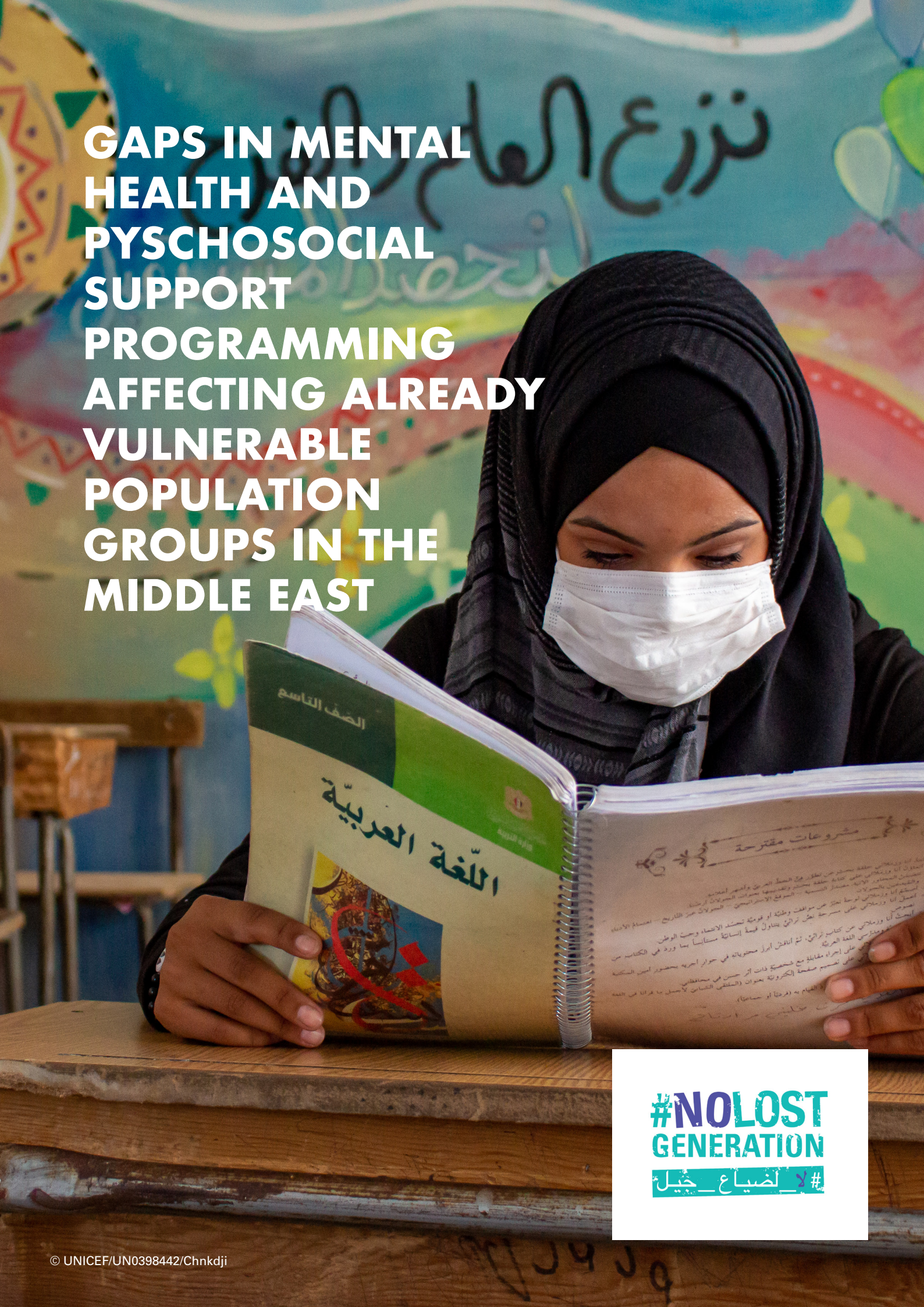
GAPS IN MENTAL HEALTH AND PYSCHOSOCIAL SUPPORT PROGRAMMING AFFECTING ALREADY VULNERABLE POPULATION GROUPS IN THE MIDDLE EAST



