MENTAL HEALTH AND PSYCHO SOCIAL SUPPORT IN THE MIDDLE EAST AND NORTH AFRICA

Iraq © Cordaid

Conference report by
Het Grote Midden Oosten Platform

This report offers recommendations to actors in the field of international cooperation in the Middle East and North Africa (MENA), and to the Dutch Ministry of Foreign Affairs. The recommendations are formulated by experts and a diverse group of professionals working in the MENA region and/or in the field of mental health or psychosocial support (MHPSS). On June 6, 2019, they gathered in The Hague for a conference and workshops, initiated by Cordaid and organised in collaboration with *het Grote Midden Oosten Platform*.

For decades, experts have been lobbying for more attention for mental health after disaster or war. Even though mental health problems globally account for 29% of all health issues, mental health is often overlooked in public health strategies, both in terms of attention and of budget allocations for treatment. The treatment gap of people with trauma is considerable in high income countries and is even larger in middle- and low-income countries. This is especially problematic in settings of war and post-conflict, where people have suffered serious traumas. Looking at Syrian refugees living in Europe for instance, it shows that 30% suffer from depression, 30% suffer from post-traumatic stress disorder, and a considerable number suffer from anxiety, while less than 10% of those in need receive mental health and psychosocial support.

Political awareness of the importance of MHPSS has been growing recently and it has become a priority for Dutch Minister for Foreign Trade and Development Cooperation Sigrid Kaag. The Netherlands Initiative on Mental Health and Psychosocial Support consists of 1) Advocacy for better integration of MHPSS in humanitarian responses directed at governments and international agencies, 2) Capacity building and scaling up of MHPSS services for international and multilateral organizations, and 3) Scaling up of financing for MHPSS through NGOs. The Netherlands Initiative on MHPSS will convene an international ministerial conference in October 2019 in Amsterdam[1].

[1] MHPSS is the commonly used acronym. This report also uses the acronym of PSS to underline the importance of cooperation with non-medical professionals

A number of aid organisations is already implementing activities in the field of psychosocial care in the Middle East, in particular in (post-) conflict countries like Syria and Iraq. Cordaid is implementing a number of MHPSS projects in North Iraq since June 2017.

Health practitioners from other parts of Iraq as well as donors and ministries in the country have started to approach Cordaid to discuss the topic. Because of the growing interest and the existing needs, Cordaid has organised a conference on MHPSS in Iraq and asked *het Grote Midden Oosten Platform* to organize a Dutch conference to provide input for current policy discussions on MHPSS and collect lessons from professionals coming from, or working in the MENA region, represented at the conference by experts from Iraq, Palestine, Libya and Egypt.

Iraq is presented as an example in the Dutch conference, representing similar circumstances of other fragile settings in Africa and Asia. Iraq has, in the past decade(s), seen multiple waves of violence and conflict which has affected millions of Iraqis. Experiencing distressful events, human rights violations, disruption of social networks, loss of property, displacement, harsh living conditions, social (violent) tensions and uncertainty all lead to an accumulation of traumas, individually and collectively. These are aggravated by loss of social support structures and very limited government support services. The MHPSS service delivery gap in Iraq was 94% in 2014 according to WHO. Since 2013, the Iraqi Ministry of Health is giving more attention and priority to the MHPSS services, but the challenges are many. Stories on

Dr. Hala Sabah Rouhi, Cordaid Iraq ©GMOP

the situation in Iraq can be found in this film and in this longread. Information on the MHPSS activities by Cordaid in Iraq can be found here.

One of the recurring discussions during the conference was on the necessity to scale up the level of available PSS in post-conflict settings like Iraq, involving and collaborating with a wide range of actors. There is a need for "layered system support" that meets the needs of different groups. More access to PSS services and increases in coverage can be reached through task delegation, and by training non-specialised staff in delivering interventions and a functional referral system. In all cases it will be important to develop a public mental health strategy rather than focusing on treating trauma through individual therapies. The PSS gap can only be addressed when whole communities are part of the strategy. Alongside MHPSS, justice, community dialogue and victim protection are crucial parts of healing collective trauma.

