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Regional action plan for mental health and psychosocial support in emergencies, 2024–2030

Executive summary

Globally, mental, neurological and substance use (MNS) conditions incur a large and growing public health burden. According to Global Burden of Disease study estimates, 25% more people were living with mental disorders in 2019 than in 2000, but since the world's population has grown at approximately the same rate, the prevalence of mental disorders has remained steady, at around 13%.[1]

Almost half of the countries in the Eastern Mediterranean Region are facing protracted emergencies, which tend to increase the population's vulnerability to MNS conditions. The Region has a high prevalence (14.7%) of mental health conditions compared with global rates, which is almost wholly accounted for by the prevailing emergencies in its countries.

Mental disorders alone account for 5.1% of the global burden of disease and 5.4% of the disease burden in the Region. They also account for 15.6% of the burden of years of healthy life lost due to disability or ill health (YLD) globally; and 18.4% of the YLD burden regionally.

According to WHO estimates, the point prevalence of the mental health conditions, schizophrenia, post-traumatic stress disorder (PTSD), anxiety, depression and bipolar disorders, in conflict-affected populations is estimated to be 22.1%. Countries in the Region facing humanitarian emergencies in the last 12 months have higher rates of mental disorders, specifically of depressive disorders, anxiety disorders (including PTSD) and idiopathic developmental intellectual disability.

The prevalence of illicit drug use in the Region is estimated at 6.7% compared with 5.8% globally. Cannabis is the most common drug used by the adult population. The number of people with drug use disorders is estimated to be 3.4 million, with the age-standardized rate for disability-adjusted life years (DALYs) having increased by 20.1% since 1990, compared to 19.0% globally.

The human, financial and institutional resources available for an effective, multisectoral response to meet these needs have been degraded in countries with emergencies, translating into a treatment gap that is as large as 90% in some low- and middle-income countries. For people with drug use disorders, the treatment rate is 1 in 13 compared with 1 in 11 globally.

This paper presents a regional action plan for mental health and psychosocial support (MHPSS) in emergencies, 2024–2030, that has been developed in consultation with regional Member States, stakeholders from civil society and academia, and partners, to protect, promote and provide for the mental health and psychosocial well-being of populations affected by emergencies and to reduce the suffering of populations across all phases of emergencies. It seeks to guide Member States in preparing for and responding more predictably and effectively to the MHPSS needs of their populations and to contribute to building more resilient communities and health and social care systems.

The regional action plan identifies a set of evidence-based actions across the domains of: leadership and governance; provision of MHPSS and workforce development; MHPSS promotion and prevention of MNS conditions; engagement and empowerment of communities and people with lived experience; and assessment,

[1] The datasets used for this paper, which were accessed in early 2024 from the Institute for Health Metrics and Evaluation (IHME) GHDx (Global Health Data Exchange), are from the 2019 Global Burden of Disease study (https://vizhub.healthdata.org/gbd-results/).

monitoring and evaluation, and research. These are complemented by a set of indicators and targets to monitor the implementation of the regional action plan.

The 71st session of the WHO Regional Committee for the Eastern Mediterranean is invited to endorse the regional action plan for mental health and psychosocial support in emergencies, 2024–2030.

Introduction

1. Over the past seven decades, the countries of WHO's Eastern Mediterranean Region have experienced wars, civil strife, natural disasters and economic turmoil that have had major implications for population health and both physical and mental well-being. In addition, natural disasters, such as earthquakes and floods, are also a regular occurrence (for example, in 2023 alone there were earthquakes in Afghanistan, Morocco and the Syrian Arab Republic and floods in Libya and Pakistan). Furthermore, the recent COVID-19 pandemic and emerging challenges, such as climate change, environmental degradation, rapid urbanization, water scarcity and increasing migration, have increased the risk to population health and well-being. According to the World Bank *(1)*, nine of the 22 countries and territories in the Region are classified as being fragile, conflict- and violence-affected, including Afghanistan, Iraq, Lebanon, Libya, Palestine, Somalia, Sudan, the Syrian Arab Republic and Yemen.

2. Mental health is crucial to personal, community and socioeconomic development. It influences how people think, feel and act. It underpins their ability to make decisions, build relationships and shape the world they live in. Mental health is determined by a complex bidirectional interplay of individual, social and environmental factors that combine to protect or undermine mental health from before birth into old age *(2)*. During and following emergencies, weakened health system capacities combined with high levels of distress, greater exposure to potentially traumatic events, the disruption of protective community networks, the transformation of social roles and changes in access to substances are all risk factors that tend to increase the population's vulnerability to mental, neurological and substance use (MNS) conditions *(3)* through the exacerbation of pre-existing problems or new problems precipitated by experiences during the emergency or due to humanitarian aid-related problems (e.g. anxiety due to a lack of information about food or other aid distribution). According to WHO estimates, the point prevalence of the mental health conditions, schizophrenia, post-traumatic stress disorder (PTSD), anxiety, depression and bipolar disorders, in conflict-affected populations is 22.1% *(4)*. This has implications for the security, safety and development of the Region's countries.

3. The proposed regional action plan for mental health and psychosocial support in emergencies, 2024–2030, has been developed for Member States and partners to help them prepare for and respond more predictably and effectively to the mental health and psychosocial support (MHPSS) needs of populations and contribute to "building back better" in terms of more resilient communities and health and social care systems *(5)*.

4. The composite term MHPSS is in line with the Sphere Handbook standards *(6)* and the Inter-Agency Standing Committee (IASC) *Guidelines on mental health and psychosocial support in emergency settings (7)* and refers to any intervention that aims to protect and promote psychosocial well-being, and prevent or treat MNS conditions.

5. The regional action plan aligns with international conventions and agreements, such as the United Nations' 2030 Agenda for Sustainable Development, WHO's forthcoming Fourteenth General Programme of Work 2025–2028 *(8)* and the WHO *Comprehensive mental health action plan 2013–2030 (9)*, as well as the two regional frameworks to scale up action on mental health and strengthen the public health response to substance use *(10, 11)*. It also draws on World Health Assembly resolution WHA77.3 on strengthening mental health and psychosocial support before, during and after armed conflicts, natural and human-caused disasters and health and other emergencies, the Sphere Handbook standards *(6)*, IASC *Guidelines on mental health and psychosocial support in emergency settings (7)*, MHPSS Minimum Service Package developed by the IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings *(12),* United Nations Office on Drugs and Crime (UNODC)/WHO international standards on drug use prevention (2018) *(13)* and UNODC/WHO international standards for the treatment of drug use disorders (2020) *(14)*.

6. The identified interventions reflect the insights of practitioners from different regions, disciplines and sectors and reflect an emerging consensus on good practice among practitioners. The regional action plan has been developed in consultation with Member States, civil society actors, academic and research institutes, international nongovernmental organizations, multilaterial organizations and the donor community.

Situation analysis

Prevalence of MNS conditions

Global

7. Globally, MNS conditions incur a large and growing burden. An estimated 25% more people were living with mental disorders in 2019 than in 2000, but since the world's population has grown at approximately the same rate, the prevalence of mental disorders has remained steady, at around 13%. According to revised WHO estimates, the prevalence of mental disorders is even higher in conflict-affected populations: a comprehensive systematic review and meta-analysis estimates a point prevalence of 22.1% for the mental disorders, depression, anxiety, PTSD, bipolar disorders and schizophrenia *(4)*; 9.1% of those affected experience a mental disorder of such severity that it can impair their ability to function and survive in the emergency environment. While good quality data on the prevalence and burden of substance use and substance use disorders in humanitarian emergencies are rare, the available findings suggest that between 1% and 20% of refugees in both camp and community settings have drug use disorders.

Regional

8. Based on data drawn from Global Burden of Disease (GBD) study estimates *(15)*, the Region has a high age-standardized prevalence rate of mental disorders (14.35%), specifically of depressive disorders (4.2%), anxiety disorders (4.64%), bipolar disorders (0.64%) and idiopathic development intellectual disability (2.12%), all exceeding the upper 95% UI of the corresponding global prevalence. Regional prevalence rates of self-harm, suicide and substance use disorders in all three regional country groups[1] are lower than the global prevalence (see Annex 1, Table A1.1).

9. A comparison of countries in the Region suffering a humanitarian emergency with those that are not confirms that countries with emergencies have higher rates of mental disorders, depressive disorders, anxiety disorders (including PTSD) and idiopathic developmental intellectual disability (see Annex 1, Table A1.1). The number of people with drug use disorders is estimated to be 0.49% in the Region as compared with 0.76% globally.

10. Closer examination suggests that for depressive disorders there is a higher rate of depression in countries with humanitarian emergencies in men aged 25–74 years, while in women the higher prevalence is seen in a younger age range, from 10–49 years (see Annex 1, Table A1.2). For anxiety disorders, the higher rate in men is focused on a younger age range of 10–24 years, while a consistently larger increase is evident across the lifespan of women. The high prevalence of idiopathic developmental intellectual disability in countries with humanitarian emergencies is also observed in all age bands. Several MNS conditions have lower median prevalence in countries with an emergency; these include eating disorders, idiopathic epilepsy and substance use disorders.

[1] The countries in the Region have been grouped according to socioeconomic development and health provision resources: Group 1 are well-resourced; Group 2 have mid-range resources; Group 3 are poorly resourced. High rates of mental disorders, depressive disorders, anxiety disorders and bipolar disorders are found in all three groups (although the median rates do not exceed the global upper 95% UI for mental disorders in Group 1, nor for anxiety disorders in Group 3). Well-resourced (Group 1) countries have high rates of eating disorders, idiopathic epilepsy and dementia, while idiopathic developmental intellectual disability shows a marked gradation from low rates in well-resourced countries (median = 600 per 100 000) to high rates in poorly resourced countries (median = 3080 per 100 000).

