



Mental Health and Psychosocial Support in Fragile, Conflict, and Violence (FCV) Situations

Five key questions to be answered

SUMMARY

Mental health challenges in FCV situations are increasingly recognized by countries and international humanitarian and development agencies. This note highlights the best practices in designing, implementing, and evaluating a project involving a mental health and psychosocial support (MHPSS) component



Source: Amnesty International.

Q1

WHY invest in mental health and psychosocial support in FCV situations?

Two billion people live in countries that are affected by FCV. While mental and substance use disorders are the leading cause of years lived with disability (YLDs) worldwide, the **prevalence of mental health disorders can double in FCV situations**. Between 15 percent and 20 percent of crisis-affected populations develop mild-to-moderate mental disorders such as depression, anxiety, and post-traumatic stress disorders (PTSD); some estimates put that figure closer to 40 percent. An estimated 3–4 percent develop severe mental disorders, such as psychosis or depression and anxiety.

Mental health problems not only harm an individual's well-being and functioning but also limit educational achievement, employment, and economic growth. It is estimated that in 2010 the global economic costs of mental

disorders were US\$2.5 trillion, among which two-thirds were indirect costs due to productivity loss, a very high proportion in contrast to other common disease groups. In an FCV context, the developmental impact of other development supports (such as education and employment supports) may be compromised without MHPSS. Inaction with mental health problems may further increase vulnerability to and perpetration of violence.

Investing in mental health has good economic returns, with the ratio of benefit to cost between 3.3 to 5.7. Many interventions have been demonstrated to be very cost effective (cost per disability-adjusted life year [DALY] $< 3 \times$ GDP per capita) (cost per DALY $< 1 \times$ GDP per capita) in low- and middle-income countries, respectfully. In scaling up mental health treatment and services, the estimated total annual costs for all incident depressive episodes in receipt of treatment, including training and other program-level costs, were as much as 2.50 International Dollars per capita for low-income countries.

The World Bank has formulated country investment cases for mental health (Ukraine, global) and strategies to systematically incorporate MHPSS in operation projects (a toolkit, FCV MHPSS website).



Source: United Nations Population Fund (UNFPA), elist10.com, and jasontanner.

Q2 WHO has mental health needs in FCV situations?

Various FCV contexts pose different mental health challenges and require tailored solutions. Mental health also needs to be addressed in a country's cultural and social context. The perception, diagnosis, and services for mental health vary across cultures. Moreover, mental health problems often coexist with other physical comorbidities, therefore requiring an integrated approach.

Victims of armed conflicts and violence experience high levels of insecurity, uncertainty, and loss, and disruption of daily life, and are more likely to develop extreme distress, depression, PTSD, somatization disorder, and alcohol abuse. Due to conflicts and violence, 65 million people (1 percent of the world's population) are forcibly displaced (24 million refugees and 41 million internally displaced), face numerous challenges during migration, and continue to experience stressors such as social isolation, poor access to education and employment, and financial hardship in the resettlement process.

Survivors of sexual violence and gender-based violence (SGBV) include not only women and girls, but also men and boys. While gender-based violence (GBV) affects 35 percent of women worldwide, it may be exacerbated by conflicts and displacement, and affects as many as 50 percent of women. SGBV can take various forms. Data on sexual violence against men and boys are less available. SGBV not only causes mental health

problems but also leads to social stigmatization toward victims, and victims may be unwilling to reveal information and seek help.

Children and adolescents are more susceptible to mental health issues than adults during conflicts. The PTSD prevalence among these groups may be as high as 50–90 percent and major depression from 6–40 percent.

Wounded and disabled people have a higher risk of developing psychosocial trauma symptoms in reaction to medical procedures, changes in their physical capacity and family and social role (for example, divorce and unemployment), and stigma or negative attitudes toward them. Psychosocial supports may be needed to help patients cope at different life stages.

People affected by pandemics and emergencies (such as Ebola) experience extremely high levels of fear, anxiety, frustration, and mistrust in the affected communities, and social isolation. While community support and leadership are necessary for effective case detection and tracking, the fear and mistrust make community engagement and community-based care extremely difficult.

Helpers and service providers (such as emergency medical staff, community leaders, community health workers, and teachers) provide essential services and help others. While helpers also experience the insecurity and fear in their daily life, they may have additional distress from work due to long hours, lack of resources, and secondary trauma by witnessing the trauma of others. These often-

Q3

WHAT interventions could be considered?

neglected individuals also need psychosocial support to improve their well-being and improve the effectiveness in helping others (see [ICRC guidelines](#) for more details). International guidelines recommend low-intensity and low-

BOX 1 International Guidelines on Providing MHPSS in FCV Situations

- [WHO's mhGAP](#) for scaling up mental health services in low- and middle-income countries ([mhGAP tools and training materials](#) are widely used to train providers)
- [IASC guideline for MHPSS in emergency settings](#)
- [WHO's Building Back Better](#) delineating 10 country experiences in building back mental health systems
- WHO and UNHCR's [toolkit for assessing MHPSS needs and resources](#)

cost MHPSS interventions in non-specialized health care and community settings complemented by referral of severe cases to specialized health facilities.