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INTRODUCTION

Already prior to the COVID-19 pandemic, 10-20% of children and young people worldwide experienced mental health conditions, with 1 in 4 children estimated to be living with a parent who is struggling with a mental health disorder.[1] Additionally, 420 million children live in conflict zones, with an estimated 56 million children requiring MHPSS interventions.[2] The WHO estimates that 10%-20% of the population may struggle with moderate forms of mental health conditions, which in turn impacts the society's ability to function.[3]

The Middle East region encompasses a worryingly high prevalence of mental health conditions due to years of conflict, violence, economic vulnerability and instability. Recent surveys have revealed that the prevalence of mental illness ranges from 15.6% to 35.5% of the region's population with depression, anxiety and Post-Traumatic Stress Disorder (PTSD) being particularly common.[4] This mental health crisis has been further exacerbated by the COVID-19 pandemic that weighed on already vulnerable populations' mental wellbeing.[5] Meanwhile, lack of awareness, limited mental health services, and stigmatization are some factors that prevent patients from seeking help.

The Inter-Agency Standing Committee (IASC)'s intervention pyramid for MHPSS in emergencies promotes the need for complementary support systems that meet the needs of different groups in emergencies. In addition to (1) the provision of specialized clinical services, the pyramid also includes (2) focused non-specialized psychosocial support, (3) strengthening the capacity of individuals, families and communities to support themselves, and (4) embedding social and psychological considerations into the way basic needs and security are delivered or established.[6]

The No Lost Generation's (NLG)'s Mental Health and Psychosocial Support (MHPSS) Taskforce consisting of members from several organizations was set up to contribute to an improved MHPSS response in 6 countries including Iraq, Syria, Lebanon, Jordan, Turkey, and Egypt.[7] In the summer of 2021, the taskforce commissioned a survey[8] to examine the status of MHPSS programming in the region, identify gaps in the sector, and offer strategy and policy recommendations based on the surveyed MHPSS providers' first-hand experience. Additionally, the taskforce wanted to understand the impact of COVID-19 on the ability of these organizations to carry out their MHPSS programs while drawing on lessons learned from the ongoing pandemic.

[1] Operational considerations for multi-sectoral mental health and psychosocial support programs during the COVID-19 pandemic. IASC Reference group on mental health and psychosocial support, 2020
[2] The funding gap for child and family mental health and wellbeing. SCI and the MHPSS Collaborative, 2020
[3] Guiding Framework for MHPSS in Development Cooperation: As exemplified in the context of the crisis in Syria and Iraq. GIZ (201
[4] Ibrahim NK. Epidemiology of Mental Health Problems in the Middle East. Handbook of Healthcare in the Arab World. 2021:133-49
[5] WHO. COVID-19 disrupting mental health services in most countries, WHO survey. Geneva, Switzerland: World Health Organization; 2020 [Available from: https://www.who.int/news/item/05-10-2020-COVID-19-disrupting-mental-health-services-in-most-countries-who-survey].
[6] IASC. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva, Switzerland: World Health Organization; 2007. [Available from: https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf].
[7] No Lost Generation. 2021 [Available from: https://www.nolostgeneration.org/who-we-are].
[8] Kindly contact No Lost Generation (NLG) for further information on the full survey.

METHODOLOGY

This report presents survey findings from in-depth individual interviews conducted between August and September 2021 with a diverse group of 18 key informants (KIs) from 15 organizations working on the MHPSS response in the 6 NLG countries. Half of the key informants had 6-10 years of experience in the MHPSS sector, while others (33.3%) had been committed to it for more than a decade. Half (50%) of the organizations they worked with were providing MHPSS services both directly and indirectly through partners, while 33% were only providing direct services and approximately 17% were only providing indirect services. More than a third (33%) provided services at all four levels of the IASC pyramid, while others (approx. 17%) focused on just one of the four levels. The MHPSS services were provided to a wide range of beneficiaries including Syrian refugees, local IDPs and host communities. The interviews were conducted online via zoom and Teams, using a semi-structured essential informant guide, while a thematic framework analysis approach was used to interpret the findings.