Burden of disease

11. In 2019, across all ages, MNS conditions together accounted for one in 10 (10.1%) disability-adjusted life years (DALYs) worldwide. Mental disorders alone accounted for 5.1% of the global health burden and 5.4% of the health burden in the Region *(2)*. In 2019, the age-standardized rate for DALYs due to drug use disorders in the Region was higher than the global rate (20.1% versus 19.0%) *(16)*. Table 1 shows the pooled point prevalence estimates for common mental disorders in the Region.

Table 1. Pooled point prevalence estimates for common disorders in the Region *(17)*

Mental disorder	No. of studies	Pooled sample size	Prevalence (%)	95% CI
Depressive disorders	41	179 637	14.8%	10.7% to 20.1%
Bipolar disorders	12	43 027	0.7%	0.3% to 1.6%
Generalized anxiety disorder	30	183 544	7.5%	5.1% to 10.9%
PTSD	16	59 767	7.8%	3.5% to 16.7%
Obsessive-compulsive disorder	12	59 258	3.2%	1.9% to 5.6%
Phobic disorders	27	133 979	2.1%	1.3% to 3.4%
Panic disorders	12	57 297	1.6%	0.8% to 3.1%
Substance use disorders	58	908 636	4.1%	3.2% to 5.3%
Psychosis	19	183 698	0.5%	0.3% to 0.9%

12. Mental disorders account for 15.6% of the years of healthy life lost due to disability or ill health (YLD) globally, and 18.4% of the YLD burden regionally. The YLD lost per 100 000 population for specific conditions such as depressive disorders, anxiety disorders, bipolar disorders and idiopathic developmental intellectual disability is also higher in the Region than it is globally (see Annex 1, Table A1.3). Within the Region, countries with emergencies have a greater YLD burden due to mental disorders, as well as specifically for depressive disorders and anxiety disorders, than countries with no emergency do. There is no indication from the GBD data that the YLD burden is higher in emergency than non-emergency countries of the Region for other MNS conditions such as schizophrenia, autism spectrum disorders, attention deficit hyperactivity disorder, conduct disorder, substance use disorders, self-harm, idiopathic epilepsy and dementias.

13. MNS conditions not only impact morbidities but also mortality. Based on findings from WHO, an estimated 41 672 lives were lost to suicide each year in the Region during the period of 2000–2019. The overall age-standardized suicide rate for the countries of the Region was estimated to be 6.4 per 100 000 population. The majority of suicide deaths occurred in the most populated countries, namely Pakistan, followed by the Islamic Republic of Iran and Egypt *(18)*. Globally, deaths related to the use of drugs were estimated at about 500 000 in 2019, 17.5% more than in 2009, while in the Region 32 000 deaths were related to drug use. Liver diseases attributed to hepatitis C are a major cause of drug-related deaths, accounting for more than half of those attributed to the use of drugs in the Region. Drug overdoses account for a quarter of drug-related deaths. Opioids continue to account for the most severe drug-related harm, including fatal overdoses, when used non-medically. At the global and regional level, two thirds of direct drug-related deaths are due to opioids *(19)*.

Resources and capacities

14. The financial and human resources available in the Region to tackle the enormous burden of MNS conditions are insufficient, inequitably distributed and inefficiently used despite the social and economic costs associated with these conditions, resulting in a large majority of people with MNS conditions receiving no care at all, creating a large treatment gap that reaches 90% in some low- and middle-income countries in the Region and around the world *(2)*. For people with drug use disorders, the treatment rate in the Region is 1 in 13 (*20)*.

15. Indicators from the *Mental health atlas 2020: review of the Eastern Mediterranean Region (21)*, updated for the Eastern Mediterranean Region in 2023,[1] show that fewer countries with emergencies have achieved the functional integration of mental health in primary health care. This is accounted for by a lower percentage of emergency countries having achieved more than 75% coverage for pharmacological and psychosocial interventions for mental health conditions in primary care, but in response to emergencies, most countries have implemented extensive training on mental health for primary care workers (see Annex 1, Table A1.4).

16. The median total number of mental health workers in the Region is 8.0 per 100 000 population and varies greatly across countries (from 1.3 mental health workers per 100 000 population in Group 3 countries to over 22 workers per 100 000 population in Group 1 countries). The median number of mental health workers in the Region is substantially lower than the median of 13.6 workers per 100 000 for countries in the rest of the world.

17. MHPSS workforce shortages and challenges constrain the response of mental health systems in emergencies. Most countries with emergencies have inadequate policies and strategies for MHPSS workforce attraction, development, retention and empowerment. Furthermore, in emergencies the health workforce tends to migrate away and those left behind are frequently working under dangerous conditions, including under those that increase the risk of burn-out.

18. Almost all countries in the Region have functional[2] mental health promotion and prevention programmes, and these are implemented in a similar proportion of countries to the rest of the world for the categories of suicide prevention, awareness and stigma, early-childhood development, schools-based programmes, workplace-based programmes, and parental and maternal programmes. More countries with an emergency than those without have suicide prevention, mental health awareness and anti-stigma programmes, whereas fewer emergency countries have early-childhood development, schools-based, workplace-based and parental and maternal programmes.

19. Ten (45%) countries in the Region have at least one functional MHPSS component in their disaster preparedness and/or disaster risk reduction programmes, compared with 39% of countries globally. Functional programmes are found more commonly in countries with an emergency as compared with those without an emergency (emergency, 50%; no emergency, 40%).

20. National MHPSS technical working groups (TWGs) have been established and are functioning in all emergency countries (10 countries in 2023). Assessment of mental health needs and resources have been carried out, with most countries using the IASC 4Ws tool to inform programme development. Mental health information systems tend to be stronger in countries without an emergency than in countries with an emergency. In contrast, emergency countries publish more mental health research papers than do countries without emergencies (see Annex 1, Table A1.5).

21. Summarizing the available data for substance use resources and capacities in the Region *(20)*, all countries responding to the *Substance use atlas 2021* questionnaire had a policy or plan for the prevention of substance use and the treatment of substance use disorders, and 81% of responding countries reported having a specific budget allocated to substance use prevention and treatment. Of the responding countries, 56% reported that they used at least one opioid agonist agent for detoxification, and 50% reported that they used at least one opioid agonist agent for opioid agonist maintenance treatment. None of the responding countries reported that naloxone was widely available, though 11 reported that naloxone was registered in the country. Between 12% and 37% of responding countries reported that various harm reduction interventions were available, depending on the specific intervention; 73% reported that screening and brief intervention services were provided in health services in the country; and 94% reported that they had interventions or programmes in place for the prevention of substance use. The number of health workers, in all professional groups, available for the treatment of substance use disorders per 100 000 adult population was generally less than one.

[1] WHO Regional Office for the Eastern Mediterranean, unpublished data, 2023.

[2] A mental health promotion and prevention programme is considered to be functional if at least two of the following three characteristics are fulfilled: 1) dedicated financial and human resources; 2) a defined plan of implementation; and 3) evidence of progress and/or impact *(21)*.

Regional status update on MHPSS in emergencies

22. WHO, in collaboration with Member States, other United Nations agencies, nongovernmental organizations, national stakeholders and academic institutions, has leveraged the current interest in MHPSS for scaling up MHPSS services for populations in need.

23. Following the escalation of hostilities in Palestine in 2023, WHO has been leading the MHPSS TWG in the West Bank and supporting the MHPSS TWG in the Gaza Strip. In collaboration with the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and local nongovernmental organizations, basic psychosocial support, psychological first aid and stress management is being provided for population groups, including children and women. WHO has also adapted capacity-building interventions to enable health professionals to provide MHPSS remotely in both the West Bank and Gaza Strip. In Afghanistan, a comprehensive project on MHPSS and drug use, including opioid agonists maintenance treatment, has been funded through the European Union. Training on the mhGAP humanitarian intervention guide and psychosocial intervention packages has been conducted in Afghanistan, Jordan, Libya, Pakistan, Sudan, Syrian Arab Republic and Yemen to build capacity for the early recognition and management of priority mental health conditions and the provision of evidence-based psychological interventions. In the Syrian Arab Republic, to improve population-level mental health and psychosocial well-being, MHPSS services have been integrated at the community level to enhance service access and reduce the stigma of mental health conditions *(22)*, while in Sudan, the integration of MHPSS and peace-building through trauma healing and improved interaction opportunities among youth is bringing together usually-isolated key actors, including clinicians, gender experts, social psychologists and conflict resolution experts.

24. WHO has supported and is leading country-level multisectoral MHPSS coordination platforms (MHPSS TWGs) *(23)* in all graded emergency countries in the Region, as well as in Djibouti, Jordan, Lebanon and Pakistan, to ensure a coordinated MHPSS response across health, education, protection, nutrition, water, sanitation and hygiene, and other sectors.

25. WHO has recently set up a regional MHPSS dashboard to monitor MHPSS resources, capacities and activities in selected countries of the Region in real time *(24)*.

The regional action plan for mental health and psychosocial support in emergencies, 2024–2030

26. Building on regional experiences, and drawing on MHPSS reference guidelines and tools (IASC, Sphere and others) and on the WHO *Comprehensive mental health action plan 2013–2030*, the regional action plan and its monitoring framework have been developed for WHO Member States in the Eastern Mediterranean Region and their partners to prepare for and respond more predictably and effectively to the MHPSS needs of populations and contribute to building back better in terms of more resilient communities and health and social care systems.