One special area of focus is Sexual and Gender Based Violence (SGBV), dealing with the communities that condone or generate it, as well as helping victims of SGBV. Existing services for SGBV survivors are often diffused. One advice is to provide access to a complete package of services for survivors, ranging from income generating activities to MHPSS, medical treatments, teaching new life skills and coping mechanisms and re-integration into the community.

Inflicted trauma can also be a political instrument by the state versus communities or between different rivalling communities. It can destabilize, demobilize, and cause social fragmentation. Socio-economic inequality, state brutality like violent crackdowns of protests, and (the threat of) torture are causing continuous traumatic stress. An effect of such system-inflicted stress is a loss of human reactions, growing political depression and a loss of agency: "everything we do is in vain." This type of trauma appears in many countries in the MENA region.

The set of recommendations on MHPSS from professionals working in the MENA region and experts on (MH)PSS that are resulting from the conference are the following:

RECOMMENDATIONS TO CORDAID AND OTHER NGOS

Strategy

1. ***Embed support in local settings through***
   - *Combining forces of international and local universities, local Community Based Organisations and INGOs.*
   - *Setting the agenda in collaboration with local actors to ensure culturally and politically appropriate interventions.*
   - *Supporting existing local initiatives, however small, that work on trauma healing.*
2. ***Integrate MHPSS in community-based work (adding to more scalable results and to sustainability)***
   - *Fostering self-help within local communities as much as possible. Using internal support structures amongst displaced populations. Training local communities on multiple tools and being able to improvise.*
   - *Focusing on training professionals as well as non-professionals. Through training programmes like the Mental Health Global Action Programme, Psychological First Aid, Problem Management plus, and Multi Family Approach, non-professionals can do a lot of work, while not necessarily needing MHPSS staff to facilitate the process.*
3. ***Invest in staff care and organizational care***
   - *Looking after your partner organisation and ensuring budget for staff and organisational self-care. Staff, facilitators, community workers, volunteers and collaborating local organisations are affected themselves and need care/self-care.*
   - *Ensuring capacity building of local institutions (e.g. the health sector and legal apparatus) on protection of victims and reconstruction of the social fabric.*
4. ***Make MHPSS programs long-term and sustainable***
   - *MHPSS should not be restricted to humanitarian aid activities. MHPSS programmes need 5 – 10 years to become sustainable.*
   - *Think about sustainability and an exit strategy. Advocate for funding, for support from (local) governments and from the community. Think about upscaling and increase coverage. Create multiplier effects.*
   - *Ensure that interventions are not used as "stand-alone therapies" or are seen as quick fixes for complex problems. Instead, use a multi-sectoral approach, e.g. by embedding MHPSS in health, education sectors, and initiate parallel interventions (e.g. generate income for victims).*
   - *Instate/strengthen a (counter) referral arrangement in a layered health system, making optimal use of existing capacity at each level.*
   - *Explore together with local actors how in post-conflict settings, MHPSS can contribute to reconciliation processes. Be careful not to force reconciliation processes.*
5. ***Be aware of and tackle the M&E challenge with MHPSS***
   - *The nature of MHPSS is that the impacts are internal (and not external) and qualitative rather than quantitative, making it difficult to report to donors. Invest in research or collaborate with academia to measure qualitative impact.*

6. Target group

- *Design your target groups carefully (e.g. youth, men, disabled, teachers) around a common problem. Be mindful of cultural, political and religious differences. They can positively offer different perspectives on how to solve the problem, but when wrongly guided can also increase the problem.*
- *Donor-focus is often on women and girls, but men and boys need MHPSS too. When working on MHPSS in cases of Sexual and Gender Based Violence: learn how and when to include men in the programmes. Involve them. Campaign on, have dialogue with and train men to change attitudes, norms and behaviours towards women and children to reduce SGBV.*

Panel discussion ©GMOP

Methodologies

1. Locally embedded and accepted interventions

- *Investing in interventions that build on local coping and resilience practices and knowledge and that have been proven effective.*
- *Working with traditional, tribal, religious leaders to see if their interpretations or tradition can be reframed to become part of a local methodology. Working with religious leaders and local groups to change traditions (e.g. that are harmful for women or other target groups)*
- *Supporting the development of more evidence-based, culturally adapted and publicly available interventions.*
- *Best trauma healing takes place within family and community structures; therefore, resettlement of minorities is not a good idea.*

