Integration of Mental Health and Psychosocial Support in Primary Health Care

for Children, Adolescents, Pregnant Women and New Mothers in the Middle East and North Africa Region

LIBYA

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Libya Country Report 2023

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Acronyms and abbreviations

ADHD	attention deficit hyperactivity disorder
CSO	civil society organization
DSM	Diagnostic and Statistical Manual of Mental Disorders
DALY	disability-adjusted life years
EMRO	Eastern Mediterranean Regional Office (WHO)
FP	family physician
GBD	global burden of disease
GSHS	Global School Health Survey
GYTS	Global Youth Tobacco Survey
ICD10	International Classification of Disease
IMC	International Medical Corps
INGO	international non-governmental organization
IOM	International Organization of Migration
IRC	International Rescue Committee
LNFHS	Libyan National Family Health Survey
LFJL	Lawyers for Justice in Libya
MENA	Middle East and North Africa
MENA	Middle East and North Africa Regional Office (UNICEF)
mhGAP	Mental Health Gap Action Programme (WHO)
MOH	Ministry of Health
MHPSS	mental health and psychosocial support
NGO	non-governmental organization
NCDC	National Centre for Disease Control
PHC	primary health care
PHCI	Primary Health Care Institute
PPD	postpartum depression
PTSD	post-traumatic stress disorder
RMNCAH	reproductive maternal, newborn, child and adolescent health
SOWC	State of the World's Children
TAG	Technical Advisory Group
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Executive summary

The mental health of children and adolescents aged 0–18 years is one of the most neglected health issues globally. Prior to COVID-19, the World Health Organization (WHO) estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by the age of 14. In the Middle East and North Africa (MENA) region, around one in six adolescents aged 10–19 years is estimated to be living with a mental disorder, with suicide as a leading cause of death of 15–19-year-olds. Additionally, many more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorders but significantly affects their health, development and well-being. Poor mental health can have profound impacts on children's and adolescents' health, learning, social well-being and participation, limiting opportunities for them to reach their full potential.

Despite this burden, there is a significant unmet need for mental health and psychosocial support (MHPSS) for children and adolescents. Globally, government expenditure on mental health accounts for only 2 per cent of the total health expenditure, despite accounting for 7 per cent of the total burden of disease. Fewer than two outpatient mental health clinics serve 100,000 people. In addition, the estimated ratio of mental health specialists with expertise in treating children and adolescents is <0.5 per 100,000 population in low- and middle-income countries. These constraints are also found in the MENA region.

To address the mental health and psychosocial well-being of children, adolescents and mothers, it is necessary to integrate a tiered approach that includes actions to promote well-being, prevent poor mental health by addressing risks and enhancing protective factors, and ensure quality and accessible acceptable and affordable care for those with mental health conditions through primary health care (PHC) and community-based mental health care services. This requires participation by all sectors, communities, youth networks, parents and children and adolescents.

The effective integration of mental health into PHC remains an unrealized goal in many countries and contributes to a significant unmet need for services. Insufficient training and support for primary-level health providers, high caseloads and time constraints, inadequate coordination and referral with specialized services, insufficient financial resources, and lack of clear guidance and protocols for integration of MHPSS into primary care services (including maternal and child health care) are common challenges globally.

In response to the pressing need to incorporate MHPSS services for children, adolescents and mothers in the region, particularly in light of the significant impact of COVID-19 on mental health, UNICEF Middle East and North Africa Regional Office (MENARO) initiated implementation research to determine the most efficient approach to integrate MHPSS in PHC.

The success of the research initiative is attributed to the implementation of a conceptual framework in six focal countries within the region: Egypt, Lebanon, Jordan, Saudi Arabia, Kuwait and Libya. The research engaged in an exploration of how MHPSS for children, adolescents and mothers can be effectively integrated into PHC to be acceptable, accessible and affordable as part of community-based services.

This report documents the applications of the regional and global conceptual framework with a review of the feedback of the Libya Technical Advisory Group (TAGs) and Libyan stakeholders during the country consultation workshop and key informant interviews. The consultation and interviews provided findings on the gaps in MHPSS service provision and the challenges in supporting MHPSS for children, adolescents and mothers in PHC.

In Libya, individuals aged between the ages of 0–18 years face a considerable burden of poor mental health. The political crisis since 2011 in Libya and the renewed war in 2019, in coincidence with COVID-19, have profoundly affected the mental health of the population, especially vulnerable groups. The limited national data and the absence of a national health information system for mental health registration reflected the extent of mental health problems in Libya.

This report identifies significant gaps in the current MHPSS response in PHC in Libya. Minimal services that cater to the mental health needs of children and adolescents in the PHCs, which have received the WHO Mental Health Gap Action Programme (mhGAP) training, and the excessive dependence on tertiary, institutional-based care and the private sector, with stigma related barriers, are overall factors that contribute to a significant amount of unmet need and delays in accessing services. The lack of standardized early diagnosis tools for mental health, including self-harm and suicide, as well as the absence of established referral protocols, are contributing to the delay in obtaining services and support, and most of the referrals are made in informal ways. In addition, it was found that there is an absence of protocols for addressing risk factors, and a lack of programmes that address positive parent care and interpersonal skills. There is a need for comprehensive and coordinated approaches to promoting mental health in communities and a shortage of MHPSS professionals. Significant gaps exist in programmes catering to marginalized, out-of-school and migrant children and adolescents.

A major challenge in implementing MHPSS-related programmes is the lack of budgetary resources and inadequacies in laws concerning mental health for children, particularly those with physical disabilities, with unclear unified governance regarding the mental health services in PHC with unified policies and plans. The main challenge found in all sectors is the inadequate number of skilled personnel, which is a significant obstacle to implementation. This factor has resulted in increased workloads, prolonged wait times for care and inconsistent delivery of interventions.

The integration of MHPSS for children, adolescents and mothers in PHC in Libya can be significantly improved, and there are several broad recommendations for MHPSS integration in PHC:

1. It is necessary to put in place a national mental health act by the parliament for every level (promotion, preventive and responsive care) with specific consideration for the protection and rights of children, adolescents and mothers, with a clear indication that the mental health act must be a separate law and not a chapter in the general health law.

2. Increase the awareness of the community members and stakeholders of the importance of a mental health law with awareness among non-health sectors of prioritizing MHPSS in their primary sectoral focus.

3. Facilitate finalizing the new national strategy of mental health in Libya and start applying the action plan while recommending engagement with other sectors, such as education, child protection, social affairs, interior and justice as well as NGOs, communities, youth networks and the private sector.

4. Consolidate efforts to improve policy, coordination and governance by sustaining the role of the National High Committee of Mental Health through members, including the Ministry of Health (MOH), Primary Health Care Institute (PHCI), National Centre for Disease Control (NCDC), mental health care providers and academia to support the PHCI in the integration effort of mental health in the PHC.

5. Standardize tools for early identification, screening and referral procedures and specific management of common mental health conditions among children, adolescents and mothers in PHC, which is contextualized and locally adapted.

6. Form a National Multisectoral Mental Health Committee, with representation from MOH and various ministries including the Ministry of Education, Ministry of Social Affairs, Ministry of Justice, Ministry of Interior and Ministry of Youth. To establish a mental health law and action plan to protect the right to mental health for children and adolescents, a key role must be assigned to the national leadership for the cross-sectoral standards regarding referral mechanisms, early detection and screening of mental health conditions, budget and resource allocation.

7. Reduce financial hardship of people suffering from mental health conditions by minimizing the out-of-pocket expenditure through strengthening MHPSS services in public health services (the provision of free-of-charge services according to the public health law No. 106).

8. Develop standard models of care that reinforces MHPSS services in modules focusing on child health (including school health services), adolescent health and reproductive health services, which respond to three tiers of actions (screening, early diagnosis and management of mild mental health conditions).

9. Strengthen the role of community-based services, in cooperation with governmental and non-governmental partners, including youth, to integrate community and outreach services, ensuring referral pathways and networks with PHC. To include stigma reduction educational programmes for any cases of violence, substance abuse, and physical and sexual abuse.

10. Conduct detailed mapping of MHPSS sector workforce (to identify gaps in numbers, qualification, skills and type of speciality) across different sectors, MOH and Ministries of Health, Education, Social Affairs, Child Protection and Justice.

It is also necessary to **strengthen the MHPSS workforce** through:

11. Integration of mhGAP training in the undergraduate medical curriculum and post-graduate training for all physicians and other PHC providers, such as nurses and midwives to provide care for children and mothers. Upgrade the learning programmes, such as diplomas for MHPSS providers and help them acquire professional expertise as one form of incentive. Improve the quality of pre- and in-service training programmes for health care practitioners, social welfare personnel, justice sector employees, educators and other school-based staff to ensure that their roles and responsibilities on MHPSS are properly aligned.

12. Enhance the provision of mental health medicines by MOH and under the supervision of the Medical Supply System to facilitate access to patients who need medications.

13. Conduct mapping of the available PHC infrastructure while defining the minimum requirement standards regarding the availability of infrastructure in PHC for the integration of MHPSS actions in the form of buildings, availability of rooms with privacy, water, sustained electricity, sound sanitation systems and diagnostic tools to facilitate MHPSS services. Create physical spaces that are comfortable and maintain privacy for individual consultation/assessment/therapy as well as spaces for group activities (parenting programmes and group therapy).

14. Ensure the government's continuous support for inpatient centres for the management and rehabilitation of addiction and substance abuse. Also, strengthen the role of mental health providers to provide qualified services.