27. The development of the MHPSS regional action plan was guided by the principles that it should: do no harm; protect and observe human rights; be evidence-informed; be responsive to gender, age, culture and vulnerability; be accountable; involve partnerships and inclusive participation; include multilayered and integrated support and systems development; involve a localized MHPSS response, building on and strengthening locally available resources and capacities; and adopt whole-of-government and whole-of-society approaches.

Vision

28. The vision of the regional action plan is that people affected by emergencies in the Eastern Mediterranean Region have their mental health and psychosocial well-being, protected, promoted and provided for in a sustainable manner.

Overall goal

29. The overall goal of the regional action plan is improved mental health and psychosocial well-being and reduced suffering of populations across all phases of emergencies in countries of the Eastern Mediterranean Region.

Objectives

30. The objectives of the regional action plan are to:

- integrate MHPSS in all national policies, strategies, plans and frameworks, with adequate and sustainable financing;
- integrate MHPSS across sectors in humanitarian response;
- strengthen health and social care systems to deliver MHPSS services across the continuum of care;
- strengthen the promotion of mental health and prevention of MNS conditions;
- empower and engage affected communities and individuals with lived experience; and
- strengthen monitoring and evaluation to guide MHPSS programme development and implementation.

31. A set of actions, identified in the Sphere standards, IASC Guidelines on MHPSS in Emergency Settings and IASC Minimum Service Package for MHPSS, are outlined that span the three emergency phases (preparedness, response and recovery), and are organized according to five domains and supported by a set of indicators and targets that have been aligned with the global monitoring and evaluation framework for MHPSS developed by the IASC Reference Group for MHPSS in Emergency Settings *(26)*. These can be adapted by Member States to collect and analyse data regularly to support the monitoring of the implementation of the regional action plan (see Annex 2 for the full list of proposed actions and monitoring framework).

Leadership and governance

32. Effective governance and strong leadership are crucial factors for coordinated, multilayered and multisectoral MHPSS action, with sustainable resource allocation.

33. To strengthen leadership and governance, the following key strategic actions are recommended:

- Advocate for and integrate MHPSS considerations within national emergency preparedness, response and recovery (EPR) and/or disaster risk management (DRM) plans, and develop appropriate standard operating procedures (SOPs) with the active involvement of all local, national and international stakeholders;
- Establish a functional, national multisectoral MHPSS coordination structure, led by and/or approved by national authorities;
- Ensure the allocation of dedicated financial resources for MHPSS plans, using the MHPSS Minimum Service Package costing tool, including for contingencies and emergency appeals.

Targets

34. Some of the targets for leadership and governance of the regional action plan are as follows:

- By 2030, 80% of Member States have integrated MHPSS components within national EPR and/or DRM plans.
- By 2030, 80% of Member States have a functional national MHPSS TWG.
- By 2030, 50% of Member States have a costed and financed MHPSS plan.

Provision of MHPSS and workforce development

35. The regional action plan promotes a multilayered MHPSS model of service, in line with the IASC MHPSS pyramid *(7)* and the Regional Director's flagship regional initiatives on strengthening the public health response to substance use, investing in and empowering a resilient and sustainable health workforce, and improving access to affordable medical products by securing resilient and efficient supply chains at regional and national levels, to contribute to the development of fit-for-purpose workforce and a system of MHPSS that ensures optimal outcomes for the population in need.

36. To strengthen MHPSS service provision and workforce development, the regional action plan recommends the following key strategic actions:

- Strengthen/establish a functional system for integrating treatment for MNS conditions into general health care, including primary health care;
- Ensure training and supervision of health care providers on evidence-based protocols to identify and manage priority MNS conditions in primary health care facilities;
- Align the national essential medicines list for MNS conditions with the WHO Model List of Essential Medicines, Interagency Emergency Health Kit and WHO Mental Health Kit 2022 and implement a system for stock-taking to ensure the uninterrupted availability of essential medications in all health and social care facilities;
- Develop and implement a staff and volunteer culture-of-care strategy.

Targets

37. Some of the targets for the provision of MHPSS and workforce development of the regional action plan are as follows:

- By 2030, 80% of Member States have established a functional system for integrating care for MNS conditions into general health care (including primary health care).
- By 2030, 50% of Member States have 80% of primary health care facilities with at least one health care provider with competencies to identify and manage priority MNS conditions.
- By 2030, 80% of Member States have medicines for MNS conditions available in their national essential medicines list in line with the WHO Model List of Essential Medicines, Inter-Agency Emergency Health Kit 2022 and WHO Mental Health Kit 2022.
- By 2030, 80% of Member States have a staff and volunteer culture-of-care strategy in place.

MHPSS promotion and prevention of MNS conditions

38. In emergency settings, it is vital to meet not only the needs of persons with defined MNS conditions, but also to protect and promote the mental well-being of all affected populations and prevent MNS conditions.

39. To strengthen MHPSS promotion and prevention of MNS conditions, the regional action plan recommends the following key strategic action:

- Develop a multisectoral strategy for the promotion of mental health and the prevention of MNS conditions, including, but not limited to, suicide prevention, mental health literacy/anti-stigma programmes, and social and emotional learning skills development among children and adolescents through schools or informal learning opportunities.

Targets

40. Some of the targets for MHPSS promotion and prevention of MNS conditions of the regional action plan are as follows:

- By 2030, 80% of Member States have a mental health promotion and MNS conditions prevention strategy in place.
- By 2030, 50% of Member States have a functional national suicide prevention programme.
- By 2030, 80% of Member States have a functional national anti-stigma programme.
- By 2030, 50% of Member States have a social and emotional learning skills development programme for children and adolescents integrated in the educational system.

Engagement and empowerment of communities and people with lived experience

41. From the earliest phase of an emergency, local communities should be involved to the greatest extent possible in the assessment, design, implementation, monitoring and evaluation of MHPSS programmes. While engaging local actors is critical to the success of humanitarian and emergency responses, it can also potentially serve for MHPSS to be a bridge for development and peace.

42. To strengthen community participation and partnership, the regional action plan recommends the following key strategic actions:

- Orient community members, PWLE, family associations, and community leaders on the integration of care for MNS conditions across sectors and engage them in assessments and the design and implementation of interventions, and monitoring and evaluation of activities, services, policies and plans;
- Build the capacities of community leaders and organizations in the provision of MHPSS, including basic psychosocial skills and psychological first aid (PFA).

Targets

43. Some of the targets for the engagement and empowerment of communities and people with lived experience of the regional action plan are as follows:

- By 2030, 80% of Member States have active associations for people with lived experience, their families and peer support.
- By 2030, 80% of Member States have trained 30% of community leaders and organizations on the provision of basic psychosocial support and PFA, as well as on screening and brief interventions, and referral to specialized diagnosis and treatment of substance use disorders.

Assessment, monitoring and evaluation, and research

44. Assessment, monitoring and evaluation, and research, are dynamic processes and should occur in collaboration with key stakeholders, especially those from the affected communities. Such work should prioritize dialogue, reflection and co-learning with and from communities and local actors, using a whole-of-society approach. This can guide the design, implementation, and monitoring and evaluation of strategies, and drive localized research agendas.

45. To strengthen assessment, monitoring and evaluation, and research, the regional action plan recommends the following key strategic actions:

- Create/adapt an MHPSS monitoring and evaluation strategy, in alignment with national, emergency risk management and/or DRM plans and other national plans;
- Conduct regular MHPSS assessment and mapping the capacity of existing MHPSS actors and services/facilities to respond to emergencies across sectors (such as health, protection and education);
- Identify national research priorities for MHPSS, in line with global, regional and national research priorities.

Targets

46. Some of the targets for the assessment, monitoring and evaluation, and research of the regional action plan are as follows:

- By 2030, 80% of Member States collect and report a core set of MHPSS indicators and targets annually.
- By 2030, 80% of Member States conduct and publish the mapping and assessment of MHPSS capacities and resources on a regular basis, using standard tools.
- By 2030, 80% of Member States have an established research agenda for MHPSS.

Key recommendations

47. The key recommendations to Member States of this technical paper are as follows:

- Endorse the proposed regional action plan for mental health and psychosocial support in emergencies, 2024–2030.
- Integrate MHPSS components in national EPR and/or DRM plans, with adequate and sustainable financing.
- Establish sustainably resourced intersectoral coordination and implementation mechanisms for MHPSS in emergencies.
- Strengthen the capacities of health and social services and systems to deliver mental health interventions across the continuum of care.
- Prioritize the promotion of MHPSS and prevention of MNS conditions.
- Empower and engage affected communities and people with lived experiences.
- Strengthen monitoring and evaluation to guide MHPSS programme development and implementation.

Conclusions

48. The current international interest in and commitment to promoting and protecting the mental health of populations is driven largely by ongoing emergencies and the recent COVID-19 pandemic. It provides an opportunity for Member States in the Region to take the lead not only in addressing the issue of the mental health and psychosocial well-being of people affected by emergencies, but also in building better before and building back better. Protecting and improving people's mental health and psychosocial well-being is critical not only to achieving the Sustainable Developmental Agenda 2030, but also to providing an opportunity to leverage health as a bridge to peace.

49. The 71st session of the WHO Regional Committee for the Eastern Mediterranean is invited to endorse the proposed regional action plan and accompanying framework, which incorporates the best available evidence-informed MHPSS options and interventions in emergencies.