A comprehensive desk review[9] was conducted in parallel to the survey in order to fill any remaining informational gaps with credible sources. Additionally, the desk review can support the coordination efforts of agencies, international and local organizations by providing an evidence base to inform future research and emphasize that MHPSS programming can be cross-cutting and multi-sectorial while also service policy and advocacy purposes.

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In the Middle East region, children and young people (10-24 years) are particularly

[9] Kindly contact No Lost Generation (NLG) for further information on the full desk review.

MAIN DESK REVIEW FINDINGS

vulnerable, with the impact of conflict extending well beyond physical and mental wellbeing. Exposure to traumatic events, loss and separation, displacement, and violence directly affects their positive coping abilities and sense of safety, and could also exacerbate pre-existing mental health conditions. This interruption of normalcy can impact the physical and mental development of children and young people, while also contributing to the breakdown of social networks and family structures.[10] [11] In the region, some of the main documented challenges in MHPSS programming are lack of investment in MHPSS, reduced number of specialized professionals and limited accessibility to MHPSS services.[12] In the review of the literature, some of the challenges particularly relevant to the Syrian and Iraqi crises were: engagement of caregivers and young people in MHPSS services, coordination of the MHPSS services, and capacity building of communities and key staff. [13]

a. Regional Situation

The Syrian crisis has resulted in 5.5 million refugees in the 5 "NLG countries" neighboring Syria, with Turkey hosting the largest number of 3.6 million Syrians. Jordan and Lebanon host the highest numbers per capita leading to multiple layers of vulnerabilities including food shortages and protection risks.[14] Refugee populations live in conditions that rely on the ability and will of host countries to provide for and integrate them.[15] Although investment is required to meet all the mental health needs of the refugees in the region, government expenditure regarding mental health in health budgets ranges from 2% to 5% in Syria, Egypt, and Lebanon. [16] In Turkey, Lebanon, Iraq, and Jordan, refugees can receive mental health care through facilities or primary health care centers. However, reliance on psychiatric care for major mental health conditions remains in the forefront of care,[17] and reliable data on prevalence rates of various mental disorders that are country specific is lacking. [18]

The COVID-19 and related lockdown measures have created new vulnerabilities resulting from physical distancing and social isolation. This has exacerbated psychosocial distress in refugee children and young people (young men, young women, boys and girls), resulting in a rise in harmful coping strategies, substance abuse, suicidal behavior, and lack of access to appropriate care for those with pre-existing mental health conditions. Additionally, an overall experience of fear due to helplessness, of separating from loved ones, of becoming ill, or of social exclusion may create feelings of stress, worry, and powerlessness. The long-term impact of COVID-19 may give rise to anger and aggression, mistrust, and stigma within families and communities.[19] In **Turkey** Pre-COVID, Syrian refugees were facing language and socioeconomic barriers to public services, now in the second year of the pandemic these barriers are risking their access to important and basic services. The regional response plan has prioritized the engagement of partners to adapt services to the current context in order to prevent disruption of services and to respond to additional needs. One of the main activities is increasing

[10] Mapping repot phase 2 report: MHPSS programs for children, adolescents, youth (24-0 years) and parents/caregivers in Syria from Syria and Iraq affected countries. No Lost Generation MHPSS Taskforce, (2019)
[11] Mental Health and Psychosocial Support for Resettled Refugees. International Office of Migration (IOM), 2020
[12] MHPSS programs for children, adolescents, youth (24-0 years) and parents/caregivers in Syria from Syria and Iraq affected countries: Desk Review. No Lost Generation MHPSS Taskforce, (2020)
[13] MHPSS programs for children, adolescents, youth (24-0 years) and parents/caregivers in Syria from Syria and Iraq affected countries: Desk Review. No Lost Generation MHPSS Taskforce, (2020)
[14] UNOCHA: 2021 overview
[15] Guiding Framework for MHPSS in Development Cooperation: As exemplified in the context of the crisis in Syria and Iraq. GIZ (2018)
[16] Strengthening mental health care systems for Syrian refugees in Europe and the Middle East: integrating scalable psychological interventions in eight countries. European Journal of Psychotraumatology (2017)
[17] Strengthening mental health care systems for Syrian refugees in Europe and the Middle East: integrating scalable psychological interventions in eight countries. European Journal of Psychotraumatology (2017)
[18] Guiding Framework for MHPSS in Development Cooperation: As exemplified in the context of the crisis in Syria and Iraq. GIZ (2018)
[19] IASC- Addressing Mental Health and Psychosocial Aspects of COVID-19 outbreak, version 1.5, February 2020