15. Conduct a rollout of specific mental health disaggregated indicators through the DHIS-2 system to access data on the caseload availability of services and medication stock, and thus support evidence-based planning for mental health services.

16. Ensure the government's support and advocacy for national surveys and research at national and subnational levels, and provide funding coverage for building evidence to promote specific actions and effective implementation models, covering the topics on mental health needs, risk factors and service deliveries.

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1. Introduction

The mental health of children and adolescents aged 0–18 years is one of the most neglected health issues globally. Prior to COVID-19, the World Health Organization (WHO) estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by the age of 14 years.[1] In the Middle East and North Africa (MENA) region, around one in six adolescents aged 10–19 years are estimated to be living with a mental disorder, with suicide as the leading cause of death of 15–19-year-olds.[2] Additionally, many more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorders but significantly impacts their health, development and well-being.

In Libya, around 31 per cent of the population is below 15 years of age. This large proportion of the population is at risk of poor mental health as a consequence of conflicts and political instability.[3] Modelled estimates from the Global Burden of Disease Study 2019 (GBD 2019) have indicated that mental disorders account for 18.91 per cent of the total burden of disease among 10–19-year-olds.[4] According to the national data, the suicide rate is estimated at 1.8 per 100,000 per year before the conflict, and mental and behavioural diseases represented 0.1 per cent of deaths in 2007.[5, 6]

Mental health and psychosocial well-being can be defined as a positive state in which children and adolescents are able to cope with emotions and normal stresses, have the capacity to build relationships and social skills, are able to learn and have a positive sense of self and identity.

Mental health condition is a broad term that encompasses the continuum of mild psychological distress through to mental disorders that may be temporary or chronic, fluctuating or progressive. During childhood and adolescence, common mental health conditions include difficulties with behaviour, learning or socialization; worry, anxiety, unhappiness or loneliness; and disorders such as depression, anxiety, conduct disorder, psychosis, bipolar disorder, eating disorders, substance-use disorders, attention deficit/hyperactivity disorder, intellectual disability, autism and post-traumatic stress disorder.

Adapted from UNICEF State of the World's Children 2021

Poor mental health can profoundly affect children's and adolescents' health, learning, social well-being and participation, limiting their opportunities to reach their full potential. This age group, from 0–18 years, encompasses a time of critical brain growth and development, especially when social, emotional and cognitive skills are formed, laying the foundation for mental health and well-being into adulthood.[7] Aside from mental disorders arising during this age, many risk factors for future poor mental health also typically have their onset in this developmental stage.[8, 9] In the MENA region, exposure to conflict and violence, displacement and the impacts of the COVID-19 pandemic are likely to be significant contributors to poor mental health.[10, 11]

The limited national data on the mental health of this age group has resulted in a further deficiency in data regarding the lost human capital from mental disorders during childhood and adolescence, where modelled estimates of GBD 2019 have indicated that mental disorders represent 0.00062 per cent (62 per 100,000) of the total deaths of adolescents aged 15–19 years in Libya.[4]

Despite this significant burden, there is a substantial unmet need for MHPSS for children and adolescents. Globally, government expenditure on mental health accounts for only 2 per cent of the total health expenditure,[12] despite accounting for 7 per cent of the total burden of disease.[13] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescents is <0.5 per 100,000 people and there are fewer than two outpatient facilities for children's and adolescents' mental health per 100,000 people.[12] These constraints have also been described in the MENA region.[14]

In Libya, there are fewer than 30 psychiatrists and one child psychiatric physician in the country, with an estimated population of 6.5 million people in 2017.[15] Furthermore, there is a relatively high concentration of health staff, social workers and psychologists involved in providing MHPSS services compared to other actors, followed by education staff.[15] Volunteers, case managers and community health workers are also relatively underreported.[16, 17] In 2012, the Ministry of Health's annual budget provided 13 million Libyan dinars for two mental hospitals, one in Tripoli and one in Benghazi, accounting for 0.45 per cent of the total public health budget.[18] This is considered less than the global government expenditure. There are also many gaps and missed opportunities to prevent poor mental health and promote well-being. Many approaches are fragmented or small-scale. In addition to inadequate human and financial resources, lack of coordination between sectors (including health, child protection and education) and substantial stigma remain significant barriers to ensuring that children, adolescents and their families have access to quality services and support.[2, 19]

Mental health and psychosocial support (MHPSS) refers to any support, service or action that aims to protect or promote psychosocial well-being or prevent or treat mental disorders.

Adapted from UNICEF State of the World's Children 2021

Libya is currently making significant efforts to address child and adolescent mental health through the provision of mental health services, school-based programmes to support early identification and prevention of poor mental health disorders, and the integration of mental health services and support into primary health care (PHC) facilities through WHO mhGAP training by the Primary Health Care Institute (PHCI). The Ministry of Health (MOH) has set new mental health standards to transition from the institution-based approach to a community-based approach to mental health care, which will be available in all areas of the country. However, access to services is still far from universal and unmet need is prevalent.[20]

The mental health and well-being of children and adolescents requires a tiered response that includes services and support to ensure:

1. Responsive care for mental health conditions
2. Preventive interventions to address risk factors and enhance protective factors
3. Actions to ensure safe and enabling environments that promote mental health and psychosocial well-being

This tiered and multi-sectoral approach is at the core of global MHPSS guidance, including UNICEF's Global Multi-Sectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers across Settings,[21, 22] and the Operational Guidelines on Community-Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered Support for Children and Families.[23] Furthermore, there is a need to support the mental health and well-being of parents and carers, including mental health for pregnant and new mothers, to address the significant burden of poor maternal mental health and its impacts on child health and development.[24]

The comprehensive package of MHPSS requires coordinated action delivered by multiple sectors. The health sector (particularly primary health care) provides a critical platform for:

1. Identifying and responding to mental health needs,
2. Delivering key interventions to address risk factors, and
3. Engaging with communities and families to support health promotion and mental health literacy.

Most mental health conditions can be effectively diagnosed and managed by non-specialist providers through primary health care. Such services are also likely to be more accessible, affordable and acceptable to children and their families, less stigmatizing, and have greater capacity to provide person-centred care and support.[25, 26] There are also critical opportunities to identify and address risk factors (such as exposure to family violence), and integrate mental health promotion.

The need to strengthen primary and community-based mental health care has also been emphasized in the WHO Mental Health Action Plan,[27] UNICEF's Global Multi-Sectoral Operational Framework,[22] and the Scaling up of Mental Health Care: A Framework for Action for the Eastern Mediterranean Region.[28] Despite this, effective integration of mental health into primary health care remains an unrealized goal in many countries and contributes to significant unmet need for services. Insufficient training and support for primary-level health providers, high caseloads and time constraints, inadequate coordination and referral with specialized services, insufficient financial resources, and lack of clear guidance and protocols for the integration of MHPSS into primary care services (including maternal and child health care) are common challenges globally and locally.[26]

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2. Aims, objectives and approach

The **aims** of the implementation research are to understand how MHPSS for children, adolescents and maternal mental health can be effectively integrated and delivered through primary health care in Libya.

The specific **objectives** are to:

- Synthesize available national-level and comparable data to describe the mental health needs (outcomes and risks) of children and adolescents aged 0–18 years and maternal mental health.
- Review national mental health policies/plans to identify the current (or potential) roles and responsibilities for primary health care in delivering MHPSS for children and adolescents, and maternal mental health (mapped against global and regional MHPSS frameworks).
- Explore current challenges and opportunities to strengthen the integration and delivery of MHPSS through primary health care (including maternal and child health).
- Identify structural and system support and capacity-building steps required for the implementation of MHPSS through primary health care through a systems-strengthening approach.
- Explore linkages between primary health care and other key sectors (including child protection and education) needed to support MHPSS.

Overview of the report

This report provides an overview of the regional and global conceptual framework, and the synthesis of the desk-based review, two consultation workshops and key informant interviews to describe:

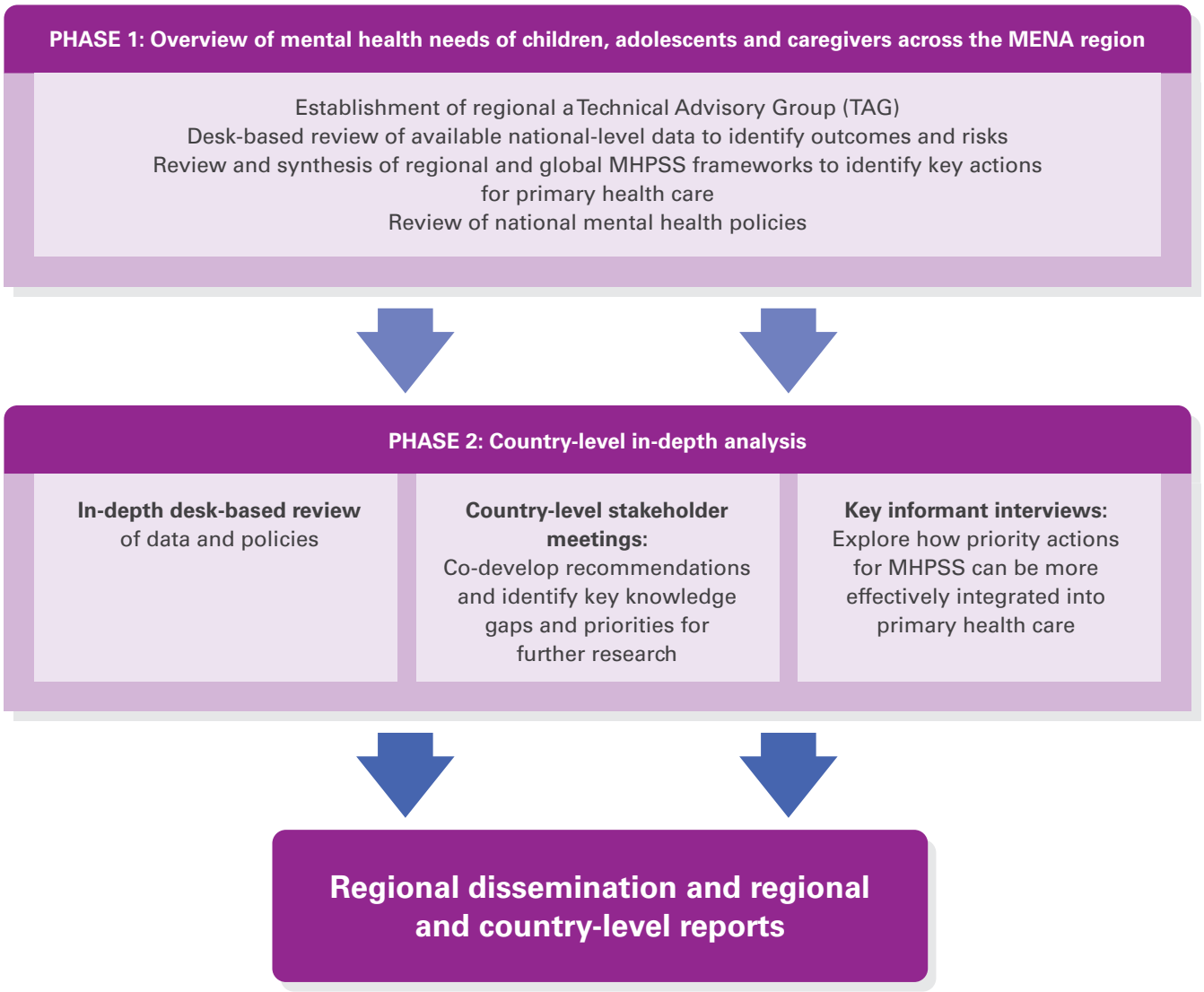
1. **The current situation of mental health and psychosocial well-being for children, adolescents and mothers:**
    a. Mental health outcomes
    b. Risks and determinants
    c. Current responses
        i. Policies, plans and strategies
        ii. Overview of the mental health system
        iii. Current programmes and approaches

2. **Challenges and recommendations to strengthen the integration process by the following pillars (or levers) of system strengthening:**
    a. Leadership, governance and political commitment
    b. Legislation, policy and plans
    c. Budget and financing
    d. Workforce
    e. Medical supply and equipment
    f. Infrastructure
    g. Data information systems and research,
    h. Service delivery
    i. Quality of care
    j. Monitoring and evaluation
    k. Engagement with communities and participation
    l. Inter-sectoral cooperation
    m. Private-sector partnerships

Approach

This research was led by UNICEF MENARO in partnership with Burnet Institute, Australia. At the national level, there was cooperation between the UNICEF Libya Country Office and Primary Health Care Institute (PHCI) with academic representatives of national universities. The approach of this research is outlined in **Figure 1**.

Figure 1: Overview of the implementation research



Components of the country-level in-depth analysis

Desk-based review

Synthesis and review of existing survey data to identify indicators that describe the mental health needs (outcome and risks) of children and adolescents aged 0–19 years and maternal mental health. The survey data includes national data, such as the Libyan National Family Health Survey (LNFHS) of 2014, Global School Health Survey (GSHS) of 2007 and Global Youth Tobacco Survey of 2010. Multiple Indicator Cluster Surveys (MICS) and World Bank data sources also were used. Most data on mental health were not available, therefore, the modelled estimates of the Global Burden of Disease (GBD) study 2019 were used.

Synthesis of available peer-reviewed and grey literature to address the gaps and limitations of survey data. Published literature mainly aimed to describe mental health needs, barriers and enablers to accessing mental health services at the primary health or community level for children and adolescents and maternal mental health, particularly in underserved or high-risk populations. This published literature was also used for the synthesis of current MHPSS programmes delivered through primary health care to describe approaches, interventions and gaps.

The published articles were quoted from Medline, Google Scholar and PubMed, whereas Psych INFO was scoured for English and Arabic articles. Three primary concepts that helped forming the basis of the search strategy included (1) mental health, (2) children and adolescents, and (3) Libya.

Concept 1: Mental health was researched using the following key phrases: mental health, psychology, psychosocial care, mental disease, suicidal behaviour, psychotherapy, anxiety management, substance abuse and several other specific mental diagnoses and psychotherapy modalities.

Concept 2: Children and adolescents, and youth were searched.

Concept 3: Benghazi, Tripoli and several other Libyan cities were among the search terms for Libya.

This desk-based review incorporated all relevant studies, including narrative reviews, systematic reviews, randomized controlled trials and observational studies.

The results of each search were uploaded to Mendeley. Forty studies were imported for screening: 3 duplicates were removed, 37 studies were screened and 24 were excluded. Therefore, a total of 13 articles were included for full-text screening and extraction as appropriate for the literature review. In addition, reference lists of relevant articles were manually searched to identify additional peer-reviewed or grey literature.

Synthesis and mapping of the existing national policies, plans, strategies and legislation from relevant government websites on mental health, child and adolescent health, maternal and child health, child protection and education, as to identify which MHPSS are (or are recommended to be) delivered through primary health care and existing linkages between key sectors. The previous points were reviewed to identify the sector, the extent to which they included specific actions for children and/or adolescents aged 0–19 years, the conceptual framework tiers addressed and a summary of key actions in relation to children and adolescents.

Country-level stakeholder consultation workshop

One half-day workshop was conducted on 3 December 2022 in Tripoli city. The workshop was attended by 33 government and non-government participants from different regions across the country, including 5 participants from the Education Sector, 8 from the Health Sector, 4 from the Ministry of Youth, 4 from the Social Affairs Sector and 12 from organizations, including international non-government organizations (INGOs) including GIZ, MSF, ICRC, IRC, IMC, and ACF), non-government organizations (NGOs) and United Nations agencies including UNICEF, WHO, IOM, and UNHCR. The workshop aimed to provide an overview of the research objectives and approach in order to present key findings from the desk-based review (in sessions A and B). The workshop then explored existing mechanisms for the delivery of MHPSS through primary health care (in session C) including group activity on the current MHPSS service delivery and how such services are delivered, and the challenges, linkages and opportunities to strengthen MHPSS (in session D: group activity of five small groups, where each group was assigned a system strengthening lever: workforce, governance and coordination, financing, participation and service delivery; and a problem tree analysis was utilized to explore current challenges related to each topic).

Key informant interviews with stakeholders

Key informant interviews were conducted to explore the following in depth:

1. Mental health needs (outcomes and risks) of children, adolescents and mothers.
2. Current MHPSS provided through primary health care services.
3. Existing linkages and referral mechanisms at secondary and tertiary levels or other sectors.
4. Current challenges (barriers and enablers) for integrating MHPSS into PHC.
5. Primary health care levers (challenges and recommendations) in these topics:
    - Political commitment and leadership
    - Governance and policy framework
    - Funding and allocation of resources
    - Engagement of communities and adolescents
    - Models of care
    - Workforce
    - Infrastructure
    - Medicine and other supplies
    - Private sector/NGO/UN agencies
    - Purchasing and payment
    - Digital technology
    - Quality of care
    - Research, data, monitoring and evaluation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The questions were sector-specific across three categories: health-sector stakeholders, non-health-sector stakeholders and youth representatives. Thirteen interviews were conducted by the team investigators with participants aged 18 years and over. These included seven government stakeholders from the health sector, one from the education sector, three youth representatives and two from NGOs. Nine interviews were conducted via Zoom and the remaining four were face-to-face interviews. It is worth mentioning that such interviews were audibly recorded. The analysis was conducted by adopting a modified directed content analysis approach, where the interviewer added notes directly into the framework immediately following the interview. Other researchers listened to the audio recording and added any additional details. Then the themes and subthemes and the key findings were formed. The interviews were all conducted in Arabic, except for one which was conducted in English. The codes were translated in the framework.

All participants provided voluntary informed consent. Ethical approval was also obtained from the Libyan National Committee for Biosafety and Bioethics.

Limitations

There are significant limitations in the Libya analysis. First, there is a lack of national surveys and research on mental health in Libya, especially among young people. The lack of online access to some policy documents has also necessitated conducting key informant interviews and consulting with the country TAG to fill in the blanks.

Due to the limited number of mental health professionals in Libya, the key informant interviews were primarily restricted to national-level stakeholders. Therefore, certain subnational approaches and challenges may not have been thoroughly examined. Moreover, a significant proportion of the attendees at the workshop were key informants, who were interviewed as part of the study due to the limited number of experts in the mental health field in Libya.

3. Conceptual and policy frameworks

This framework was adapted by reviewing the existing global and regional frameworks for mental health and reviewing the feedback of the country TAG and the Libyan stakeholders during the consultation workshop and key informant interviews.

Existing global and regional frameworks for MHPSS were mapped to identify actions recommended to be delivered through primary health care for children, adolescents and maternal mental health. Frameworks from which the adaptation was derived included:

- UNICEF Global Operational Framework for MHPSS for children, adolescents and caregivers in all settings.
- WHO Mental Health Action Plan (2013–2030).
- WHO Scaling up mental health care: A framework for action for the Eastern Mediterranean region.
- UNICEF Community-based MHPSS in humanitarian settings.