[Partners in Health's mental health value chain](#) (Table 1) and [a review of 61 MHPSS programs](#) summarized the **general best practices for delivery of MHPSS services in FCV contexts:**

- Deliver services at both the community level and the facility level
- Train community health workers and non-specialized health professionals to deliver services
- Work on the whole value chain: prevention, case finding, enrollment, treatment, follow-up, and reintegration

Specific best practices for various vulnerable groups

Victims of armed conflicts and violence: [ICRC](#), [IASC](#), [UNHCR](#), and [WHO](#) have summarized good practices in providing mental health programs targeting victims of armed conflicts and violence, including internally displaced persons (IDPs) and refugees. In brief, programs could include:

- Capacity building for health staff and/or key community actors to provide basic individual or group psychosocial supports;
- Providing MHPSS support to victims by mental health practitioners, health staff, or key community actors through individual consultation, home visits, and group support; and
- Advocacy, information provision, and sensitization. Some successful programs are [Problem Management Plus \(PM+\)](#) in Pakistan, and the [step-by-step](#) e-mental health program in Lebanon.

Survivors of SGBV: [IASC](#), [ICRC](#), [WHO](#), [UNHCR](#), [UNFPA](#), [UNICEF](#), and the [empirical literature](#) have outlined good practices in providing supports to victims of GBVs. In practice, a multi-sectorial integrated package of services could be provided (see [World Bank Project in DRC, Burundi, and Rwanda](#)) including medical, psychosocial, forensic, legal, and security supports. The delivery of GBV programs could leverage [phone-based interventions](#) or synergize with the provision of reproductive and maternal health services, HIV services, or other basic health services to reduce stigma associated with seeking GBV care and improve continuity of care. At the community level, good interventions include advocacy and community sensitization programs to reduce stigma; [offender rehabilitation](#) programs to prevent GBVs; and [economic empowerment and livelihood programs](#) to help the vulnerable individuals achieve economic reintegration, boost self-esteem, and improve economic independence.

Children: UNICEF has extensive resources on [MHPSS for children](#). A [systematic review](#) of 11 randomized control trials demonstrated the beneficial effect of focused psychosocial support interventions for children. In brief, MHPSS for children needs to be age appropriate, safe, and help children to learn and develop life skills and coping mechanisms. Other commonly implemented and evaluated practices include Mercy Corp's [advancing adolescents program](#) in Jordan, Lebanon, Iraq, Syria, and Turkey; [comfort for kids \(C4K\)](#) program ([World Bank project](#) in Liberia); [game-based interventions](#) for Syrian refugees in Turkey; and a wide range of [school and community-based interventions](#), and [children friendly spaces](#) worldwide.

The wounded or disabled: Training and supervision of 1) hospital and/or physical rehabilitation staff, 2) local psychologists or counsellors, and 3) family members and care-givers to provide MHPSS for preoperative patients, post-operative patients, and during the rehabilitation stage can be considered.

People affected by pandemics and emergencies: [IASC](#) has developed guidelines for MHPSS in the acute emergency and post-emergency phases of pandemics. Besides managing mental health problems, restoration of the community's trust and resilience are also crucial goals

TABLE 1 Partners in Health's Mental Health Value Chain for MHPSS (excerpt from Marquez (2016))

Training and Supervision: Clinical, Programmatic, Academic/Research					
Safety, Quality, Outcomes Measures (M&E), and Performance Improvement					
Prevention	Case Finding	Enrollment	Treatment	Follow-up	Reintegration
	Health facility	Health facility	Health facility	Health facility	
<ul style="list-style-type: none"> Community stigma reduction School/religious-based activities Staff and community education Parent and family education 	<ul style="list-style-type: none"> Screening Referral Evaluation 	<ul style="list-style-type: none"> Diagnosis Formulation Mental status exam Medical exam laboratory/imaging Triage severity 	<ul style="list-style-type: none"> Psychoeducation Choosing treatment plan Medication management Psychotherapy Hospitalization Crisis management Social interventions 	<ul style="list-style-type: none"> Ongoing clinical care: Monitoring of symptoms and functioning Medication adherence support and monitoring of side effects Social interventions Psychotherapy 	
	Community	Community	Community	Community	
		Referral to health center by: <ul style="list-style-type: none"> CHW Community member Traditional healer Family members Church School 	<ul style="list-style-type: none"> Psychoeducation Psychotherapy Social interventions Monitoring (medication) 	Ongoing: <ul style="list-style-type: none"> Coordination Symptom monitoring Medication monitoring Adherence support Psychosocial support Psychotherapy Observation 	<ul style="list-style-type: none"> Staff and community education Social interventions Peer support groups Intersectional collaborations