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Annex 1. Prevalence, burden, capacity and resources for MNS conditions

Table A1.1. Age-standardized prevalence rates of MNS conditions and suicide per 100 000

Data extracted from: GBD results [online database]. Seattle, WA: Institute for Health Metrics and Evaluation; 2023 (https://vizhub.healthdata.org/gbd-results/, accessed 9 June 2023).

Blue italic font indicates upper and lower 95% uncertainty intervals. Red font indicates higher prevalence than global upper 95% UI. Green font indicates lower prevalence than global lower 95% UI.

	Mental disorder[a]	Depressive disorders[b]	Anxiety disorders[c]	Schizophrenia	Bipolar disorders	Autism spectrum disorders	Idiopathic developmental intellectual disability[d]	Other mental disorder	Self-harm	Suicide[e]	Substance use disorders[f]	Drug use disorders
Global prevalence	12 262	3440	3780	287	490	369	1427	1429	177	9.16	1998	713
lower 95% UI	*11 383*	*3097*	*3181*	*246*	*408*	*306*	*874*	*1108*	*146*	*6.72*	*1800*	*611*
upper 95% UI	*13 213*	*3818*	*4473*	*331*	*581*	*441*	*1992*	*1816*	*205*	*12.58*	*2237*	*821*
Eastern Mediterranean Region	14 355	4280	4648	255	643	308	2129	1436	134	5.85	1105	455
Eastern Mediterranean Region countries												
Afghanistan	16 496	4945	4851	218	700	287	3764	1468	114	5.96	909	502
Bahrain	13 965	4528	4938	271	781	317	762	1531	133	7.20	880	413
Djibouti	11 576	4461	3255	221	607	393	549	1480	38	11.95	1721	363
Egypt	13 917	3940	4588	248	724	292	1904	1479	93	3.41	713	331
Iran (Islamic Republic of)	18 016	4861	7268	254	817	370	1394	1369	154	5.13	1023	730
Iraq	14 203	3933	5338	246	677	287	1503	1470	133	4.74	741	352
Jordan	14 189	4152	4934	255	782	300	1588	1488	75	1.98	817	422
Kuwait	13 121	4060	4600	274	810	305	591	1493	91	2.66	819	444
Lebanon	15 483	4653	6051	254	941	302	1366	1453	123	2.76	1114	719
Libya	14 741	4406	5324	250	770	286	1633	1475	125	4.49	1235	827
Morocco	15 032	5079	4800	243	745	287	1852	1465	159	7.29	877	482
Oman	13 181	3963	4612	264	686	303	849	1546	84	4.47	795	361
Pakistan	12 590	3943	3474	279	388	298	2345	1371	187	9.77	1782	445
Palestine	17 184	6199	5546	248	791	292	2470	1467	85		808	426
Qatar	12 787	3951	4264	285	745	345	428	1606	104	4.66	898	418
Saudi Arabia	13 072	4216	4554	263	762	311	586	1518	104	5.43	857	434
Somalia	14 098	4847	3273	188	581	379	3152	1457	41	14.66	1494	333
Sudan	15 352	4423	4746	233	732	287	3007	1469	58	4.76	697	318
Syrian Arab Republic	15 451	4133	5608	242	774	284	2564	1452	77	2.11	757	367
Tunisia	15 197	5049	5164	252	788	290	1644	1461	105	3.18	829	443
United Arab Emirates	11 920	3578	4243	275	752	331	609	1584	108	5.24	1264	740
Yemen	15 925	4895	4784	226	726	286	3442	1465	126	7.00	679	301

	Mental disorder[a]	Depressive disorders[b]	Anxiety disorders[c]	Schizophrenia	Bipolar disorders	Autism spectrum disorders	Idiopathic developmental intellectual disability[d]	Other mental disorder	Self-harm	Suicide[e]	Substance use disorders[f]	Drug use disorders
Median prevalence in regional country groups[g]												
Group 1	13 096	4012	4577	272	757	314	600	1538	104	4.95	869	426
Group 2	15 114	4530	5331	249	778	291	1639	1466	114	3.41	823	435
Group 3	14 725	4654	4110	223	653	293	3080	1466	86	8.42	1202	348
Median prevalence in countries in the Region with and without an emergency[h]												
Emergency	15 402	4538	5129	244	751	287	2517	1467	99	4.74	812	395
No emergency	13 151	4138	4594	264	749	308	806	1486	104	5.19	878	439
Difference between prevalence rate in countries in the Region with an emergency compared with those with no emergency												
Difference	2251	400	535	−19	3	−21	1711	−19	−5	−0.45	−66	−44

[a] Includes: schizophrenia; anxiety; bipolar, depressive, autism spectrum, attention deficit hyperactivity, conduct and other mental disorders; idiopathic developmental intellectual disability; and eating disorders.

[b] Includes major depressive disorder and dysthymia.

[c] Includes all anxiety disorders and PTSD.

[d] A residual category capturing intellectual disability not attributed to any of the other causes.

[e] Suicide rates extracted from the WHO Global Health Observatory (https://www.who.int/data/gho, accessed 10 June 2023).

[f] Includes alcohol use disorders and drug use disorders.

[g] A classification based on socioeconomic development and health provision resources. Group 1 contains six countries with high income and resources. Group 2 contains 10 middle-income countries with mid-range resources. Group 3 contains six countries facing major constraints and with low levels of resources. See: Fifty-ninth Regional Committee for the Eastern Mediterranean: Cairo, Egypt, 1–4 October: technical paper: health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. Cairo: WHO Regional Office for the Eastern Mediterranean; 2013 (EM/RC59/Tech.Disc.1; http:/applications.emro.who.int/docs/RC_technical_papers_2012_Tech_Disc_1_14613_EN.pdf).

[h] Countries/territories in the Region with an humanitarian emergency in 2019: Afghanistan, Iraq, Jordan, Lebanon, Libya, Palestine, Somalia, Sudan, Syrian Arab Republic and Yemen.

Table A1.2. Median prevalence rates per 100 000 of depressive disorders, anxiety disorders and idiopathic developmental intellectual disorders, by sex and age band, in countries with and without an emergency

	Male		Female	
	Emergency	No emergency	Emergency	No emergency
Depressive disorders				
0 to 9	72	74	123	123
10 to 24	2916	2909	4500	4282
25 to 49	5177	4927	7627	7237
50 to 74	5489	5331	8246	8254
75+	4532	4496	5927	5902
Anxiety disorders				
0 to 9	1118	1092	1517.42	1389.75
10 to 24	5108	4874	8594.76	7988.52
25 to 49	4182	4089	8314.49	7635.86
50 to 74	3775	3713	6530.90	5931.09
75+	2599	2572	5382.52	4877.99
Idiopathic developmental intellectual disability				
0 to 9	3285	1008	2758	878
10 to 24	3134	979	2666	870
25 to 49	2636	834	2314	765
50 to 74	1876	600	1693	560
75+	968	394	907	418

Table A1.3. Burden of MNS conditions in the Region: YLDs attributable to MNS conditions per 100 000

Data extracted from: GBD results [online database]. Seattle, WA: Institute for Health Metrics and Evaluation; 2023 (https://vizhub.healthdata.org/gbd-results/, accessed 9 June 2023).

Blue italic font indicates upper and lower 95% uncertainty intervals. Red font indicates higher prevalence than global upper 95% UI. Green font indicates lower prevalence than global lower 95% UI.

	Mental disorder[a]	Depressive disorders[b]	Anxiety disorders[c]	Schizophrenia	Bipolar disorders	Autism spectrum disorders	Idiopathic developmental intellectual disability[d]	Other mental disorder	Self-harm	Substance use disorders[e]	Drug use disorders
Global	1566	578	360	184	105	56	58	105	11	284	153
lower 95% UI	*1160*	*406*	*249*	*134*	*64*	*37*	*30*	*68*	*8*	*201*	*106*
upper 95% UI	*2043*	*789*	*494*	*235*	*162*	*82*	*96*	*160*	*15*	*378*	*202*
Eastern Mediterranean Region	1861	761	443	163	138	47	84	106	9	182	115
Eastern Mediterranean Region countries											
Afghanistan	2043	890	457	136	148	43	154	106	10	188	147
Bahrain	1981	823	474	173	169	48	34	113	7	160	112
Djibouti	1650	770	312	142	131	60	21	110	2	191	52
Egypt	1815	697	442	159	157	45	80	110	6	127	88
Iran (Islamic Republic of)	2296	890	696	162	176	56	56	101	8	242	211
Iraq	1844	691	510	157	145	44	58	108	8	124	84
Jordan	1898	744	475	164	170	46	64	110	4	159	118
Kuwait	1859	724	443	176	175	47	27	110	5	148	109
Lebanon	2126	842	579	161	203	46	57	107	6	270	229
Libya	1967	791	510	159	166	44	63	109	8	326	284
Morocco	2056	935	460	155	161	44	70	108	11	173	132
Oman	1810	708	444	170	149	46	36	115	4	132	88
Pakistan	1601	678	328	177	83	45	89	100	15	224	88
Palestine	2397	1169	529	157	169	44	103	108	5	140	100
Qatar	1815	708	411	182	161	53	20	118	5	155	106
Saudi Arabia	1846	749	437	168	164	47	27	112	5	162	119
Somalia	1775	842	311	120	125	57	125	107	3	160	42
Sudan	1945	798	455	149	158	44	118	108	4	114	75
Syrian Arab Republic	1954	731	536	154	166	43	101	107	5	142	102
Tunisia	2106	930	497	162	171	44	66	108	6	167	127
United Arab Emirates	1712	629	409	177	163	50	27	117	7	298	244
Yemen	2041	891	455	143	155	43	138	108	10	107	68

	Mental disorder[a]	Depressive disorders[b]	Anxiety disorders[c]	Schizophrenia	Bipolar disorders	Autism spectrum disorders	Idiopathic developmental intellectual disability[d]	Other mental disorder	Self-harm	Substance use disorders[e]	Drug use disorders
Median rate in regional country groups[f]											
Group 1	1830	716	440	175	164	48	27	114	5	158	111
Group 2	2011	817	510	159	168	44	65	108	6	163	123
Group 3	1860	820	392	143	140	45	122	107	7	174	72
Median rate in countries in the Region with and without an emergency[g]											
Emergency	1961	820	492	155	162	44	102	108	6	151	101
No emergency	1830	736	442	169	162	47	35	110	6	165	111
Difference between rate in countries in the Region with an emergency compared with those with no emergency											
Difference	130	84	50	−14	0	−3	67	−2	0	−14	−9

[a] Includes: schizophrenia; anxiety; bipolar, depressive, autism spectrum, attention deficit hyperactivity, conduct and other mental disorders; idiopathic developmental intellectual disability; and eating disorders.