3.1 General concepts

Well-being: It is the positive state of being resulting from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence a child's and adolescent's ability to grow, learn, socialize and develop to their full potential.[29]

Mental health and psychosocial well-being: It is a positive state in which children and adolescents can accommodate emotions and normal stresses, have the ability to build social relationships and skills, are able to learn and have a positive sense of self and identity.[30]

Mental health and psychosocial support (MHPSS): It refers to "any support, service, or action that aims to protect or promote psychosocial well-being or prevent or treat mental disorders".[30]

MHPSS workforce: "MHPSS practitioners who have professional on-the-job training and have technical competencies in mental health and psychosocial support, including those with the following backgrounds: child and adolescent psychology, counselling, psychology, psychotherapy, expressive art therapy, family therapy, educational psychology, social work, school counselling, psychiatric care, psychiatry, psychiatric nursing, occupational therapy, doctors/primary care physicians and nurses trained in mental health and/or staff who meet the necessary years of on-the-job training and technical competencies for the services that they are delivering."[29]

The psychiatric team includes the entire MHPSS workforce, whereas the para-psychiatric team includes all MHPSS, excluding the psychiatric physicians.

The guiding principles and approaches of the framework of MHPSS integration into primary health care is dependent on the following:

1. **Universal health coverage:** Patients with mental health problems, regardless of age, sex, socioeconomic status, race or ethnicity, should have access to the essential health requirement and social services, enabling them to achieve the highest attainable standard of health and well-being.[31]
2. **Human rights and equity:** Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the international and regional human rights instruments that not do not conflict with the country's national, religious and cultural components. It is also necessary to ensure equity and non-discrimination in the availability and accessibility of MHPSS support.[31, 32]

3. **Socio-ecological approach:** It is to address MHPSS and acknowledge that the mental health and well-being of children, adolescents and mothers are profoundly influenced not only by individual characteristics and experiences but also by relationships with family, peers, communities and the larger environment in which children live, learn and socialize.[33]
4. **Evidence-based practice:** Mental health strategies and intervention for treatment, prevention and promotion must be based on scientific evidence, taking cultural considerations into account.[31]
5. **Life-course approach:** Responses to mental health needs and risks must be adapted to developmental stages and needs, rather than being based on a rigid application of biological age, considering the cumulative effect of risks across life.[31, 33]
6. **Sustainability:** It is to provide MHPSS services in an accessible, acceptable and sustainable manner with adequate human and financial resources, and continued support for both human and financial resources over time.
7. **Multi-sectoral approach:** A comprehensive and coordinated response for mental health requires partnerships with multiple sectors, such as health, education, justice, social affairs, interior, labour and other relevant sectors as well as the private sector and the non-governmental mental health organizations.[31]
8. It is necessary to ensure that MHPSS is **gender-responsive, accessible and inclusive with active participation of children and adolescents and their families** in the assessment, design, implementation, monitoring and evaluation of humanitarian response.[31, 33]
9. **Multi-disciplinary interventions:** Different professional disciplines are required to provide multi-specialty approaches to manage patients with mental health problems and adequately meet their needs. This includes psychiatrists, psychiatric nurses, psychologists, social workers and occupational therapists.[34]
10. **Giving the PHC appropriate role in MHPSS:** PHC should cater to all human problems and needs by building the capacity of PHC professionals and providing them with the necessary support while giving general practitioners or family physicians the right to prescribe antidepressant medication and first-line medication according to commonly accepted guidelines.[35]

3.2 Three tiers of action

Global and regional guidelines and policies with the country consultation outline the services and supports for MHPSS delivered at PHC level that relate to three tiers of action.

The framework defines the three main tiers of actions (responsive, preventive and promotional actions) required to ensure the mental health and well-being of children, adolescents and mothers. Many actions for MHPSS can be effectively delivered through primary health care – either as stand-alone mental health programmes or by being integrated into other service-delivery platforms (such as maternal and child health care, nutrition programmes, physical health services, reproductive health and adolescent health). These include services and support related to:

3.2.1 Responsive care for those with mental health conditions

Responsive care includes age-appropriate and developmentally appropriate care, as well as care that is gender responsive and disability inclusive, sustainable, accessible and non-discriminatory. The key actions include:

- **Early identification, screening, assessment and diagnosis of mental health conditions, including self-harm or suicidal behaviour:** This entails identifying children, adolescents and mothers who are at risk or having mental disorders by identifying the priority conditions using standard guidelines and training for the psychiatric team, general practitioner or family doctors in PHC. This includes screening the hidden expression of mental health conditions behind the somatic complaints.

- **Psychological first aid and emergency care** for acute mental disorders or suicidal behaviours as well as for survivors of conflicts and wars. This requires developing an operational national action plan for suicide prevention and psychological first aid training that should be incorporated into all emergency responder-tailored trainings at the national level while implementing best practices for MHPSS in emergencies.
- **Provision of care and management (including psychosocial interventions and pharmacological interventions):** This should meet the needs of children, adolescents and mothers, including the type of care, which is developmentally appropriate, accessible, non-discriminatory, universal and culturally appropriate. Either for **clinically manifest mental disorders,** where the diagnosis refers accordingly to the classification system of the Diagnostic and Statistical Manual of Mental disorders (DSM 5th edition) or the International Classification of Disease (ICD10), or for **subclinical mental conditions,** where the sign and symptoms of mental or psychosocial illness are below the threshold for the mental disorders. Treatment plans and psychosocial intervention guidelines must also be developed. **Maintenance care is also needed** for chronic mental health disorders that fluctuate over life to ensure the best outcomes. All of this can be achieved by integrating the delivery of cost-effective, feasible and affordable evidence-based interventions for mental health conditions into primary health care.
- **Strong referral mechanisms** for specialist mental health services and support for severe and complicated cases.
- **Strong referral mechanisms with other sectors** (education, social affairs, child protection, justice, interior) **must be adopted** to ensure timely assessment and care through health services and for health services to refer individuals and families for other forms of support.
- **Multi-disciplinary care models** to provide person-centred care and support that promotes recovery and rehabilitation, including working actions for psychiatrists, psychologists, psychotherapists, occupational therapists, social workers and counsellors.
- **Identification and care for parents' and caregivers' mental health** (including maternal mental health) through early recognition and management of maternal depression.

3.2.2 Preventive care for poor mental health by addressing risk and protective factors

Preventive care actions aim to address risk factors for poor mental health and enhance protective factors. They can be universal or targeted through the socio-ecological model. Prevention measures will be dependent on self, family, school and community programmes:

- **Programmes that build social and emotional learning and interpersonal skills** for building individual assets of children, adolescents and mothers (physical health, intellectual development, psychological and emotional development, and social development). These aspects can be realized by integration into early childhood development programmes and delivery of psychosocial interventions and other support to build social and emotional learning and skills for those at risk of poor mental health (pregnant adolescents and adolescent caregivers, those living with chronic illness or disability and those affected by conflict or displacement).
- **Positive parenting programmes:** Through delivery of positive parenting care programmes, either in universal form for the whole community or by targeting families at risk or indicated for families with children living with poor mental health conditions, which includes detecting harmful parenting, addressing parental mental health and providing parents with positive parenting practices and improving their skills.
- **Addressing risk factors** by identification, screening, psychosocial interventions and referral for substance use.
- **Identification, screening, psychosocial interventions and referral** for exposure to or witnessing violence, including family violence, intimate partner violence, sexual violence, maltreatment and neglect, and peer victimization. This includes the integration of MHPSS into services for survivors of violence.

- **Safe and enabling learning environments** ensure that the places where children, adolescents and mothers are connected are not subject to harmful exposure and provide support and linkages with schools and other settings to create **safe and enabling learning environments** (school health services, teacher well-being, maternal health services, referral mechanisms, support for education staff capacity in mental health and behavioural management).

3.2.3 Promotion of mental health

Mental health promotion includes the following actions to create safe and enabling environments:

- **Support for stigma reduction by conducting stigma-reduction campaigns** and taking stigma reduction into account in the design and delivery of mental health services to facilitate the access of affected people to MHPSS services, either by integrating the MHPSS into primary health care gradually through integration with other specialities, or as a stand-alone speciality.
- **Raising awareness and supporting programmes to improve community mental health literacy.**
- Creating opportunities and mechanisms **that enable and encourage the participation of children, adolescents and their families** in the design, planning, delivery and evaluation of MHPSS – including adolescent-responsive health services.
- **Linkages, collaboration and coordination with other sectors,** including social affairs, to address social determinants of mental health and well-being.
- **Policy and legislation:** This requires for providing a safe and enabling environment by increasing the awareness of the importance of mental health legislation and importance of standard policy for organized, non-discriminatory, accessible and acceptable universal MHPSS services. Both legislation and policy enable and protect the rights of children, adolescents and mothers with mental health conditions, protecting them from risks associated with poor mental health.

3.3 Actions by sector

Each sector within the government must have guidelines for their role in the three tiers of the MHPSS framework to reinforce inter-sectoral cooperation. The **actions related to each sector are as follows:**

The main sectors: Health, education, social affairs, justice and family and the Childhood Office of Interior Ministry)

Health sector: This sector is the main core sector and the only sector that covers all tiers of the MHPSS actions. It plays an essential role in the responsive mental health services for children, adolescents and mothers with mental health disorders. The actions provided by this sector within the primary health care (PHC) vary from early identification, screening, referral and management by non-specialist multidisciplinary providers through services integrated into the primary health care facilities, such as general practitioners, family physicians, gynaecologists, paediatricians, nurses, midwives, paramedics, mother child health (MCH), adolescent health, vaccination or specialist providers for complicated or severe cases, such as child and adolescent psychiatrics, behavioural paediatricians, clinical psychologists, occupational therapists and speech therapists, who are either available in the polyclinic level in the primary health care facilities or in the mental health outpatient clinic of the tertiary-level general hospitals (preventing stigma) through strong standardized referral systems. The PHC role in preventive care appears mainly in targeted prevention for those with a risk of poor mental health, such as children and adolescents with other health comorbidities or displaying risk behaviours, such as substance use or violence exposure. The role also includes preventive interventions for parents with risk of poor of mental health. Mental health promotion is the main role of PHC. The leading action for other sectors at this level is to reduce the stigma around MHPSS through mental health awareness.