2. Adapt methods to local context and infrastructure

- *Outreach methods can include mobile phones, Facebook, etc. as well as face-to-face in rural areas.*
- *Using bottom-up approaches in communities. In addition, education of students in school, even of social workers in university.*
- *Be aware of difference in interest and needs, e.g. between refugee/displaced groups and non-displaced groups.*

RECOMMENDATIONS TO THE NETHERLANDS MINISTRY OF FOREIGN AFFAIRS

Advocacy

1. ***Political and justice advocacy***
   - *Recognize that trauma is often used as a political instrument to destabilize society and citizens, and to cause social fragmentation. Support justice and rule of law, help develop legislation and security sector reforms that protect citizens, also in so-called stable countries in the MENA region.*
   - *Hold MENA governments accountable for the mental wellbeing of citizens.*
   - *In post-conflict settings: Support mechanisms for transitional justice, in order to prevent new or added traumatization of certain minorities (or political opponents)*
   - *Hold governments and perpetrators accountable for SGBV. Support governments to make protective legislation for SGBV survivors.*
2. ***Methodology and sustainability***
   - *Advocate internationally for more integrated MHPSS in the MENA-region, with a longer-term focus.*
   - *Advocate for diversification of MHPSS methodologies, with involvement of local stakeholders, local knowledge and practices.*
   - *In post-conflict settings, MHPSS can contribute to reconciliation processes.*
3. ***Local partners - staff care and agenda setting***
   - *Advocate for more training and self-care for national and international MHPSS providers.*
   - *Donors alone should not set the agenda. They need to work together with academics, local actors and stakeholders and journalists, who get their information from activists, diaspora, exiles, to develop unified plans and objectives.*

Funding

1. ***Local setting***
   - *Reconstruct funding mechanisms, so small local partners can play their crucial role in MHPSS (rather than being overlooked by the big multilateral agencies).*
   - *More power and staff for local embassies to select local partners.*
   - *Allocate funding for more training and self-care for national and international MHPSS providers.*
2. ***Research and development***
   - *Allocate funding for research and development, evidence based, cultural-sensitive and/or local methodologies, that go beyond the clinical interventions (like psychiatrists)*
   - *There is need of a stakeholder analysis, which actors can play a role, both locally and internationally. Encourage collaboration of a wide range of actors, like local and international universities, local initiatives and INGOs.*

3. *Long-term and sustainability*

- *MHPSS should not be restricted to humanitarian aid activities but should rather be part of long-term programs. Public Mental Health programs need 5-10 years to become sustainable.*
- *The MHPSS gap in MENA countries can only be addressed when whole communities are included in interventions. Such situations are best addressed through a generic public mental health (PMH) model, multi-sectoral, multi-modal and multi-level, that accommodates a variety of preventive and curative interventions.*
- *Allocate funding for diversification of MHPSS methodologies, with involvement of local stakeholders, local knowledge and practices.*