[b] Includes major depressive disorder and dysthymia.

[c] Includes all anxiety disorders and PTSD.

[d] A residual category capturing intellectual disability not attributed to any of the other causes.

[e] Includes alcohol use disorders and drug use disorders.

[f] A classification based on socioeconomic development and health provision resources. Group 1 contains six countries with high income and resources. Group 2 contains 10 middle-income countries with mid-range resources. Group 3 contains six countries facing major constraints and with low levels of resources. See: Fifty-ninth Regional Committee for the Eastern Mediterranean: Cairo, Egypt, 1–4 October: technical paper: health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. Cairo: WHO Regional Office for the Eastern Mediterranean; 2013 (EM/RC59/Tech.Disc.1; http:/applications.emro.who.int/docs/RC_technical_papers_2012_Tech_Disc_1_14613_EN.pdf).

[g] Countries/territories in the Region with an humanitarian emergency in 2019: Afghanistan, Iraq, Jordan, Lebanon, Libya, Palestine, Somalia, Sudan, Syrian Arab Republic and Yemen.

Table A1.4. Integration of mental health in primary health care

Country	Guidelines for mental health integration into primary health care available and adopted at national level	Estimated percentage of primary care facilities in your country that typically have available pharmacological interventions for mental health conditions	Estimated percentage of primary care facilities in your country that typically have available psychosocial interventions for mental health conditions	Health workers at primary care level receive training on management of mental health conditions	Mental health specialists are involved in training and supervision of primary care professionals	Functional integration of mental health at primary health care level (score out of 5)	Functional integration of mental health at primary health care level (score 4 or 5)
Afghanistan	✓	25 to 50%	50 to 75%	✓	✓	3	
Bahrain	✓	More than 75%	More than 75%	✓	✓	5	✓
Djibouti		NA	NA			1	
Egypt	✓	NA	25 to 50%	✓	✓	3	
Iran (Islamic Republic of)	✓	More than 75%	More than 75%	✓	✓	5	✓
Iraq	✓	More than 75%	More than 75%	✓	✓	5	
Jordan	✓	25 to 50%	25 to 50%	✓	✓	3	
Kuwait	✓	25 to 50%	25 to 50%	✓	✓	3	
Lebanon	✓	More than 75%	Less than 25%	✓	✓	4	✓
Libya		NA	Less than 25%	✓	✓	2	
Morocco	✓	25 to 50%	Less than 25%	✓		2	
Oman	✓	More than 75%	Less than 25%	✓	✓	4	
Pakistan	✓	NA	NA	✓	✓	3	
Palestine	✓	25 to 50%	25 to 50%	✓	✓	3	
Qatar	✓	More than 75%	More than 75%	✓	✓	5	✓
Saudi Arabia	✓	More than 75%	50 to 75%	✓	✓	4	✓
Somalia	✓	Less than 25%	Less than 25%	✓	✓	3	
Sudan	✓	Less than 25%	Less than 25%	✓	✓	3	
Syrian Arab Republic	✓	Less than 25%	Less than 25%	✓	✓	3	
Tunisia	✓	Less than 25%	Less than 25%	✓	✓	3	
United Arab Emirates	✓	50 to 75%	50 to 75%	✓	✓	3	
Yemen	✓	NA	Less than 25%			1	
Percentage of countries meeting the criteria							
Emergency	90%	20% more than 50% coverage	20% more than 50% coverage	90%	90%		20%
No emergency	100%	50% more than 50% coverage	42% more than 50% coverage	92%	83%		42%

Table A1.5. Summary of mental health system capacities and resources drawn from *Mental health atlas 2020*

Data drawn from regional update of the Mental Health Atlas carried out during October–November 2023, using the *Mental health atlas 2020* questionnaire completed by 19 Member States, supplemented by *Mental health atlas 2020. Blank in a tick column indicates the required criteria are not met. Blank in a numbers or currency column indicates that data are not available.*

Domain		Governance					Financial and human resources		Mental health service availability			Promotion and prevention activities					Mental health information and research	
	Emergency	Mental health policy/plan	Mental health legislation	Dedicated inspection body	Service user collaboration	Inclusion in national health insurance scheme	How people pay for mental health care	Mental health staff per 100 000	Integration into primary health care	Mental health beds for adults per 100 000	Suicide prevention	Mental health awareness and stigma	Early-childhood development	Schools-based programmes	Work-place based programmes	Parental/maternal programmes	Reporting on six core indicators	Number of research publications
Global/rest of the world		51%	39%	58%	35%	66%	76%	13.0	31%	17.8	39%	51%	45%	51%	35%	29%	65%	6
Eastern Mediterranean Region		68%	64%	45%	27%	45%	82%	8.0	32%	5.2	50%	73%	45%	68%	32%	41%	45%	13
Eastern Mediterranean Region countries																		
Afghanistan	1	✓	✓				✓	2.7		1.2		✓		✓		✓	5	16
Bahrain		✓	✓	✓			✓	31.3	✓	12.6		✓	✓	✓	✓	✓	6	6
Djibouti		✓				✓	✓	4.6		3.6							5	1
Egypt				✓		✓	✓	4.8		4.9	✓	✓		✓		✓	6	29
Iran (Islamic Republic of)		✓	✓	✓		✓	✓	85.7	✓	39.2	✓	✓	✓	✓	✓	✓	6	216
Iraq	1		✓	✓			✓	2.2	✓	4.0	✓	✓	✓	✓			6	27
Jordan	1	✓	✓	✓	✓	✓	✓	3.8		4.0	✓	✓	✓	✓	✓	✓	6	31
Kuwait			✓				✓	18.6		14.5	✓	✓					0	6
Lebanon	1	✓	✓	✓		✓	✓	49.0	✓	24.8	✓	✓		✓	✓		5	45
Libya	1				✓		✓	130.3				✓					4	1
Morocco		✓	✓	✓	✓	✓	✓	6.5		6.7			✓	✓			6	13
Oman							✓	12.6	✓	5.7			✓				6	7
Pakistan		✓	✓				✓	0.8				✓		✓			4	65
Palestine	1	✓	✓	✓			✓	6.9		3.5	✓	✓		✓			2	
Qatar		✓	✓		✓	✓	✓	32.9	✓	10.4	✓	✓	✓	✓	✓	✓	6	9
Saudi Arabia			✓		✓	✓	✓	16.9	✓	11.4			✓	✓			0	45
Somalia	1	✓						1.1		5.6							5	8
Sudan	1							1.9		0.7		✓	✓	✓	✓	✓	6	3
Syrian Arab Republic	1	✓	✓					34.0		4.2	✓	✓					0	40
Tunisia		✓		✓		✓	✓	9.2		7.1	✓			✓		✓	5	27
United Arab Emirates		✓	✓	✓	✓	✓	✓	67.0		4.9		✓	✓	✓	✓	✓	6	4
Yemen	1	✓						1.2		1.8	✓	✓					5	2

Domain	Governance			Financial and human resources				Mental health service availability		Promotion and prevention activities						Mental health information and research	
	Emergency	Mental health policy/plan	Mental health legislation	Dedicated inspection body	Service user collaboration	Inclusion in national health insurance scheme	How people pay for mental health care	Mental health staff per 100 000	Integration into primary health care	Mental health beds for adults per 100 000	Suicide prevention	Mental health awareness and stigma	Early-childhood development	Schools-based programmes	Work-place based programmes	Parental/maternal programmes	Reporting on six core indicators	Number of research publications
Percentage or median in country groups in the Region[1]																		
Group 1		50%	83%	33%	50%	33%	100%	24.9	67%	10.9	33%	67%	83%	67%	50%	50%	67%	6.5
Group 2		70%	70%	80%	30%	70%	90%	6.9	30%	6.7	80%	80%	40%	80%	30%	40%	50%	29
Group 3		83%	33%	0%	0%	17%	50%	1.9	0%	1.8	17%	67%	17%	50%	17%	33%	17%	5.5
Percentage or median in countries in the Region with and without an emergency[2]																		
Emergency		67%	60%	40%	20%	30%	60%	3.3	20%	4.0	60%	90%	30%	60%	30%	30%	30%	16
No emergency		70%	67%	50%	33%	58%	100%	14.7	42%	6.9	42%	58%	58%	75%	33%	50%	58%	11
Difference between percentage or median in countries in the Region with an emergency compared with those with no emergency																		
Difference		-3%	-7%	-10%	-13%	-28%	-40%	-11.4	-22%	-2.9	18%	32%	-28%	-15%	-3%	-20%	-28%	5

[1] A classification based on socioeconomic development and health provision resources. Group 1 contains six countries with high income and resources. Group 2 contains 10 middle income countries with mid-range resources. Group 3 contains six countries facing major constraints and with low levels of resources. See: Fifty-ninth Regional Committee for the Eastern Mediterranean: Cairo, Egypt, 1–4 October: technical paper: health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. Cairo: WHO Regional Office for the Eastern Mediterranean; 2013 (EM/RC59/Tech.Disc.1; http:/applications.emro.who.int/docs/RC_technical_papers_2012_Tech_Disc_1_14613_EN.pdf).