Education sector (social services office and school health): This sector deals with a large group of children and adolescents and can provide universal preventive intervention and ensure a safe and enabling environment for mental health promotion. The education sector includes MHPSS personnel who are determined by standards related to the MHPSS workforce management (ex., teachers, social workers, school-based psychologists, psychotherapists and counsellors as well as volunteer as peer counsellors). With a strong referral system and inter-sectoral cooperation with other sectors, mainly PHC facilities, this multidisciplinary team plays a vital role in early detection and assessment of mental health needs and referral with appropriate management.

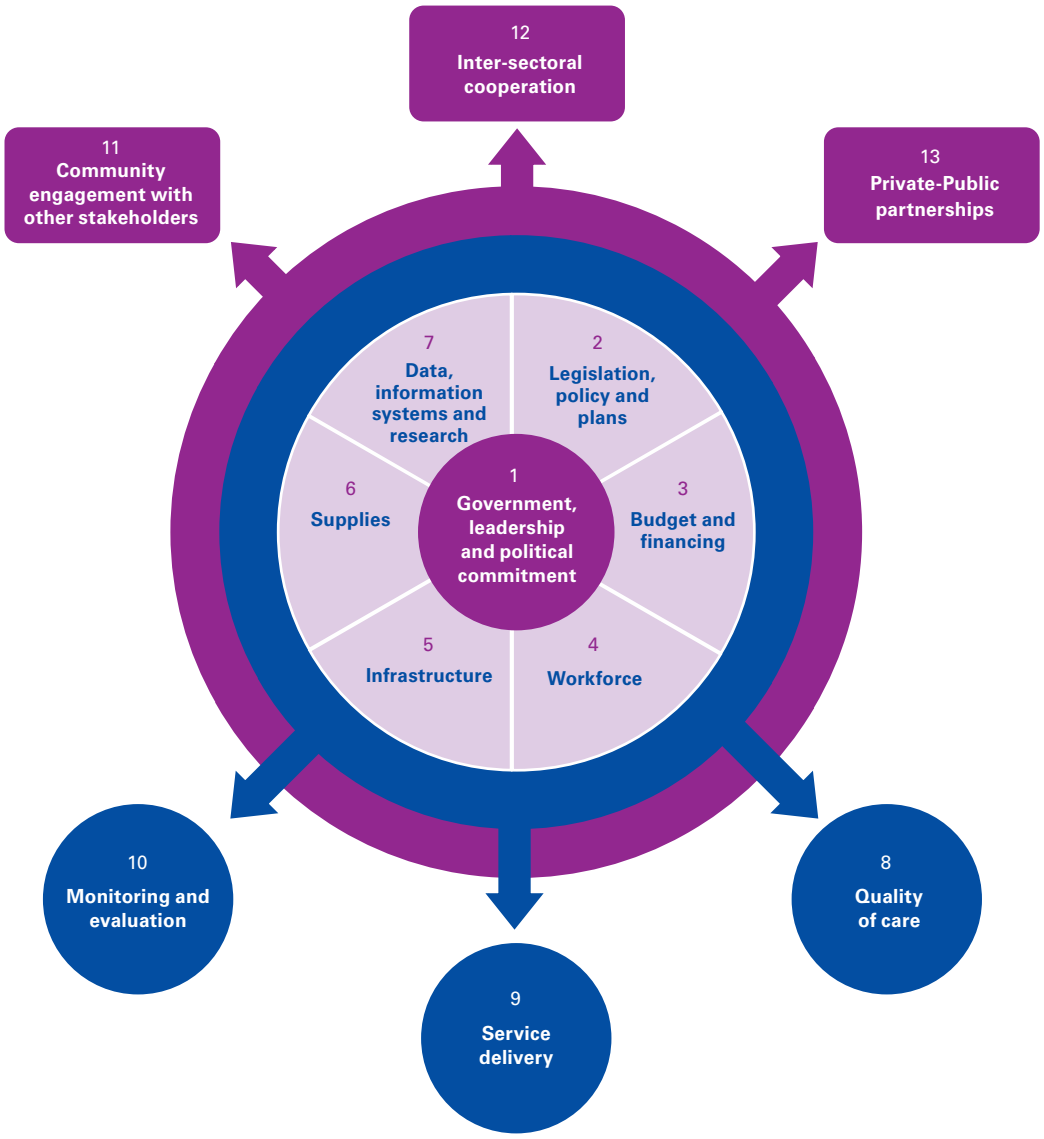
Social affairs sector: This sector plays an essential role given that it deals with family and children issues, especially people with disabilities and social problems. Through the Office of MHPSS and in cooperation with the health sector and other sectors when necessary, the three layers of MHPSS can be covered. This sector must be provided with an effective referral system for cases that need intervention. Focusing on child protection and working with families at risk, the social affairs sector has a crucial role in delivering targeted prevention intervention measures to address risk factors in children, adolescents and their families with a high risk of poor mental health. This also includes responsive programmes, such as identification and screening along with provision of responsive care for mental health conditions as part of a multidisciplinary team.

Justice sector: Children or adolescents in conflict with the law or as victims or witnesses of violence are at increased risk of poor mental health. The work within this sector will be through the Mental Health and Psychosocial Support Office, where responsive measures are determined according to need by treating existing mental health conditions (or making referrals to the nearest PHC or specialized care) and preventing further harm by detention. A robust referral system with inter-sectoral coordination and a multidisciplinary team is needed for mental health and psychosocial support.

Interior sector (family and child protection office): This office was newly established in 2018 and works in accordance with laws, decisions and regulations related to child and family protection and under regional and international agreements ratified by the Libyan state. It mainly deals with all issues related to children and families, promptly responding to complaints and reports about them, conducting investigations into crimes and adopting scientific and professional methods in dealing with the child and the family and taking the necessary measures to prevent abuse against and protect children and family members from all forms of violations and exploitation. The interior sector has been contributing and is participating in awareness campaigns and activation programmes in the field of child and family rights, preparing studies and research on child and family issues, to collect data and information on criminal phenomena, in which children and families are involved and preparing responsive plans to confront them. Also, it has a role in implementing universal preventive measures by raising the awareness of students on substance use and drug addiction and targeted preventive intervention, e.g., displaced population regarding the violence toward mothers and children.

All these actions through primary health care and other main sectors must be strengthened by 13 levers (or pillars) of system strengthening. These levers are divided into six main components (budget and financing; workforce; data information systems and research; legislation, policy and plans; supplies; and infrastructure) that must be prioritized, updated and redesigned as needed (see **Figure 2**). Governance, leadership and political commitment (at the centre of the diagram in **Figure 2**) coordinate and hold the six components together. Service delivery, quality of care, and monitoring and evaluation are outputs of the components, and community engagement and participation, inter-sectoral cooperation and public-private partnerships support all aspects of system strengthening for primary health care.

Figure 2: Diagram of the 13 levers for system strengthening for integrating MHPSS in primary health care



The 13 levers within this framework help enable effective and equitable implementation of actions within primary health care as follows:

1. **Leadership and governance**
   Strong leadership and governance enable coordination within and across sectors, and between levels of government, non-government and informal service providers, with clearly defined roles, responsibilities and accountability. Having strong leadership and governance will effectively connect all areas for action, formulating financially informed and evidence-based actions, with explicit attention to equity, respect for the inherent dignity and human rights of people with mental disorders and psychosocial disabilities, and the protection of vulnerable and marginalized groups.

2. **Legislation, policy and plans**
   Legislation, policy and plans promote a safe environment and provide up-to-date legal and regulatory frameworks to support the integration of MHPSS, especially for children, adolescents and mothers. The policies and plans aim to strengthen systems and service delivery. The frameworks should include codes of practice and mechanisms to monitor the protection of human rights and implementation of legislation in line with evidence-based best practices, the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child (CRC) and other international and regional human rights instruments that do not conflict with religious and cultural rules.

3. **Budget and financing**
   Adequate allocation and expenditure of resources and financing mechanisms ensure equitable access and quality of services. It is preferable to consider some economic incentives for recruiting mental health professionals and to include mental health services in the insurance and out-of-pocket payments in the funding of health services.

4. **Workforce**
   The MHPSS workforce in primary health care and other sectors have defined roles and titles, competencies, training, supervision, incentives and qualifications that must be identified. In addition, there needs to be a rapid means by which their numbers and qualifications can be increased.

5. **Infrastructure**
   Appropriate physical infrastructure is needed to improve the delivery of MHPSS through providing private counselling rooms, creating safe spaces and ensuring access to electricity, building maintenance services and sanitation systems.

6. **Supplies**
   For primary health to function, ensure the availability of supplies. This includes a uniform policy of drug and equipment availability across primary health care according to evidence-based assessment and community needs. There must also be available national guidelines of drug lists for addressing mental health that are sustainable, accessible and non-discriminant in facilities. This means including mental health drugs in the Essential Primary Health Care Medical Drug List.