Workshop Scaling up of MHPSS-professionals ©GMOP

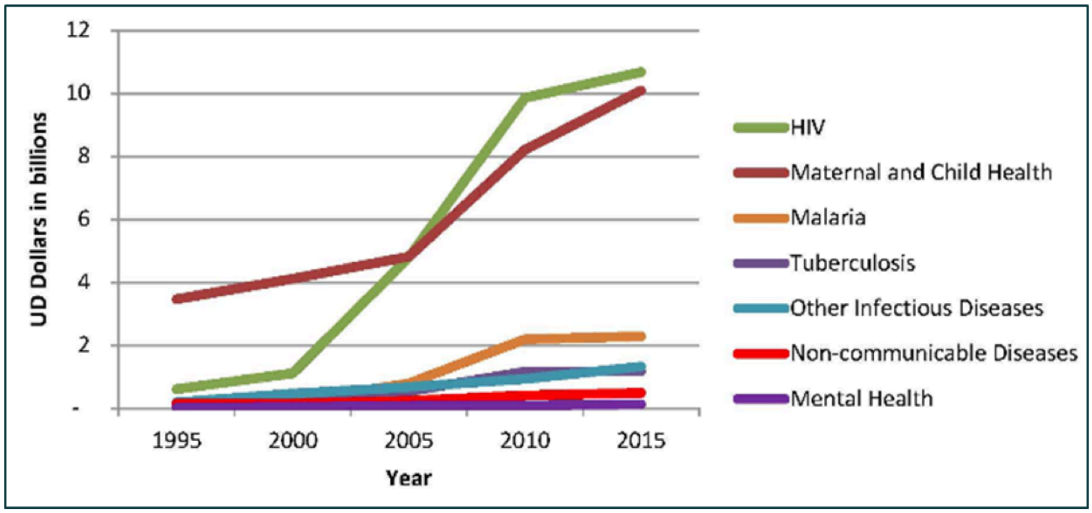
SOME NUMBERS TO PUT MHPSS IN THE MIDDLE EAST IN PERSPECTIVE

MHPSS not priority
Funding GAP & Access , services, resources/capacity

- In the 2016 Syrian Arab Republic Humanitarian Response Plan, MHPSS represented less than 0.1% of the overall budget of the humanitarian response.

- On average, globally, < 1 mental health worker per 10,000 people
- Low/Middle Income Countries < 1 mental health worker per 100,000 people
- High Income Countries 1 mental health worker per 2000 people

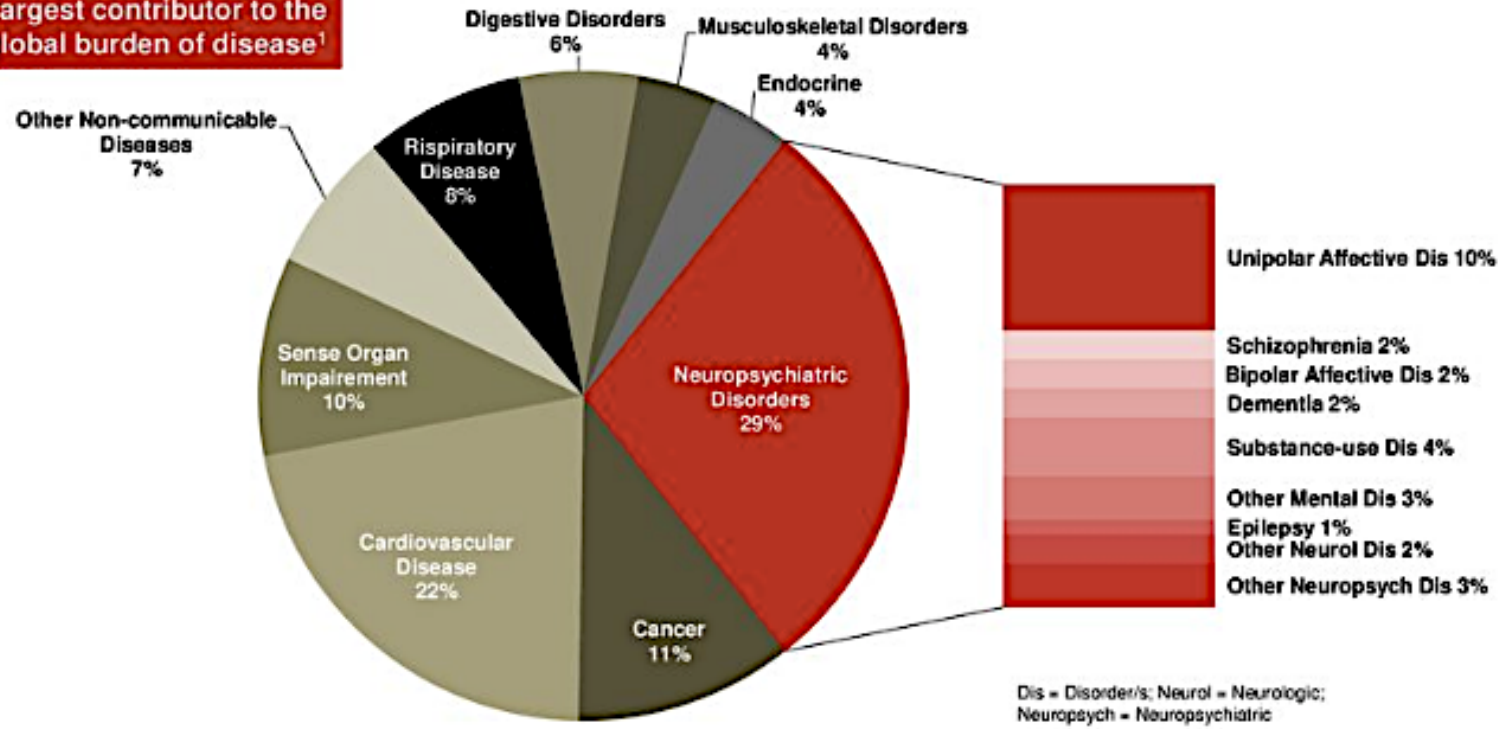
WARTRAUMA FOUNDATION



Development assistance for health (from presentation of Dutch Ministry of Foreign Affairs):