Source: Marquez, Patricio V. 2016. [Mental health among displaced people and refugees: making the case for action at the World Bank Group](#) (English). Washington, D.C.: World Bank Group.

of the psychosocial interventions. From a health policy perspective, the need for an [emergency mental health plan](#) with surge capacity for emergencies was an important lesson from the Ebola crisis.

Helpers and service providers: [Psychosocial support programs for helpers](#) could incorporate structural support, use workshops and meetings to train helpers to help themselves, train helpers as peer support facilitators, train helpers to help others, and provide supervision to helpers.

The employed: Comprehensive programs are available to improve the mental health of the employed and entrepreneurs ([World Bank Project in Pakistan](#)) with the objective to improve economic productivity and business growth.

WHO's guidelines include a five-step process for

BOX 2 Technologies to Support Mental Health Programs

- Globally, [mobile technology](#) has been applied to improve mental health care.
- People affected by conflicts, particularly displaced populations, have high ownership rates of [handphones and smartphones](#).
- In FCV contexts, [SMS](#) has been used to diagnose depression among refugees.
- Technology has also been used to deliver therapeutic interventions: A [digital game intervention](#) for Syrian refugee children in Turkey effectively improved refugee children's skills and mental health; [tele-psychiatry](#) and psychological counseling have been used for service delivery for Syrian refugees in Lebanon and other countries; and an [e-mental health](#) intervention has been conducted in Lebanon. [Smartphone-based mental health programs](#) have been delivered to refugees in Middle East and Europe with support from peer refugees and nonprofessional helpers.



Q4

WHAT has been done at the World Bank? What are the challenges and lessons learned?

38 World Bank projects with a MHPSS component

- 8 Health, Nutrition & Population (HNP) Global Practice operation projects (Appendix A)
- 30 [Operation and knowledge management projects \(2010–2015\)](#) in non-HNP Global Practices: Social, Urban, Rural, and Resilience (21), Social Protection and Jobs (4), Education (4), Finance, Competitiveness and Innovation (1)
- [Ukraine, global](#) and strategies to systematically incorporate MHPSS in operation projects ([a toolkit](#), [FCV MHPSS website](#)).

7 World Bank reports and papers on MHPSS

- [Moving the needle: mental health stories from around the world](#) (2018)
- [Mental health in transition](#) (Ukraine) (2017)
- [Mental health among displaced people and refugees](#) (2016)
- [Mental health in Afghanistan: burden, challenges, and the way forward](#) (2011)
- [Mental Health and Conflicts: Conceptual Framework and Approaches](#) (2005)
- [Funding Mental Health in Post-Conflict Countries](#) (2004)
- [Integrating mental health and psychosocial interventions into World Bank lending for conflict-affected populations: a tool kit](#) (2004)

3 World Bank resource websites on MHPSS

- [Resources for Psychosocial Support in Fragile and Conflict-Affected Settings](#)
- [World Bank mental health website](#)
- [Violence against women and girls—resource guide](#)

BOX 3 Financing Mental Health Care

- There has been very limited financing for mental health in FCV countries. More funding from donors, country governments, and development agencies is needed to scale up mental health services in FCV contexts.
- A [World Bank report](#) explored innovative funding mechanisms for mental health care, including the social impact bond, development impact bond, and other financial instruments.

BOX 4 Voices from the Field

Common Challenges Emerged from Task Team Leader Interviews

- **Limited funding:** Lack of mental health funding from donors and country budgets
- **Demand side:** Government, communities, and target populations may have low awareness of mental health problems and needs. Many cultures also have stigmas toward mental health issues and medicalize mental health issues.
- **Supply side:** Some countries have low capacity for mental health care (such as very low number of qualified mental health professionals and lack of specialized mental health facilities, medicines, and health data)
- **Sustainability:** Large-scale mental health programs are expensive. There is uncertainty in program scale-up by the national government without additional funding after completion of a World Bank project.