7. **Data, information systems and research**
   Mechanisms for data collection, analysis and dissemination of reliable and timely information must be adopted to support planning, implementation, monitoring and evaluation. Mental health indicators must be determined as a platform for data collection by using surveys or DHIS2. It is also necessary to determine research priorities and knowledge gaps.

8. **Quality of care**
   Quality of care monitors whether the provision of health care adequately meets the population's needs and whether the quality of clinical care delivered within a health care setting is of the required standards. This requires the availability of standardized national management guidelines and referral tools.

9. **Service delivery**
   Mental health service delivery is developed to ensure services are equitable, inclusive, accessible to all, and age/developmentally appropriate. It includes actions that can be integrated into existing platforms and identifies what new models or platforms are required dependent on the evidence-based protocols and practice.

10. **Monitoring and evaluation**
    To support quality assurance and accountability, monitor and evaluate service provision according to evidence-based results to determine the performance and effectiveness of governance, leadership, financing, policy and plans.

11. **Community engagement and participation**
    Engagement and participation of children, adolescents, families and communities in the planning, design, delivery and evaluation of MHPSS is needed. This engagement includes social behaviour change initiatives, which take into consideration social norms and gender-responsive planning to increase health service's utilization and civil society organizations' (CSOs') active participation in MHPSS.

12. **Inter-sectoral cooperation**
    MHPSS services are supported through different inputs and services. Sectors that provide comprehensive services include education, social affairs and labour, and the Ministry of Youth.

13. **Private-public partnerships**
    Cooperation and partnerships between public and private entities improves access to quality health services and improves referral mechanisms, especially where access to public sector services is limited.

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4. The current situation for children, adolescents and mothers

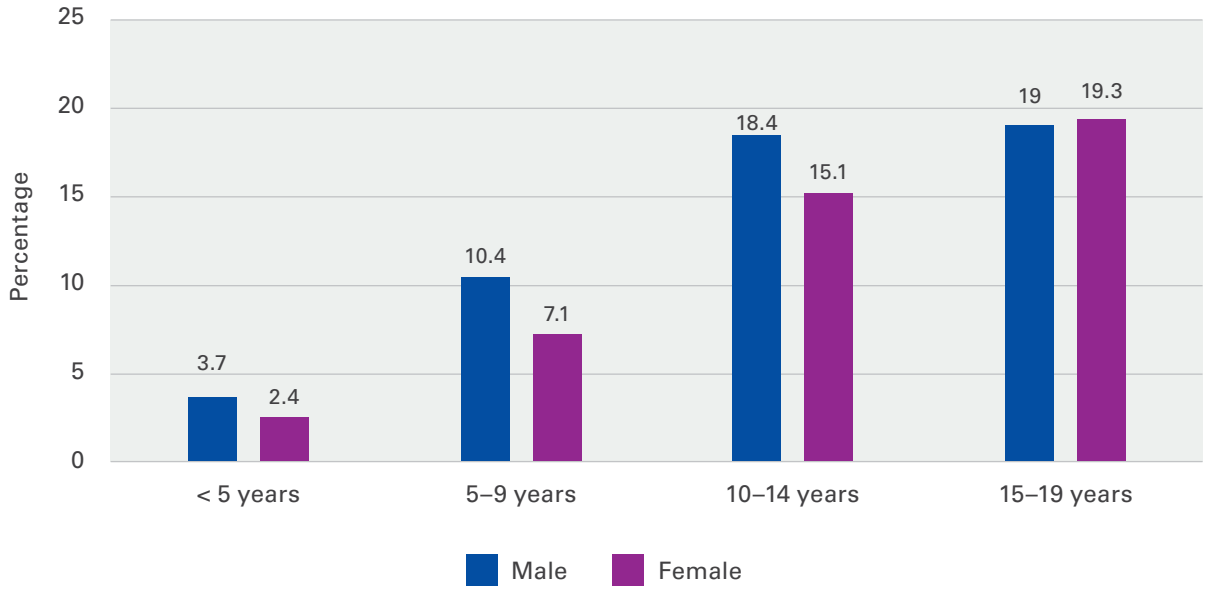
4.1 Mental health needs (outcomes and risks) of children and adolescents

4.1.1 Mental health outcomes for children and adolescents

Children and adolescents experience a substantial burden of poor mental health. Nationally representative data from the Libyan National Family Health Survey (LNFHS), 2014, indicated that **mental health problems were common** for the age groups of 0–4, 5–9 and 10–19 years. It was also found that 1.6 per cent of late adolescents (15–19 years old) have a psychological illness, of which 38.1 per cent are treated by psychiatrists and 42.8 per cent receive medication for psychological illness.[36] The modelled estimates from the Global Burden of Disease Study (GBD 2019) indicate that mental disorders account for 18 per cent of the total prevalent cases among 10–19 year olds in Libya.[4] The total prevalence of mental disorders (all causes) increases with age in both genders, where, in each age group, the prevalence in boys is more than girls except in the age group of 15–19 years, in which female prevalence (19.28 per cent) of mental disorders is slightly higher than males (19 per cent) (**Figure 3**).[4]

The prevalence of most mental disorders, such as anxiety, depression, conduct disorders and developmental disorders, increases with age. Anxiety and depressive disorders are the most common mental disorders among 15–19-year-olds. Anxiety and conductive disorders are more predominant in early adolescence, whereas anxiety followed by developmental disorders are predominant in childhood. The prevalence of anxiety and depression is higher among girls than boys across all age groups, while boys have higher rates of conduct disorder and developmental disorders (**Figures 4, 5 and 6**).[4]

Figure 3: Prevalence of mental disorders in children and adolescents, by gender

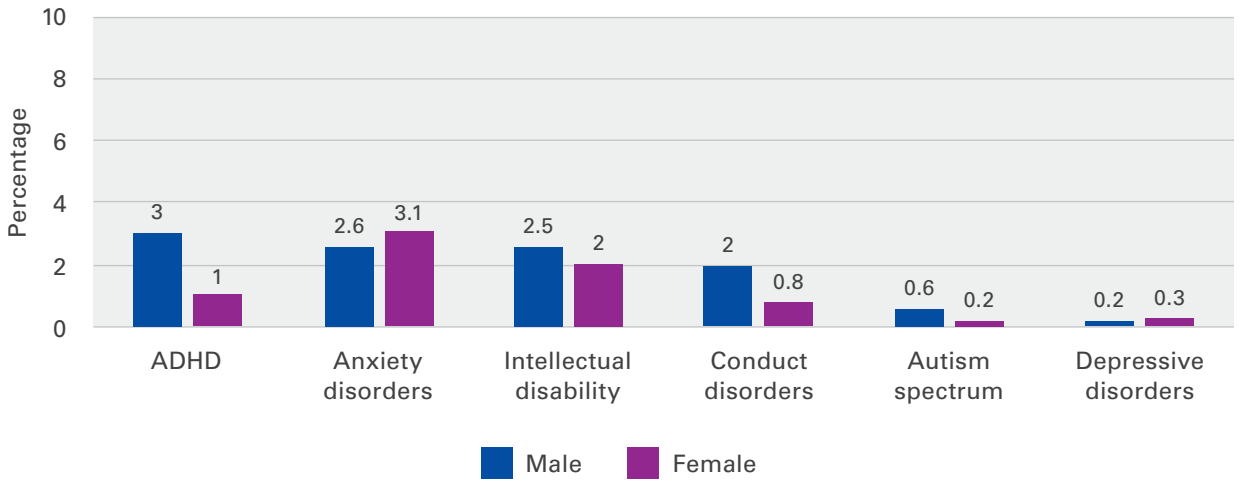


Source: GBD 2019.

Limited primary data is available describing national-level estimates of mental disorders among children and adolescents. Before the 2011 conflict, there was no published data on the prevalence of mental health disorders in Libya.[37] Anxiety disorders and depression have doubled in the context of humanitarian emergencies from a baseline of about 10 per cent to 20 per cent, while people with severe mental disorders (2–3 per cent) are especially vulnerable in such contexts and must have access to care, according to WHO.[37, 38] Drug use has been on the rise since the beginning of the conflict.[37, 39]

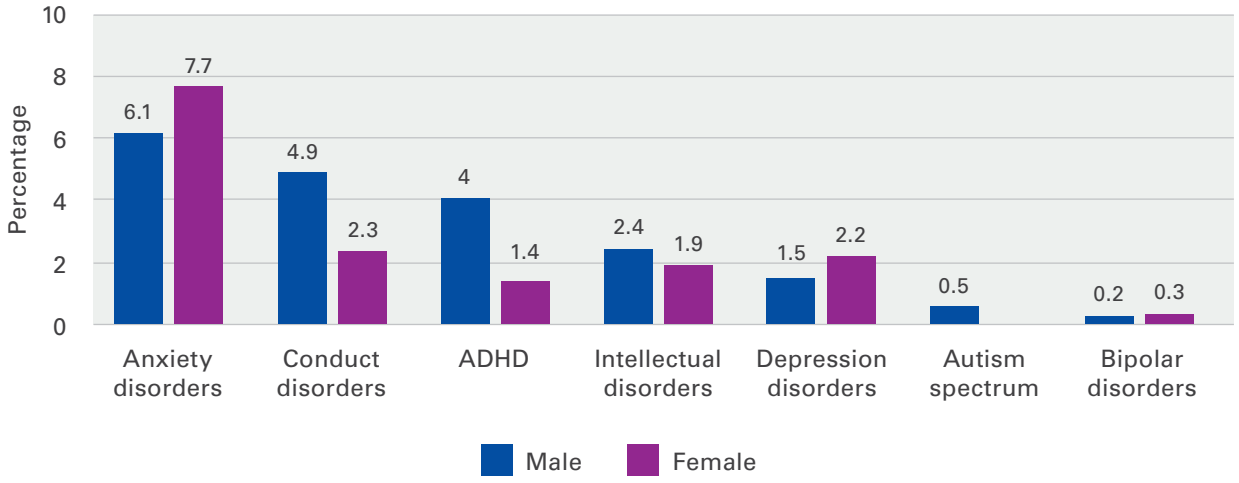
According to Charleston et al. (2012), predictions on the impacts of mental health after the 2011 conflict in Libya and the estimated prevalence of depression and post-traumatic stress disorder (PTSD) vary. The prevalence of depression is higher than that of PTSD and may be as high as 30–40 per cent of the population in areas that were severely affected by conflict.[37, 40, 41] PTSD among Libyan children and adolescents has not been studied yet. However, there have been efforts to assess the problem, including a case series by Sulliman et al.[41]