community engagement to provide public awareness on and supporting public institutions to develop platforms to learn life and vocational skills. [20]

The **Lebanese** Crisis Response Plan, has emphasized a protection centered lens to all interventions due to social tension and increased negative communal relations. Additionally, community engagement through trusted channels to decrease risks and continue life-saving activities. Lebanon has prioritized the support of primary health care, through case management and medical supplies, in addition to emergency cash, flexible education programs, and food assistance.[21]

The socioeconomic challenges in **Jordan** have increased the toll of stress from increasing vulnerabilities and access to basic needs. There was an increase in reported violence against women and girls, challenges with education through distance learning and engagement of parents.

The political situation compounded with the COVID-19 pandemic has created a unique situation in **Iraq** due to lack of freedom of movement and limited access to public services and crucial personnel, for example, MHPSS service providers. That being said, one of the key activities promoted in Iraq is to support health institution and the Department of Health, in addition to WASH, and COVID-19 capacity building and health awareness. Refugees, asylum seekers, unaccompanied and separated children and youth, and vulnerable host communities are all facing the worsening vulnerabilities created by COVID-19.

[20] Regional Refugee and Resilience Plan in Response to the Syria Crisis: COVID-19 Response (2020)
[21] Regional Refugee and Resilience Plan in Response to the Syria Crisis: COVID-19 Response (2020)

UNHCR reports that community based psychosocial workers in **Egypt** were able to continue working in urban settings. This was done through maintaining a helpline 24 hours per day, conducting various activities related to MHPSS programming when permitted, those including: follow up, psychological counseling, crisis response, and home-based support. With changing restrictions, a growing dependency on creativity was implemented through: telephone calls, WhatsApp discussion groups, and Facebook posts on parenting advice and self-care.[22]

As the number of COVID-19 cases continues to rise in the region, the situation remains unstable and increases feelings of anxiety and stress. In response, providing remote awareness and psychological counselling for concerned persons and health workers is proving to be pivotal. UNHCR, IMC, ACF, World Vision, World Child Holland and other MHPSS providers in the region have provided mental health and psychosocial support remotely in 2020 and 2021. These services included: remote psychological intervention, psychoeducation and awareness sessions, online psychosocial support activities for children via social media, radio programs, Psychological First Aid for children, sensitization on positive parenting skills and home schooling, online support to health workers and more.

b. MHPSS as cross-cutting Programming

In an effort to promote social cohesion and peace building, multi-sectorial links with MHPSS services reduce stress and avoid future cycles of violence. [23] This will help increase the scope and sustainability of the MHPSS interventions in the long-term, [24] and will improve methods by which children and families are supported when they are in distress.[25]

Examples of such integration include: **WHO's MhGap, PM+, and Thinking Healthy.[29]**

Health Through awareness raising activities and health education, integration of MHPSS programming with health can improve access, wellbeing and reduce stigma. The most vulnerable populations can often suffer from health and mental health comorbidities, thus they are more easily reached through this integration.[26] Early recognition and early intervention of mental health conditions can lead to an improved quality of life. This can be done through capacity building and supervision of health staff on trauma sensitive approach, and linking psychological symptoms with patient's history in order to improve current functioning.[27] Awareness raising activities can help reduce stigma of help seeking behaviors, address fears, and build trust in people and health systems.[28]

Examples of such integration include: **Save the Children's Social Emotional Learning.[32]**