Key Lessons Learned

- Focus on **community-level and primary care provision of psychosocial counseling and referral of severe cases**
- Aim to improve well-being, functioning, and **resilience** at individual and community levels
- Build **local capacity** (community health workers, community leaders, and so on)
- Close **collaboration** and coordination with partners and key stakeholders are critical to success
- **Pre-launch period** to allow system to adjust and ensure language, cultural, and social appropriateness of programs in local context
- MHPSS programs should be part of the **cross-sectoral efforts** (including basic services, education, livelihood, and other community resilient programs) to **restore normality of life**.
- Use emergency MHPSS program as an opportunity for the country to **develop or harmonize the national mental health strategy**, and improve awareness and preparedness of country to future emergencies and related mental health issues (see [Turkey](#) example)

Q5

HOW should we evaluate mental health interventions?

systematically [evaluating mental health programs and policies](#), as well as an [assessment instrument for evaluating mental health systems](#). A [systematic review](#) of empirical literature also highlighted several emerging trends in practices of evaluating mental health programs in FCV contexts.

Study Design	Six Dimensions to Measure	Measurement Instruments
<ul style="list-style-type: none"> • Mixed methods evaluation to evaluate both the program rolling out and outcomes (example 1) • Good designs (RCTs and quasi-experiment study designs) preferred if context appropriate • Potentially harmful effects of mental health interventions (article 1, 2) need to be considered • Differential impacts to subgroups (such as children, women, those who experienced GBV, more severe cases) are important 	<ul style="list-style-type: none"> • Program output indicators (such as the number of community health workers trained and supervised and the number of individuals or households that received MHPSS services) • Recipients' mental health outcome indicators (such as stress and distress, depression, cognition, and functioning) • Resilience and coping indicators • Education and livelihood performance indicators • Service referral indicators (such as number of people referred for medical and other services) • Cost and cost-effectiveness indicators 	<ul style="list-style-type: none"> • A set of standardized instruments validated in FCV settings are available to measure various indicators, including: program output, anxiety, depression, and other mental health disorders, quality of life, stress, insecurity, traumatic stress, function and coping, resilience, hope, social support, cognitive outcomes, education performance, and economic productivity. Moreover, customized instruments are also available for targeted groups such as victims of wars, GBV, and youth. New technology such as biomarkers and tablet-based cognitive tests and surveys are increasingly used.



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For more information on other HNP topics, go to www.worldbank.org/health

Health, Nutrition and Population Global Practice Operational Projects

Country	Project	Project Size (million \$)	Year of Approval	TTL/Key Contact Person	Mental Health and Psychosocial Interventions	Challenges and Lessons Learned
Bosnia	(P044424) War Victims Rehabilitation Project	9.85	1996	Nedim Jaganjac	Community-based psychosocial rehabilitation (Technical Annex)	ICR report
Afghanistan	(P129663) Afghanistan: System Enhancement for Health Action in Transition Project	650	2013	Ghulam Sayed, Mohammad Hashemi	Mental health services as part of Basic Package of Health Services (Project paper)	
DRC, Burundi, Rwanda	(P147489) Great Lakes Emergency Sexual and Gender Based Violence & Women's Health Project	44.4	2014	Hadia Samaha, Patricia Fernandes, Verena Phipps-Ebeler, Miriam Schneidman	Integrated support for GBV survivors and violence prevention at community and health facility level. Integrated supports include medical, mental, forensic, legal, social supports, and economic empowerment. The project also promoted integration of GBV screening, support, and prevention with maternal and reproductive services and other basic health services (PAD)	ISR reports
Liberia	(TF0A0088) Community-Based Psychosocial Support to the EVD Outbreak	0.8	2015	Rianna Mohammed-Roberts, Preeti Kudesia	Comfort for Kids (C4D) Program (blog article)	GRM report
Liberia	(P146591) Supporting Psychosocial Health and Resilience in Liberia	2.75	2015	Preeti Kudesia, Rianna Mohammed-Roberts	Psychosocial support and capacity building to improve long-term psychosocial health and resilience at the individual and community level (PID)	ISR reports
Guinea, Liberia, Sierra Leone	(P152359) Ebola Emergency Response Project	390	2015	Preeti Kudesia, Ibrahim Magazi, Shiyong Wang	Counseling and other psychosocial support for patients and families in response to Ebola crisis (PAD , PAD for additional financing)	
Yemen	(P161809) Emergency Health and Nutrition Project	483	2017	Moustafa Abdalla	Basic mental health services delivered by mobile teams in an integrated outreach model, and household level psychosocial support to women and children conducted by a network of community health volunteers and midwives. (PAD)	
Lebanon	(P163476) Lebanon Health Resilience Project	150	2017	Nadwa Rafeh	Provision of basic mental health package at primary health care clinics. Package includes (1) screening and case management of depression, psychosis, developmental disorder, and alcohol/substance abuse; (2) consultations with psychiatrists, psychologists, general practitioners, and social workers; lab tests and medication treatment (PAD)	