[2] Countries/territories in the Region with an humanitarian emergency in 2019: Afghanistan, Iraq, Jordan, Lebanon, Libya, Palestine, Somalia, Sudan, Syrian Arab Republic and Yemen.

Annex 2.
Proposed strategic regional framework for mental health and psychosocial support actions in the Eastern Mediterranean Region

The proposed strategic regional framework for mental health and psychosocial support (MHPSS) actions in the Eastern Mediterranean Region describes a recommended set of actions for Member States to meet the objectives of the regional action plan for mental health and psychosocial support in emergencies, 2024–2030. It serves as a comprehensive guide to reach the overall goal of improving mental health and psychosocial well-being and reducing the suffering of populations across all phases of emergencies in the WHO Eastern Mediterranean Region.

Please note the following:

- Each emergency setting is different in terms of needs, resources, capacities and stakeholders. As a result, the strategic MHPSS actions proposed are to be adapted, as appropriate, to national priorities and specific national contexts.
- Any adaptation should be carried out in collaboration with people with lived experience (PWLE) of MNS conditions and their communities, and with the active engagement of national and local experts in line with resources and capacities.
- With Member State oversight, actions can be delegated to actors based on their expertise and experience; these actors can include: local, national and international organizations; academic and research institutes; the MHPSS in emergencies technical working group; and the United Nations Office for the Coordination of Humanitarian Affairs cluster system.

This framework is organized according to five domains (D1–5) and a set of actions (D1A1, D1A2, etc.) that span the three emergency phases (preparedness, response and recovery), and these are shown in the green coded sections of the tables below. A recommended core set of indicators is integrated into the framework for Member States to adapt, collect and analyse regularly, and these are shown in the blue coded sections of the tables below. Please note the following:

- The narrative description of the indicators shows their connection to the recommended action(s). This assures alignment between the actions and the indicators.
- All Member States will be requested to collect baseline measures to compare with the target(s) for achievement by 2030.
- The footnotes, which provide further detail to support the understanding of concepts and/or processes, should be carefully reviewed.

Domain 1	Leadership and governance		
Actions	**Preparedness**	**Response**	**Recovery**
D1A1	Adapt, contextualize and translate IASC guidance and other principles and standards.[1]	Implement the adapted and contextualized guidance, principles and standards.	Review the use of guidance, principles and standards; contextualize these further based on lessons learned.
D1A2	Advocate for and integrate MHPSS considerations within national emergency preparedness, response and recovery (EPR) and/or disaster risk management (DRM) plans and develop appropriate standard operating procedures (SOPs)[2] with the active involvement of all local, national and international stakeholders.	Implement the MHPSS component of national EPR and/or DRM plans and SOPs.	Based on lessons learned, revise national EPR and/or DRM plans (including SOPs) to strengthen the integration of MHPSS considerations.
D1A3	Advocate and integrate MHPSS considerations into legal instruments and legislative provisions to protect the rights of people with MNS conditions aligned with national and international human rights instruments and humanitarian laws.	Ensure that the rights of persons with MNS conditions are protected and promoted and strengthen/put in place mechanisms for monitoring of human rights provisions of persons with MNS conditions and reporting of any violations.	Use lessons learned to revise and strengthen MHPSS considerations in legal instruments and legislative provisions. Strengthen mechanisms of monitoring and addressing human rights violations of persons with MNS conditions.
D1A4	Develop a cross-sectoral and multilayered MHPSS plan.	Implement the cross-sectoral multilayered MHPSS plan.	Revise the MHPSS plan, based on lessons learned.
D1A5	Identify, recruit and build the capacity of staff members in the EPR and/or DRM department, dedicated to integrating MHPSS across all EPR and/or DRM activities. Build the capacity of stakeholders in humanitarian law and human rights standards.	Support ongoing capacity-building of staff in implementing the MHPSS as part of the emergency risk management and/or DRM plans. Provide refresher training, as needed, on humanitarian law and human rights standards for stakeholders.	Support staff in identifying lessons learned from integrating MHPSS into emergency risk management and/or DRM activities; and revising the national emergency risk management and/or DRM plan, based on lessons learned. Support continued capacity-building in humanitarian law and human rights for stakeholders.
D1A6	Where international actors are involved (e.g. in cluster/sector system activation) ensure alignment of their emergency response plans (e.g. strategic preparedness, readiness and response plans in public health emergencies, refugee response plans in refugee settings, migrant response plans in displacement contexts) with national EPR and/or DRM plans.	Where international actors are involved ensure they implement their emergency response plans in a coordinated manner, in line with the national EPR and/or DRM plans.	Where international actors are involved ensure they revise their emergency response plans and plan for transition and handover to in-country actors and stakeholders.
D1A7	Establish a functional[3], national, multisectoral MHPSS coordination structure, led by and/or approved by Member State authorities.	Activate the inter-cluster or intersectoral MHPSS technical working group (TWG), including subnational working groups where relevant.	Use the MHPSS coordination structure as a forum for evaluation and to identify lessons learned. Revise the MHPSS coordination structure, based on lessons learned.
D1A8	Ensure the allocation of dedicated financial resources for MHPSS plans, including for contingencies and emergency appeals.	Ensure that the MHPSS response receives the required resources and is integrated in all funding appeals.	Enhance resource allocation for MHPSS plans based on lessons learned.
D1A9	Integrate MHPSS with universal health coverage priority benefit packages to facilitate sustainable financing *(4)*.	Engage with national authorities and donors to advocate and secure predictable public financing for MHPSS emergency response, in line with priority benefit packages and the MHPSS Minimum Service Package.	Use the MHPSS response as a proof-of-concept to attract further funding, with a lens towards building back better and systems strengthening.

[1] For guidance, see (*1–3)*.

[2] At minimum, include the following steps: 1. hazard and vulnerability assessments; 2. mechanisms for coordination and activation of the planning; 3. key MHPSS preparedness and response activities to be provided based on needs, with clear roles and responsibilities defined; 4. procedures to a) guide decision-making (e.g. SOPs) and b) test the plan (simulation exercises); 5. dedicated human and financial resources to implement the plan; 6. contingency planning for protection of at-risk groups (e.g. protection for people living in psychiatric hospitals and other institutions, evacuation planning) and to maintain access to essential services during emergency-related disruptions; and 7. dedicated human and financial resources to support the implementation of the previous steps.

[3] A functional MHPSS coordination structure has defined terms of reference, documentation or minutes of regular meetings, multisectoral membership (including people with lived experience), and coordinates the development, implementation, monitoring and evaluation of MHPSS plans and activities, in line with the best evidence and guidance.

Domain 1	Proposed indicators, targets and means of verification		
Narrative description	**Indicators**	**Target**	**Means of verification**
Integrate MHPSS components within national EPR and/or DRM plans (D1A2).	% of Member States with integrated MHPSS components within national EPR and/or DRM plans	By 2030, 80% of Member States have integrated MHPSS components within national EPR and/or DRM plans.	National EPR and/or DRM plans
Establish a functional,[1] national MHPSS coordination structure (D1A7).	% of Member States have a functional, national MHPSS coordination structure	By 2030, 80% of Member States have a functional national MHPSS TWG.	Government and ministry of health records MHPSS TWG minutes Survey assessing characteristics of functionality
Develop a costed and financed MHPSS plan.	% of Member States that have a costed and financed MHPSS plan	By 2030, 50% of Member States have a costed and financed MHPSS plan.	Government and ministry of health records
Allocate dedicated, financial resources to MHPSS (D1A8).	% of Member States with % of health budget allocated for MHPSS	By 2030, there are 50% of Member States with at least a 5% increase over the baseline budget allocated for MHPSS.	

[1] A functional MHPSS coordination structure has defined terms of reference, documentation or minutes of regular meetings, multisectoral membership (including people with lived experience), and coordinates the development, implementation, monitoring and evaluation of MHPSS plans and activities, in line with the best evidence and guidance.