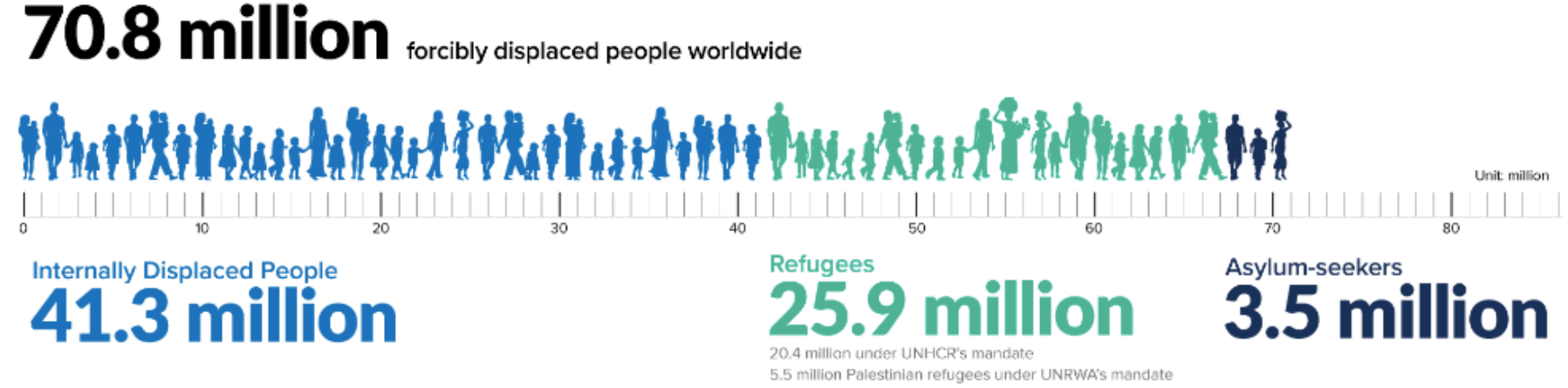
Contribution of Non-communicable diseases disability-adjusted life years

By 2013, depression is projected to be the largest contributor to the global burden of disease[1]



Prince et al. Lancet 2007; 370: 859–877

Lundbeck Institute
Campus



The burden of displacement and its distribution around the globe (UNHCR 2019)

LIST OF SPEAKERS

Joop de Jong MD, PhD, Emeritus Professor Cultural Psychiatry & Global Mental Health Amsterdam UMC, Boston University School of Medicine, Rhodes University S Africa

Martine van der Does, Senior Humanitarian Advisor at Dutch MoFA, on Dutch policy process

Dr. Hala Sabah Rouhi, Cordaid Iraq on MHPSS in Iraq and Cordaid's work to address MHPSS.

Albert van Hal, Programme Manager Iraq Cordaid to introduce the background and objectives of this conference.

WORKSHOP INTRODUCTIONS

1. MHPSS in working with Gender Based Violence
    - *Dr. Hala Sabah Rouhi (Cordaid Iraq)*
    - *Nicolien Zuijdgeest (Libya)*
2. Scaling up of MHPSS professionals
    - *Elise Griede, War Trauma Foundation (Iraq/Palestine)*
    - *Dr. Bayan Rasul, Emma Organization (Iraq)*
3. Politics & Local narratives of trauma
    - *Mw. Dr. Vivienne Matthies-Boon, Assistant Professor in the International Relations of the Middle East at the University of Amsterdam (Egypt)*
    - *Ms. Inas Miloud (Libya)*
4. Setting up a multilevel, multimodal MHPSS program
    - *Prof. Dr. Joop de Jong (global/Middle East)*
    - *Dr Riyadh Al Rudaini (Iraq)*

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