Education for children and young people has a normalizing effect and may thus lessen the psychosocial effects of extreme stressors and displacement and protect at-risk groups. It is recommended to increase the provision of evidence-based psychological ***interventions*** for children and young people (young men, young women, boys and girls), and build the capacity of non-MHPSS specialist workforce. For individuals and organizations who work with children, high intensity capacity building to better meet their mental health needs,

[22] Emerging practices: mental health and psychosocial support in refugee operations during the COVID-19 pandemic, UNHCR. 2020
[23] The silent pandemic: the impact of COVID-19 pandemic on the mental health and psychosocial wellbeing of children in conflict affected countries. World Vision (WV) and War Child (WC), (2021)
[24] Delivering mental health and psychosocial support interventions to women and children in conflict settings: a systematic review. BMJ global health, 5(3), e002014
[25] The silent pandemic: the impact of COVID-19 pandemic on the mental health and psychosocial wellbeing of children in conflict affected countries. World Vision (WV) and War Child (WC), (2021)
[26] Delivering mental health and psychosocial support interventions to women and children in conflict settings: a systematic review. BMJ global health, 5(3), e002014
[27] Tool kit for the integration of mental health into general health care in humanitarian settings. International Medical Corps (IMC),
[28] Guiding Framework for MHPSS in Development Cooperation: As exemplified in the context of the crisis in Syria and Iraq. GIZ (2018)
[29] Mental health and psychosocial support (MHPSS) cross-sectorial strategic framework in humanitarian settings. Save the Children (SCI), 2019-2021

this includes: teachers, social workers, protection, child protection and GBV case workers[30] Training of teachers on trauma sensitive approach, recognizing psychological distress, Psychological First Aid (PFA), and referrals to a network of MHPSS actors, can create access and decrease stigma around mental health.[31]

Examples of such integration include: **IRC's Women Rise: A GBV Toolkit.**[34]

Child Protection- Gender based violence In humanitarian settings, women and girls experience different forms of trauma, some of which can include GBV incidents. Additionally, living in patriarchal societies leaves the women without equal access to power and decision making. When protection related challenges are experienced, psychosocial interventions aim to reduce stress, address stigma, and promote empowerment of the survivors, and can be integrated in all aspects of GBV case management.[33]

Examples of such integration include: **Action Against Hunger's Employability Package.**

Livelihoods and Employability Integrating MHPSS programming with livelihoods projects, especially for youth, can provide intervention that would stop the vicious cycle where mental health impacts employability, and socioeconomic disparities impact mental health. Livelihoods and employability projects integrated with mental health support can increase internal and external support available to youth through identify the stressors at the family and individual level, therefore leading to more motivated and productive members of society. Interventions should be flexible and accessible to youth, and should address the mental wellbeing challenges resulting from the socioeconomic conditions.

MAIN SURVEY FINDINGS

a. Overview of most prevalent concerns and ongoing MHPSS response

Most surveyed key informants served beneficiaries whose main concerns were depression/anxiety, COVID-19, trauma, primary mental health illnesses, suicidal thoughts, and child labor. Very few of the organizations were offering services for severe mental health cases. The majority only provided basic services that focused on specific conditions, while special populations like children were not considered. The different organizations they worked for were at different stages of integrating their MHPSS services within the other services they were offering, while others did not consider this approach. Most organizations had limited consideration for gender and disability aspects but had plans to incorporate them into their strategies in the near future.

"We focus mainly on trauma and refer other cases to government facilities. We do not have options for follow-ups on our referrals." – KII007

Some organizations worked with partners offering specialized services for severe mental health cases. However, most institutions did not offer any structured services aimed at addressing severe mental health cases and certain regions did not have any services for such cases. This was particularly the case for Syria as a whole, where mental health services have been deeply affected by the ten-year conflict, while stigma surrounding mental health treatment also remained very much ingrained in the local culture. Nevertheless, in northern Syria, WHO-supported specialized MH services were available in at least three areas, while in-patient MH services for children were still lacking.