Domain 2	Provision of MHPSS and workforce development		
Actions	**Preparedness**	**Response**	**Recovery**
D2A1	Develop/adapt existing MHPSS case management tools, templates and referral protocols.[1]	Promote the use of adapted/contextualized tools, templates and referral protocols.	Contextualize the tools, templates and referral protocols further, based on lessons learned.
D2A2	Promote establishment of benchmarks for licensing and accreditation on minimum competencies for MHPSS providers, relevant to the context, sector and complexity.	Activate MHPSS providers who have met the appropriate benchmarks.	Use lessons learned to inform the review of licensing and accreditation of MHPSS providers.
D2A3	Develop a cadre of supervisors and trainers providing competency-based training and supervision of MHPSS providers across all sectors.	Support continued capacity-building and supportive supervision of health and social sector staff to provide quality MHPSS services.	Use lessons learned to inform and strengthen training and supervision capacities.
D2A4	Test the capacities of MHPSS provision in simulation exercises.	Deploy MHPSS providers and offer refresher trainings linked to capacities and needs.	Adapt regular simulation exercises in line with lessons learned.
D2A5	Create a mechanism and protocol for rapid recruitment and deployment of MHPSS workers; and ensure MHPSS is integrated and strengthened within existing mechanisms of surge response including emergency medical teams and rapid response teams.[2]	Activate the rapid mechanism for recruitment and deployment of MHPSS workers. Activate surge emergency medical teams and rapid response teams.	Update the mechanisms/protocols and rosters for rapid recruitment and deployment, based on lessons learned.
D2A6	Strengthen/establish a functional[3] system for integrating treatment for MNS conditions into general health care, including primary health care (PHC), by: • strengthening/establishing an operations team for the integration of care fo rMNS conditions into general health care, including PHC; • mapping and identifying specialized MHPSS services for training, referral and supervisory support; • training and supervision of health care providers on evidence-based protocols to identify and manage priority MNS conditions in PHC facilities; • developing a roster of trained providers to identify and manage priority MNS conditions in general health care services, including PHC facilities, and including at-risk and vulnerable populations; • engaging specialist staff to provide ongoing supervision through care planning meetings and individual support to health care providers.	Activate the roster of trained PHC personnel to identify, treat and care for people with MNS conditions, including at-risk and vulnerable populations. Provide continuing competency-based training and supervision to health care providers in general health services, including PHC, to identify, treat and care for people with MNS conditions. Support specialized services to provide specialized MHPSS services and for training, referral and supervisory support for PHC.	Conduct and utilize research to scale up the integration of MNS conditions in general health care, including PHC. Use after-event lessons learned to strengthen specialist services to build back better for enhancing access to services for MNS conditions.
D2A7	Advocate for and support the reorientation of institutions providing treatment for MNS conditions and strengthen community-based care for persons with MNS conditions.	Maintain advocacy and support for reorienting institutions providing treatment for MNS conditions and provide community-based care for persons with MNS conditions. Ensure that basic needs of people living in institutions are met and address protection concerns.	Build on response strategies to: • reorient institutions providing treatment for MNS conditions and scale up community-based care for persons with these conditions; • ensure the basic needs of people living in institutions are met and addressed.

[1] For guidance, see *(5)*.

[2] A roster of staff available to be quickly deployed to increase the capacity to respond to an emergency, as part of an emergency medical team or a rapid response team.

[3] The integration of mental health into PHC is considered to be functional only if at least four of the following five criteria are fulfilled: 1) guidelines for mental health integration into PHC are available and adopted at the national level; 2) pharmacological interventions for mental health conditions are available and provided at the primary care level; 3) psychosocial interventions for mental health conditions are available and provided at the primary care level; 4) health workers at primary care level receive training on the management of mental health conditions; and 5) mental health specialists are involved in the training and supervision of primary care providers. Definition from *(6)*.

Domain 2	Provision of MHPSS and workforce development		
Actions	**Preparedness**	**Response**	**Recovery**
D2A8	Align the national essential medicines list for MNS conditions with the WHO Model List of Essential Medicines *(7)*, Interagency Emergency Health Kit *(8)* and WHO Mental Health Kit 2022. Implement a system for stock-taking to ensure the uninterrupted availability of essential medications in all health and social care facilities.	Ensure a regular supply of essential medicines for MNS conditions for people in need.	Evaluate and update mechanisms to maintain a regular supply of essential medicines for MNS conditions.
D2A9	Develop and implement a staff and volunteer culture-of-care strategy *(9)*, including: • identifying focal points to help implement provisions of the strategy; • recruiting staff to provide interventions for workers; • building capacity to identify work-related mental health conditions among MHPSS care providers.	Ensure that the health and well-being of staff and volunteers are taken care of during emergencies and implement a culture-of-care strategy.	Update the culture-of-care strategy, based on lessons learned.

Domain 2	Proposed indicators, targets and means of verification		
Narrative description	**Indicators**	**Target**	**Means of verification**
Test competencies of MHPSS actors in simulation exercises (D2A4).	% of Member States with yearly simulation exercises to test competencies of MHPSS actors.	By 2030, 80% of Member States have held at least one simulation exercise in the last year.	Government and ministry of health records
Establish a functional[1] system for integrating care for MNS conditions in general health care, including PHC (D2A6).	% of Member States with a functional system for integrating care for MNS conditions into general health care, including PHC.	By 2030, 80% of Member States have established a functional system for integrating care for MNS conditions into general health care.	Government and ministry of health records Survey assessing characteristics of functionality
Train health care providers on the evidence-based protocols to identify and manage priority MNS in PHC facilities (D2A6).	% of Member States have % of PHC facilities with at least one health care provider with competencies to identify and manage priority MNS conditions.	By 2030, 50% of Member States have 80% of PHC facilities with at least one health care provider with competencies to identify and manage priority MNS conditions.	Government and ministry of health records Surveys, key informant interviews and/or focus group discussions with health care providers
Develop a roster of trained providers who can be activated to provide focused and specialized care, including to at-risk and vulnerable populations (D2A6).	% of at-risk and vulnerable people receiving focused and specialized care within % of Member States.	By 2030, 80% of at-risk and vulnerable people receive focused and specialized care within 80% of Member States.	Government and ministry of health records
Uninterrupted availability of medicines for MNS conditions in the national essential medicines list in line with the WHO Model List of Essential Medicines *(7)*, Interagency Emergency Health Kit *(8)* and WHO Mental Health Kit 2022 (D2A8).	% of Member States with medicines for MNS conditions available in their national essential medicines list in line with the WHO Model List of Essential Medicines, Interagency Emergency Health Kit and WHO Mental Health Kit 2022.	By 2030, 80% of Member States have medicines for MNS conditions available in their national essential medicines list in line with the WHO Model List of Essential Medicines, Interagency Emergency Health Kit and WHO Mental Health Kit 2022.	Ministry of health records and national essential medicines lists.
Implement a staff and volunteer culture-of-care strategy (D2A9).	% of Member States with a staff and volunteer culture-of-care strategy.	By 2030, 80% of Member States have a staff and volunteer culture-of-care strategy.	Government and ministry of health records

[1] The integration of mental health into primary health care is considered to be functional only if at least four of the following five criteria are fulfilled: 1) guidelines for mental health integration into PHC are available and adopted at the national level; 2) pharmacological interventions for mental health conditions are available and provided at the primary care level; 3) psychosocial interventions for mental health conditions are available and provided at the primary care level; 4) health workers at primary care level receive training on the management of mental health conditions; and 5) mental health specialists are involved in the training and supervision of primary care providers. Definition from *(6)*.

Domain 3	MHPSS promotion and prevention of MNS conditions		
Actions	**Preparedness**	**Response**	**Recovery**
D3A1	Develop a multisectoral strategy for the promotion of mental health and prevention of MNS conditions, including, but not limited to: • mental health literacy/anti-stigma programmes; • suicide prevention; • social and emotional learning skills development among children and adolescents through schools or informal learning opportunities.	Implement the strategy based on emerging needs, vulnerabilities and risks, through programmes for: • promotion of mental health literacy and stigma reduction, including using innovative ways and technology-based platforms where feasible; • suicide prevention; • social and emotional learning skills development among children and adolescents through schools or informal learning opportunities.	Expand the promotion and prevention programmes to cover more segments of affected and vulnerable populations.
D3A2	Facilitate participatory discussions with PWLE and community members in all phases of the development (topic identification, design and content development, and message delivery) of culturally and age-relevant key messages that promote mental health and well-being, and stigma minimization activities, for MNS conditions.	Adapt key messages with PWLE, community members and other actors and disseminate key messages through multiple channels and methods.	Revise key messages based on lessons learned.

Domain 3	Proposed indicators, targets and means of verification		
Narrative description	**Indicators**	**Target**	**Means of verification**
Establish a multisectoral strategy for the promotion of mental health and prevention of MNS conditions (D3A1).	% of Member States with a mental health promotion and prevention of MNS conditions strategy in place.	By 2030, 80% of Member States have a mental health promotion and prevention of MNS conditions strategy in place.	Government and ministry of health records
Implement evidence-based and functional[1] promotion and prevention programmes (D3A1).	% of Member States have a functional national suicide prevention programmes.	By 2030, 50% of Member States have a functional national suicide prevention programme.	Government and ministry of health records Survey assessing characteristics of functionality
	% of Member States have a functional national anti-stigma programme.	By 2030, 80% of Member States have a functional national anti-stigma programme.	Government and ministry of health records
	% of Member States have a social and emotional learning skills development programme for children and adolescents integrated in the educational system.	By 2030, 50% of Member States have a social and emotional learning skills development programme for children and adolescents integrated in the educational system.	Government and ministry of education records
	% of Member States have a functional national programme on the prevention of substance use.	By 2030, 50% of Member States have initiated substance use prevention and harm reduction programmes.	Government and ministry of health records

[1] A mental health promotion and prevention programme is considered to be functional only if at least two of the following three characteristics are fulfilled: 1) dedicated financial and human resources; 2) a defined plan of implementation; and 3) evidence of progress and/or impact. Definition from *(6)*.

