight of each of these lessons with the methodology of these case studies, the lessons may be very useful in informing future mhGAP operations. These are as follows:

- **Programmatic support** can be key to initiating change in contexts where there are many competing priorities and limited resources. In each of the four cases, WHO contributed technical support to various stakeholders and collaborated on moving mental health initiatives forward both through mhGAP implementation and through wider policy support, capacity-building, coordination and other approaches to system strengthening. In the cases of South Sudan and Libya, WHO facilitated funding for solutions to systemic challenges, such as procurement of medications or professional training and education and other support. These investments established strong bases which supported mhGAP operations. Likewise, INGO actors in the four countries continued this support for further advancement in their respective projects. For instance, in Libya, IRC donated medical supplies, equipment and other resources in order to build relationships and ensure equitable access. Similar actions were taken in other countries, and may be necessary to advance mental health actions in complex contexts.

- **Providing formal recognition for training** and health-care providers can be crucial to ensuring mhGAP uptake. In Ukraine, the inclusion of mhGAP training hours as valid professional vocational training credits, which are counted towards continuous professional development requirements, was essential to ensuring that staff were able to allocate precious time in overburdened health systems. In Libya, WHO's support for national professionals over time was crucial to building a professional workforce that was foundational in IRC's mhGAP programme. In the case of Belize, on the other hand, the lack of such support was a barrier to ensuring wider mhGAP-HIG implementation.

- **Emphasizing wider system development and sustainability** is crucial for ensuring that an mhGAP project is successful. This is particularly true when mhGAP-HIG projects are led by INGO providers whose likelihood of remaining in the country may be time-limited. A wider systemic focus is the foundation of WHO's mhGAP operational approach and includes development of national policies and plans, strengthening of coordination and referral systems, consistent and sustainable medication procurement pathways and intentional selection and training of providers, trainers and staff, among other actions. In these cases, the mhGAP programme emphasizes system strengthening and sustainability through the establishment of national mhGAP operations teams and by facilitating vocational training for national professionals who will later serve as mhGAP supervisors, trainers and practitioners. The programme also supports changes to mental health systems, such as increasing access to medications through policy revision or procurement support, building or revamping information systems, restructuring or strengthening referral pathways and supporting coordination mechanisms. This long-term view was also transferred to participants in the mhGAP-HIG capacity-building project, who have subsequently emphasized systems strengthening in their projects. Such a view can also be translated to internal restructuring and organizational changes, which can lead to successful future mhGAP implementation.

- **Advocacy and awareness raising** are critical to ensuring that stakeholders are supportive of implementing a project and that community members are able to access services. This includes generating buy-in from both local communities and affected persons as well as local, regional and national government authorities. Cultivating local champions who can lead these efforts can be crucial. In all four cases, implementers began mhGAP-HIG projects by advocating for them with key stakeholders. In multiple cases, awareness-raising and the reduction of stigma were also essential to success. In Libya, a national campaign was undertaken that set the stage for continued awareness raising by IRC actors. Meanwhile in South Sudan, Medair's engagement with local traditional health and community health workers was essential to increasing service uptake.

- **Establishing working relationships** can also lead to greater trust and collaboration among partners, which is essential for implementation. In South Sudan, both the support and backing of WHO and the previous success of humanitarian programming by Medair in Leer county were crucial for developing buy-in and support from local authorities, stakeholders and service providers. Likewise, in Libya, Ukraine and Belize, the long-term relationships and trust built between WHO, the national Ministry of Health and other stakeholders played a role in setting the stage for successful mhGAP roll-out.

- **Engaging coordination mechanisms**, such as MHPSS technical working groups (if in place), contributes to the success of a project. In Ukraine, efforts across the many actors working to respond to the emergency were coordinated through the national mhGAP operations team, the national MHPSS working group and regional sub-working groups led by implementing agencies. Similar links were established with coordination groups in South Sudan and in Libya. In making these connections, effective coordination can lead to increased service utilization and effective referral, as well as to conservation of resources and reduced levels of duplication.

- **Adaptation of materials, training structures or service provision approaches** is essential to ensure that contextual needs are met within the limits of local resources and other limitations. This may be particularly true in settings that have fewer human resources or limited support in the way of professional time allocation. In Ukraine, implementing agencies developed a blended model of the mhGAP-IG and mhGAP-HIG. In all three conflict-affected settings, contextualization workshops were held and attended by key partners to ensure adequate adaptation of the materials to the local setting. In many cases, training approaches were also adapted to fit practical needs. For instance, in Ukraine, MdM developed a training approach in which the blended mhGAP modules were discussed individually in separate sessions to allow for case discussions and experiential learning and to save time. In South Sudan, Medair implemented an apprenticeship system to pair less experienced or skilled workers with more experienced practitioners to promote on-the-job learning and quality service provision. These and other important adaptations were essential to ensuring that mhGAP projects were contextualized to meet unique local needs and complexities.

- **Engaging both general practitioners and specialists can increase confidence and helps to build the mental health system.** By demonstrating the usefulness of the mhGAP-HIG at the primary and secondary general care levels, systems can be strengthened by building confidence and familiarity across different levels of care in settings where referral pathways have previously been limited or non-existent. Such was the case in Ukraine, where psychiatrists and psychologists working in larger cities were invited to participate in trainings alongside family doctors and general care providers. Through these experiences, personal and professional trust and bonds were created that helped to enhance referral systems and build a less centralized system.

Conclusion

Mental health continues to be one of the most neglected areas of public health and humanitarian health responses, despite the enormous burden of disease from mental health conditions. While almost one billion people (13% of the world's population) live with a mental disorder, countries spend on average less than 2% of their health budgets on mental health, and less than 1% of all international development assistance for health goes towards mental health. In low- and middle-income countries, the fact is that the vast majority of people with mental health conditions receive no treatment. In humanitarian settings, where these conditions may be more common, these figures are even worse due to struggling, overwhelmed and damaged health systems, inadequate resources and limited capacity. In response, international guidelines, such as the Sphere standards and the IASC Guidelines on MHPSS in Emergency Settings, underline that humanitarian assistance should address mental health and psychosocial issues through intersectoral actions that include both the formal integration of mental health care within primary care settings and a range of other complementary MHPSS activities, such as actions aimed at strengthening community supports and community networks.

WHO's mhGAP programme provides scalable and accessible solutions to effectively increase access to mental health services in primary care settings in these fragile contexts, but governmental partners, INGOs and UN agencies, and other stakeholders must work together to ensure that these solutions are advanced and taken to scale. However, doing this can be particularly challenging without the necessary technical support or experience, and stakeholders may be unsure about how to begin implementation in the contexts in which they work.

This report highlights key examples across diverse settings to demonstrate the feasibility of mhGAP-HIG implementation by INGO actors following targeted capacity-building and with ongoing mentorship and support. In addition to providing a narrative evaluation of the project, it is also intended to inspire other humanitarian response actors and stakeholders by presenting these four case studies to illustrate varied strategies that have proved successful in the field.

> THIS REPORT HIGHLIGHTS KEY EXAMPLES ACROSS DIVERSE SETTINGS TO DEMONSTRATE THE FEASIBILITY OF mhGAP-HIG IMPLEMENTATION BY INGO ACTORS FOLLOWING TARGETED CAPACITY-BUILDING AND WITH ONGOING MENTORSHIP AND SUPPORT

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