Most of the organizations were offering age-specific MHPSS services. The services targeting children were sometimes organized to target the different age

[30] NLG MHPSS TF Advocacy Brief (2021)
[31] Guiding Framework for MHPSS in Development Cooperation: As exemplified in the context of the crisis in Syria and Iraq. GIZ (2018)
[32] Mental health and psychosocial support (MHPSS) cross-sectorial strategic framework in humanitarian settings. Save the Children (SCI), 2019-2021
[33] Guiding Framework for MHPSS in Development Cooperation: As exemplified in the context of the crisis in Syria and Iraq. GIZ (2018)
[34] https://www.youtube.com/watch?v=TIyIqdZczik

"We have doctors or psychiatrists who work with severe MH cases in at least three locations in northern Syria, and there are three psychiatric units funded by WHO for adult in-patient and outpatient services. However, there are no in-patient services for children." – KII 016.

"We are trying to mainstream it into all our programs and practices because not all programs are taking MHPSS into consideration. They do not want to send out a message that MHPSS is a crucial part of their intervention." – KII 002

"By working collaboratively with partners and the community, we progressively continue to contribute to building capacity at the local level." – KII 003.

"Integration across programming is key and will allow sustainability. Making sure MHPSS key messages and big objectives are integrated into education, food security, livelihood, life skills programming." – KII 012.

groups. A variety of tailored services were available for the different age groups and categories of people. Others were providing integrated services, offering services depending on the needs of the individuals. Services provided included group and individual counselling, protection services, and psychosocial support. Most had integrated services targeting different groups depending on the identified needs. The organizations utilized different manuals to deliver MHPSS interventions based on the type of intervention, with some developed in-house while others were adopted from other institutions, including WHO.

b. Provision of MHPSS as integrated and cross-cutting services

The different organizations were at varying levels of integrating their MHPSS services within the other services they were providing. Some had made tremendous strides as far as integration of the services. Some were still at the planning stages, while others had not started the integration process and ere till offering mental health and PSS services as standalone programs.

Among those that had advanced in this process, they integrated mental health services into PSS and protection services, while others succeeded in integrating them into health services or facilities. Several organizations were in discussion with other service providers to ensure the integration of such services.

We have three thematic areas we try to integrate with MHPSS: Child protection, PSS and Education. KII 006.

Previously, most organizations had limited consideration for gender and disability aspects. However, there was a shift with increased consideration of these aspects, with several institutions conducting gender mainstreaming for all their programs. Some organizations already had gender and disability inclusion experts who ensured that these aspects were considered in their programs. Others had specific programs targeting vulnerable groups, including females and persons with disabilities. All staff were trained on gender and disability inclusion to ensure that all vulnerable groups were considered.

c. Sustainability of MHPSS interventions and associated challenges

As a sustainability strategy, most organizations worked closely with communities, building the local providers' capacity and creating awareness on MHPSS to ensure continuous service provision. This was viewed as a critical pillar for provision of services in the long term. There was also continuous peer supervision and staff training to sustain the MHPSS services. Increased collaboration and exchange of ideas among MHPSS service providers were seen as key for sustainability.

With funding for some organizations coming to an end after a defined period of time, collaboration was seen as a way of ensuring the continued provision of services with those having funds sustaining service provision with existing of others. Hence, working in collaborations such as consortium was noted to be vital for ensuring sustained service provision. Capacity building for other humanitarian organizations working in the settings was also noted to be essential. Besides, most organizations formed partnerships with government agencies and other non-governmental organizations to provide the MHPSS services.

Other organizations worked to transfer the skills and expertise to local service providers and engaged academic institutions such as universities. Other adopted training approaches with implementation partners. When the funding period ended, the partners whose capacity had been built could continue providing the same services. Integration of services provided into a variety of programs was also seen as an essential sustainability approach.

Strengthening the existing structures was also a key part of the sustainability approach utilized by most organizations. Others worked with donors to ensure sustained funding while engaging the governments to take full ownership of MHPSS service delivery. Involving key opinion leaders in the community was also noted to be essential for sustainability. In addition, a holistic approach that considers sustainability from the onset of the intervention was considered essential for sustained such services.