Figure 4: Prevalence of selected mental disorders in children aged 5–9 years, by gender



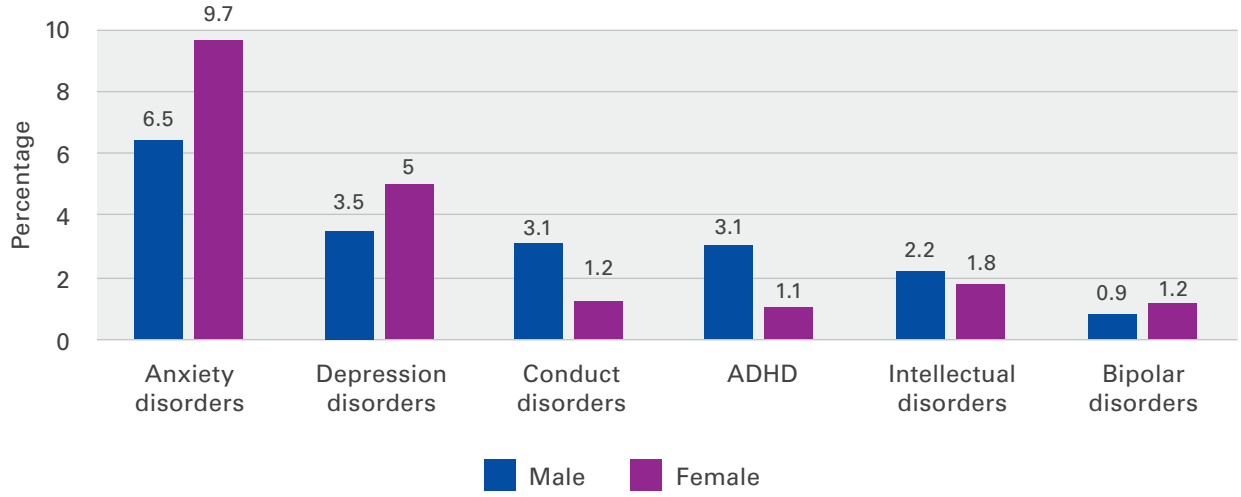
Source: GBD 2019.

Figure 5: Prevalence of selected mental disorders in children aged 10–14 years, by gender



Source: GBD 2019.

Figure 6: Prevalence of selected mental disorders in adolescents aged 15–19 years, by gender



Source: GBD 2019.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The impact of mental disorders and intentional self-harm on health can be estimated using the **disability-adjusted life years (DALYs),** which measures the total disease burden in terms of years of healthy life lost due to disability (illness) or premature mortality. In the MENA region, mental disorders and self-harm are estimated to account for around 20 per cent of the total disease burden among adolescents aged 10–19 years, the leading cause of poor health in this age group.

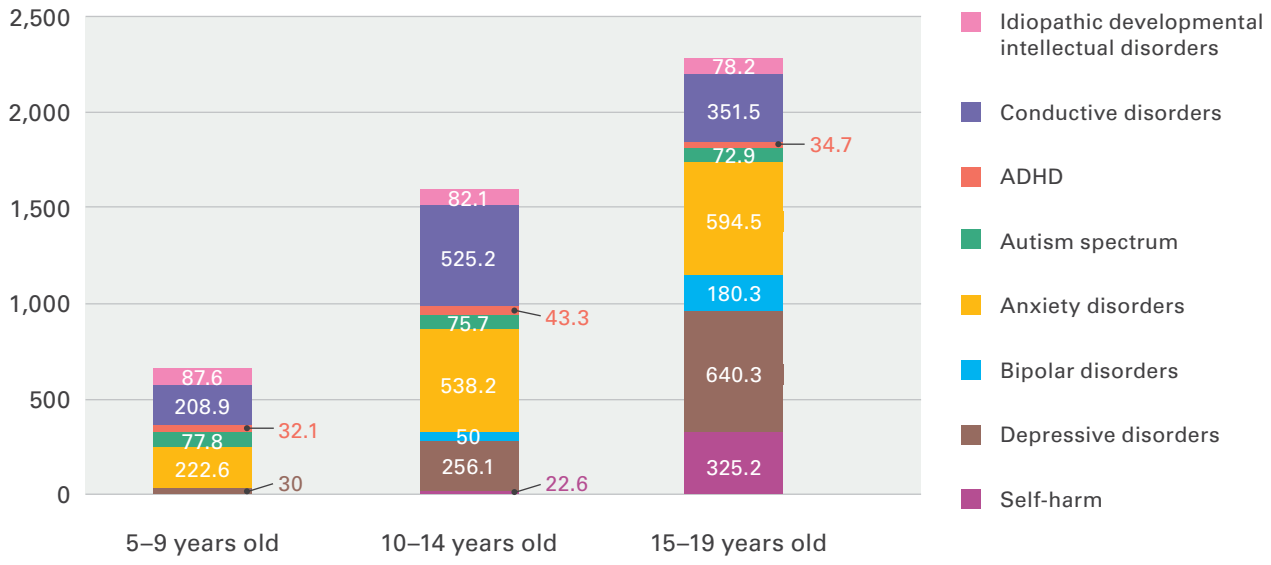
Modelled estimates from the GBD (2019) have indicated that mental disorders and self-harm account for 18.91 and 1.43 per cent, respectively, of the total disease burden among 10–19 year-olds in Libya.[4]

GBD estimates have demonstrated a rapid increase in the rate of DALYs due to mental disorders from early adolescence. During the childhood period, neurodevelopmental disorders are predominant compared to other age groups. From the age of 10 years and older, there is a significant increase in the burden of poor mental health due to anxiety and depressive disorders. Girls have a higher burden of poor mental health overall compared to boys due to depression and anxiety. On the other hand, boys have a higher burden of poor health due to conduct disorders that emerge in later childhood into late adolescence. As for self-harm, it has emerged in early adolescence in both genders with the highest burden among late adolescents. The burden of self-harm was also more prominent in boys than girls throughout the early and late adolescent age groups4 (**Figures 7 and 8**).

In Libya, modelled estimates from GBD 2019 have also demonstrated a higher burden of poor mental health among girls aged 10–19 years compared to boys, mainly due to an excess burden of depressive, anxiety and bipolar disorders (**Figure 9**).[4]

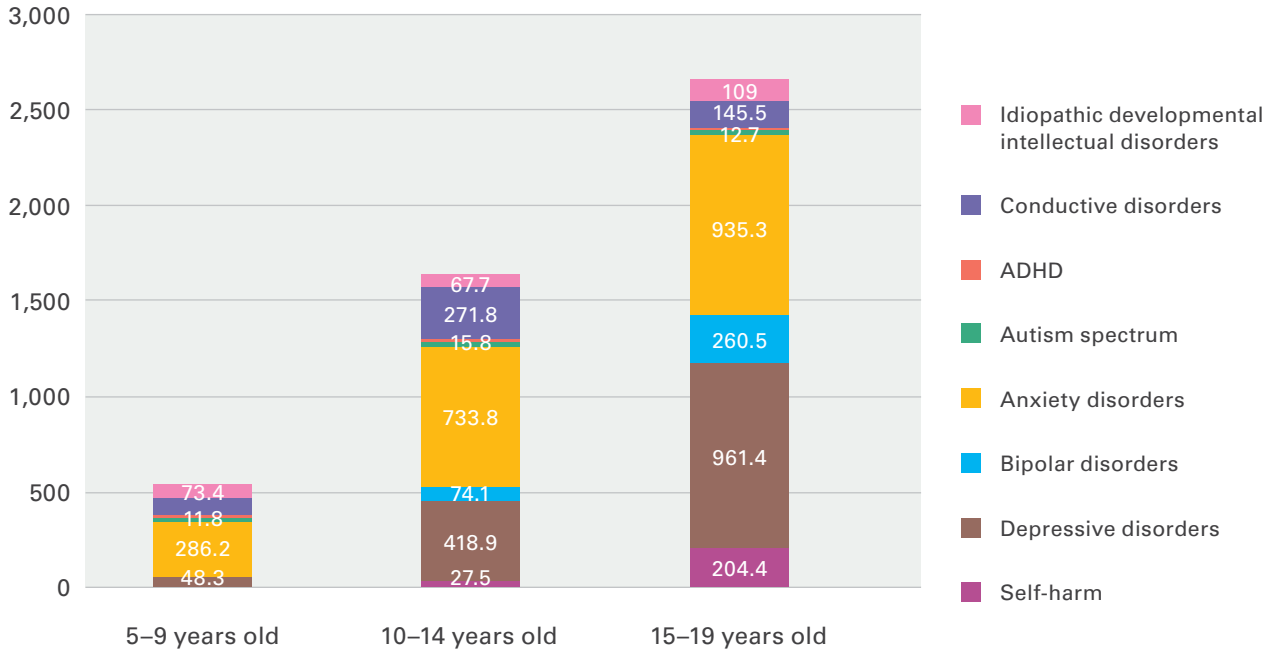
Suicide is closely related to poor mental health, and national data in Libya estimated the suicide rate was 1.8 per 100,000 per year before the conflict.[5, 6]