Domain 4	Engagement and empowerment of communities and people with lived experience		
Actions	**Preparedness**	**Response**	**Recovery**
D4A1	Identify pre-existing community-support structures, resources and activities that strengthen coping and social support and minimize harm, as well as providing treatment and care for MNS conditions.	Provide technical, financial and/or in-kind support for community-led or community-based activities that promote mental health and psychosocial well-being and minimize harm, as well as providing treatment and care for MNS conditions.	Conduct and utilize research and lessons learned to inform and support sustained community-led or community-based MHPSS structures activities and interventions.
D4A2	Orient community members, PWLE, family associations, and community leaders on the integration of care for MNS conditions across sectors and engage them in assessments and the design and implementation of interventions, and monitoring and evaluation of activities, services, policies and plans.	Facilitate and support the engagement of PWLE, family associations, community members and community leaders in assessments and the implementation, and monitoring and evaluation, of activities strengthening support for MNS conditions.	Conduct qualitative research to assess the process and impact of engagement processes with community members and leaders. Strengthen functional collaboration[1] with PWLE, family associations, community members and community leaders to advocate for and revise national plans across relevant sectors to integrate activities to strengthen support for MNS conditions.
D4A3	Build the capacities of community leaders and organizations in the provision of MHPSS, including basic psychosocial skills and psychological first aid (PFA).[2]	Support community leaders and organizations in the provision of MHPSS, including basic psychosocial skills and PFA.[3]	Use lessons learned to inform advocacy plans and capacity strengthening of community leaders and organizations.
D4A4	Train teachers, childcare workers, protection actors and other community members (such as youth, women's groups and faith leaders) in structured MHPSS activities.	Support the capacity-building of education personnel to promote the mental health and psychosocial well-being of children.[4] Support building up MHPSS capacities of youth and women's groups to support affected populations, including children, vulnerable people and those with disabilities.[5] Support capacity-building of faith leaders to provide psychosocial support. Provide MHPSS through safe spaces for women and girls.[6] Support activities for children's mental health and psychosocial well-being across sectors.[7]	Conduct and utilize research and lessons learned to inform and support the sustainability of group-based, community-led/-based MHPSS mechanisms and services. Identify and support structured MHPSS activities that are appropriate for the context of affected communities.
D4A5	Develop capacities of caregivers, family members and close contacts to support and foster the reintegration into communities of people who are living in institutions or experiencing a MNS condition.	Continue to build capacities of caregivers, family members and close contacts to support and foster the reintegration into communities of people who are living in institutions or MNS condition.	Use lessons learned to inform capacity-building packages/methodologies.

[1] A "functional collaboration" meets two of the following three criteria: 1) a formal agreement or joint plan; 2) dedicated funding from or to the partner; and 3) regular meetings with the partner (at least annually). Definition from *(6)*.

[2] For guidance, see *(10)*.

[3] For guidance, see *(10)*.

[4] For guidance, see (*11)*.

[5] For guidance, see *(12)*.

[6] For guidance, see *(13)*.

[7] For guidance, see *(14)*.

Domain 4	Proposed indicators, targets and means of verification		
Narrative description	**Indicators**	**Target**	**Means of verification**
Empower PWLE, family associations, community members and community leaders to engage in the assessment, design, implementation, monitoring and evaluation of services for MNS conditions (activities, policies and plans) (D4A2).	% of Member States that strengthen the capacity of PWLE, family associations and community members to engage in service and policy development for MNS conditions.[1]	By 2030, 80% of Member States have active associations for PWLE, their families and peer support.	Government and ministry of health records Surveys, key informant interviews and/or focus group discussions with PWLE and communities
Build the capacity of community leaders and organizations in the provision of basic psychosocial support and PFA, as well as screening, brief interventions and referral to specialized diagnosis and treatment of substance use disorders (D4A3).	% of Member States have trained % of community leaders and organizations on the provision of basic psychosocial support and PFA, as well as on screening and brief interventions and referral to specialized diagnosis and treatment of substance use disorders.	By 2030, 80% of Member States have trained 30% of community leaders and organizations on the provision of basic psychosocial support and PFA, as well as on screening and brief interventions, and referral to specialized diagnosis and treatment of substance use disorders.	Government and ministry of health records
Develop capacities of caregivers, family members and close contacts to support and foster the reintegration into communities of people who are living in institutions or experiencing MNS conditions (e.g. through training in communication skills, stress management, problem-solving, conflict management or vocational skills) (D4A5).	% of caregivers, family members and close contacts in % of Member States who have received training to support reintegration into communities of people who are living in institutions or experiencing MNS conditions.	By 2030, 50% of caregivers, family members and close contacts in 80% of Member States have received training to acquire the skills to support reintegration into communities of people who are living in institutions or experiencing MNS conditions.	Pre/post survey Brief Coping Orientation to Problems Experienced (COPE) inventory Key informant interviews Focus group discussions
Affected people and caregivers experience subjective well-being (e.g. feeling calm, safe, strong, hopeful, capable, rested, interested and happy) (D4A5).	% of affected people and caregivers in % of Member States who report subjective well-being.	By 2030, 50% of affected people and caregivers in 80% of Member States report subjective well-being.	Pre/post survey WHO-5 Well-Being Index WHO Disability Assessment Schedule Key informant interviews Focus group discussions

[1] This indicator implies that PWLE, family associations and communities have the capacity to act as participants in programmes and policies that are implemented across preparedness, response and recovery phases.

Domain 5	Assessment, monitoring and evaluation, and research		
Actions	**Preparedness**	**Response**	**Recovery**
D5A1	Create/adapt a MHPSS monitoring and evaluation strategy,[1] in alignment with national, emergency risk management and/or DRM plans and other national plans.	Revise MHPSS activities based on ongoing monitoring.	Use lessons learned to inform and reshape monitoring and evaluation strategies/plans, for building back better, and system strengthening.
D5A2	Develop, adapt, contextualize and maintain (and regularly update) a repository of existing and available MHPSS tools, resources and assessments.	Utilize and update the repository of MHPSS tools, resources and assessments.	Utilize and update the repository of MHPSS tools, resources and assessments.
D5A3	Conduct regular MHPSS assessment and mapping the capacity of existing MHPSS actors and services/facilities to respond to emergencies across sectors (e.g. health, protection and education).	Conduct rapid desk reviews and MHPSS assessments for emerging needs. Integrate MHPSS aspects in sectoral and multisectoral assessments (e.g. health, protection, including gender-based violence and child protection, education). Map and assess existing and new MHPSS actors and services/facilities and their capacities using standardized tools.	Use lessons learned to inform and reshape long-term planning for building back better and system strengthening.
D5A4	Integrate mental health and substance use indicators in national health information management systems.	Use national health information management systems to guide the mental health and substance use response and fill the identified gaps.	Evaluate and update national health information management systems using lessons learned.
D5A5	Identify national research priorities for MHPSS *(16)*, in line with global, regional and national research priorities *(17)*. Implement research on support services for substance use conditions to fill the gaps in knowledge related to the burden, patterns of substance use and successful interventions *(18)*.	Implement and/or commission the agreed-upon research priorities for MHPSS.	Update the MHPSS research agenda based on lessons learned for building back better and systems strengthening.
D5A6	Strengthen the capacity of regional and national research institutes to be able to provide timely localized evidence to inform MHPSS response.	Rapidly synthesize evidence to facilitate evidence-informed decision-making to ensure that response activities meet the affected population's needs.	Update the MHPSS research agenda based on lessons learned for building back better and systems strengthening.
D5A7	Host knowledge dissemination and exchange events based on the research findings, within the country and across countries.	Continue supporting knowledge dissemination.	Host knowledge dissemination and exchange events based on the research findings, within the country and across countries.

[1] For guidance, see *(15)*.

Domain 5	Proposed indicators, targets and means of verification		
Narrative description	**Indicators**	**Target**	**Means of verification**
Create an MHPSS monitoring and evaluation strategy with agreed-upon indicators and targets (D5A1).	% of Member States collecting and reporting a core set[1] of MHPSS indicators and targets anually.	By 2030, 80% of Member States collect and report a core set of MHPSS indicators and targets annually.	Government and ministry of health records
Conduct mapping and assessment of capacities and resources of MHPSS actors and services[2] (D5A3).	% of Member States conducting and publishing mapping and assessment of MHPSS capacities and resources, on a regular basis, using standard tools.	By 2030, 80% of Member States conduct and publish mapping and assessment of MHPSS capacities and resources, on a regular basis, using standard tools.	Government and ministry of health records MHPSS TWG minutes, reports and dashboard
Integrate mental health and substance use indicators into other assessments across health, education and social sectors (D5A3).	Number of health and social sector assessments with integrated mental health and substance use indicators.	By 2030, 100% of health and social sector assessments have integrated a core set of mental health and substance use indicators.	Health and social sector surveys and reviews Government and ministry of health records
Integrate mental health and substance use indicators in national health information management systems (D5A4).	% of Member States collecting and reporting a core set[1] of MHPSS indicators and targets anually.	By 2030, 80% of Member States collect and report a core set of MHPSS indicators and targets annually.	Government and ministry of health records
Identify national research priorities for MHPSS) (D5A5).	% of Member States with an established MHPSS research agenda).	By 2030, 80% of Member States have an established research agenda for MHPSS).	Government and ministry of health records Desk review of research outputs and publications on mental health and substance use

[1] A “core set” is defined as the entire monitoring framework shown in this regional action plan.

[2] Including conducting a mapping of MHPSS services and capacities in health and social systems.

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