Self-reflective practices among service providers, and continuous monitoring and evaluation of service provision was another suggested approach for sustainability. Besides, with the challenge of human resources for the provision of MHPSS, task shifting was seen as an essential pillar where other health providers could be trained on the provision of MHPSS to ensure sustained service delivery even with the scarcity of skilled MHPSS providers.

"We usually have specialized centers in agreement with E-centers for consultancy and psychiatric services. We have staff-care sessions for all the staff, both group and individual sessions." – KII 007.

Building the capacity of field teams was also highlighted as key to expand coverage. In order to ensure local capacity building, one organization had plans to roll out a diploma program on child and adolescent mental health in the Middle East region. However, limited funding was a barrier hindering the sustainability of capacity building efforts and subsequently impacting the coverage and quality of services in the long term.

d. Provision of staff care

The stressful work environment in the humanitarian setting affected the MHPSS workers, significantly increasing the need for staff care services. All of the key informant's organizations were providing some form of staff care at no cost. COVID-19 increased prioritization of staff care, pushing organizations to develop guidelines on the same. One had a consultancy agreement for staff care services provision.

Several organizations tapped on peer-to-peer support to bridge gaps in staff care provision. They also had procedures and guidelines for staff care including organized workshops and trainings. They also conducted frequent surveys on staff care to better understand the needs and gather feedback on the quality of the services that are being offered.

"Due to COVID-19, staff care sessions were disrupted, and remote sessions were not so effective." – KII007

Nevertheless, the area of staff care was also impacted by inadequate funding while the teams offering these services were under immense pressure to meet the set targets affecting the quality of services offered. There was also limited expertise in staff care provision. In addition, COVID-19 was identified to have resulted in the disruption of staff care provision. Utilization of these services was also low due to stigma, misconceptions, and lack of awareness.

e. Impact of the COVID-19 pandemic

"People lost their jobs. This affected them psychologically because there's no income. Relatives died from COVID-19." – KII015

COVID-19 pandemic and the associated economic recession resulted in adverse effects on the mental wellbeing of people in the region. It increased the suffering among individuals already dealing with challenges associated with war which is known to result in depression, anxiety, low esteem, and distress. Most household heads lost their jobs during the pandemic while income dwindled, which increased mental health distress. The measures to control COVID-19, including lockdown and curfew, disrupted people's social lives as they could not meet face-to-face for interactions; hence, they had to rely on online platforms. With the restrictions associated with COVID-19, accessibility of mental health services become a challenge. At the same time, the pandemic control measures in place exacerbated the already existing mental health situation, resulting in an increased burden of mental health symptoms and disorders.

"Children were greatly affected. They have been away from school (place of truth), which was traumatizing for them."– KII005

"It led to increasing child abuse and high level of domestic violence affecting women and children, depression level increased."– KII013

"We have gone remote, and, in some context, we have managed to maintain face to face with social distancing, reduced size of activities due to social distancing regulation. We have modified our packages for delivery in remote areas as well in terms of content and modality of intervention".– KII003


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Children were also significantly affected, and they could no longer access their formerly safe spaces, including school and playground, which were closed. Services meant for vulnerable children become less accessible, and this increased their suffering and distress.

Cases of child abuse increased significantly with the pandemic, with domestic violence incidences also being commonly reported. COVID-19 had also disproportionately affected people living with disabilities and increased their PSS needs. It resulted in a shift in focus from mental health issues to the COVID-19 control measures in most countries, including the acquisition of vaccines.

COVID-19 greatly affected the delivery of mental health services in the region, including referral services. Communication between service providers was also noted to be a key challenge. MHPSS programming was greatly affected by COVID-19, with most interventions being modified in terms of mode of delivery and content. It also resulted in most programs stalling before completion while others were reorganized to conform with the existing realities, especially being limited in scope and reoriented to specific areas. New modalities had to be developed and deployed rapidly, such as online service delivery, to reach beneficiaries during the period. Besides, most organizations had to conduct capacity building for their staff, improve coordination mechanisms and address the existing gaps in service delivery.

CONCLUSION & RECOMMENDATIONS

It is evident that depression, anxiety, COVID-19 and child labor are the most prevalent concerns of MHPSS beneficiaries in the Middle East region. Meanwhile, the pandemic has only intensified the vulnerability and mental health impacts among residents of the region. While several organizations operating there hold diverse MHPSS interventions to address mental health needs, including children and adolescents, a myriad of challenges hindered successful and effective service delivery. Integration of MHPSS was still a challenge, with many organizations running a variety interventions with key aspects linked to mental health or PSS left out. Limited services for severe mental health conditions remains a key gap

in the response. In addition, limited funding earmarked for MHPSS programs in the region hindered the sustainability and impact of the overall response in the long term. Lastly, a lack of investment in capacity building and mental health care for MHPSS staff is also a major challenge to the good continuation of MHPSS activities in the region.

RECOMMENDATIONS:

Long term funding coupled with sustainable MH strategies at the national levels:

- Flexible and sustainable funding for tailored MHPSS in the region is needed in order to provide quality services.
- The need to advocate for local funding for MHPSS was also seen as essential, especially as concerned governments were providing very little or no funding for these essential services.
- Sustainable capacity building at national level are also needed to ensure that the people working in the sector have the right skills and knowledge to design long-term strategies.
- Concerned governments in the region need to come up with sound strategies and policies on mental health. They also need to push for the full implementation of the MH plans already set by governments and focus on the provision of affordable and accessible specialized MH services for local populations in need.
- Lastly, The need for a secure environment for the provision of mental health services and training of the service providers was also essential for the sector, considering the fragile security situation in the region.

Localization of MHPSS services:

- The need to localize MHPSS is also essential if significant progress is to be made through strengthened and empowered local actors in the sector.
- Increasing the local capacity through training of the local service providers was noted to be essential for sustainability.
- Improvement in partnership with government systems can also contribute to the mainstreaming of service delivery.
- Improvement in the referral systems to ensure smooth referral for clients in need of specialized services was also identified as an urgent need.
- Increased understanding of the sector and more robust monitoring and evaluation systems were seen as crucial components needed for the sustainability of service delivery at local levels.

Staff care and capacity building:

- Increased focus on staff wellbeing and staff care is a key area in need of further attention and investment.
- Improved capacity building for staff offering cross border or remote services is also encouraged due to the enormous skills gap.
- Mentorship programs meant to increase junior staff's skills set from senior staff are also key in building capacity and enhancing the sustainability of the services offered in the long term.
- There is also a need to develop training curriculums tailored to specific areas and targeted vulnerable groups.
- Further collaboration among the different sectors was also suggested as a way of building capacity, especially when communities are involved, and their capacity enhanced for them to take over the service delivery roles.

The collaboration was recommended to be extended to existing local institutions to build their capacity to train MHPSS service providers and design interventions essential for improved MH wellbeing of the residents.

Need for integrated programming and scaling up of awareness activities:

- Integrating MHPSS services within other modalities of service delivery in parallel to a collaborative approach with partners is needed to enhance coverage and scope of interventions.
- A scaling up of specialized MH services tailored for severe cases is urgently needed across the region.
- The development of long term awareness strategies and bottom up approaches to address the deep routed stigmatization of MH in the region is still needed.
- The design of awareness activities and MHPSS activities tailored to the specific needs of children and youth remains essential.

Adapting MHPSS response post COVID-19 pandemic:

- Further research is needed to identify MHPSS interventions that were successful during the pandemic in addition to needs assessments that could provide updates on the MH context in the region post COVID-19.
- Both service providers and beneficiaries need to be well equipped when the service provision becomes remote (ie internet, mobile phone, awareness videos etc.).
- The need to improve the capability of the service providers in offering remote interventions was also highlighted as a priority aimed at ensuring continued service delivery.
- The need for increased support for adolescents during COVID-19 is also key, particularly if they are being home schooled, or turning to negative coping mechanisms such as child labor.
- Improved and timely collaboration and coordination on MHPSS among service providers and governments is also needed during crisis periods such as the COVID-19 pandemic.

The No Lost Generation (NLG) team would like to thank all key informants who were interviewed for the purpose of this study.

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