Figure 7: DALYs per 100,000 male children and adolescents due to mental disorders and self-harm, by age group



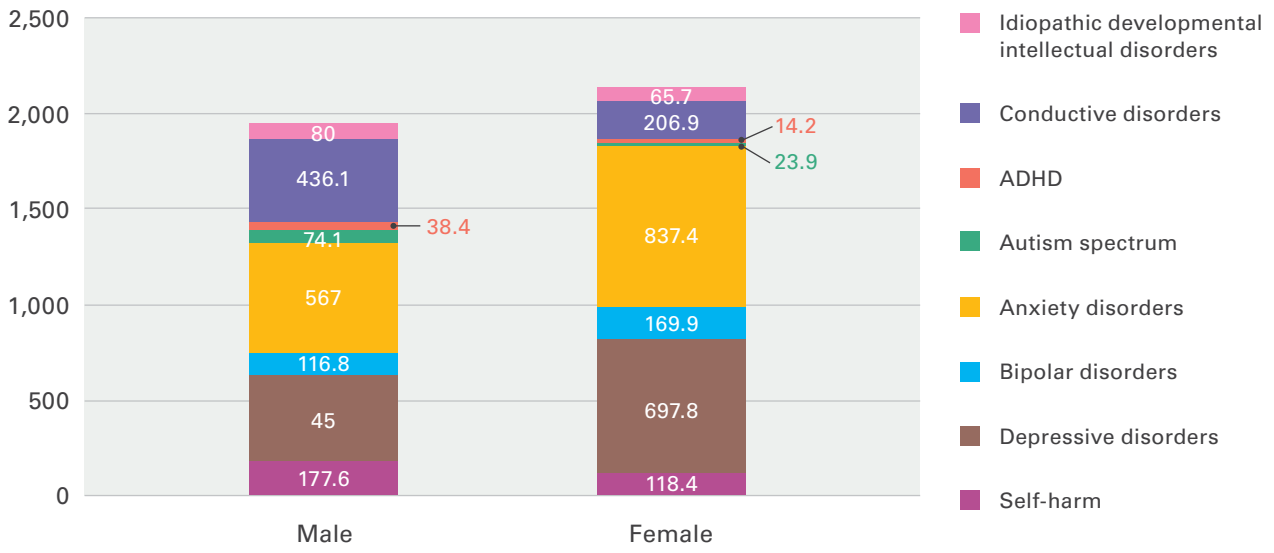
Source: GBD 2019.

Figure 8: DALYs per 100,000 female children and adolescents due to mental disorders and self-harm



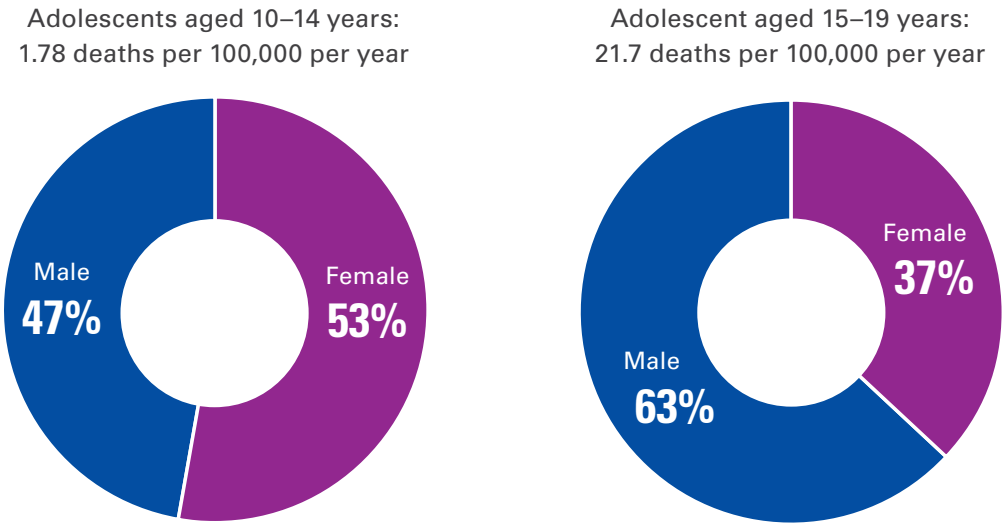
Source: GBD 2019.

Figure 9: DALYs per 100,000 10–19-year-olds due to selected mental disorders and self-harm



Source: GBD 2019.

Figure 10: Total estimated deaths due to suicide, by age group and gender, in 2019

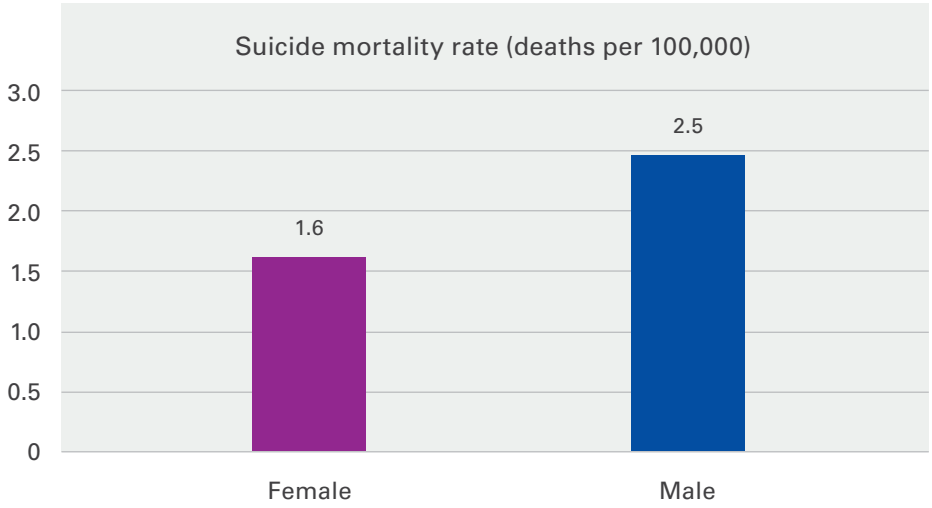


Source: GBD 2019.

National-level age-disaggregated data that describe **suicide mortality** for adolescents in the region is extremely limited. Adjusting for missing data (e.g., deaths not reported) or misclassification of cause of death, the **GBD 2019 estimated that there are almost 1,800 deaths annually due to suicide among 10–19-year-olds, which is the third leading cause of death for adolescents in the region.**

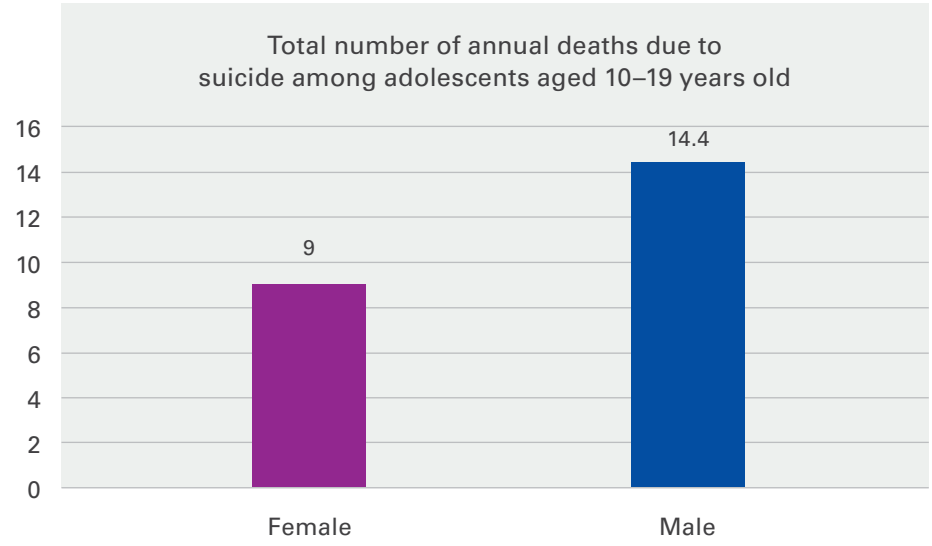
The limitation of national data on mental disorders in Libya has resulted in a further deficiency in data regarding the lost human capital from mental disorders during childhood and adolescence. The Libyan Cause of Death Report revealed that mental and behavioural diseases are one of the causes of death, representing 0.1 per cent in 2006 and 2007.[5] The GBD 2019 have also estimated that there are almost 23.48 deaths per 100,000 due to suicide among 10–19-year-olds in Libya. Just over half of suicide deaths among young adolescents aged 10–14 years are among girls. However, during late adolescence, boys account for almost two thirds of all suicide deaths (**Figure 10**). Boys aged 10–19 years old have a substantially higher mortality rate than girls, where the rate of suicide among boys is almost double that of girls (**Figures 11 and 12**).[4]

Figure 11: Suicide mortality rate per 100,000 children and adolescents aged 10–19 years, by gender



Source: GBD 2019.

Figure 12: Annual deaths due to suicide among children and adolescents aged 10–19 years, by gender



Source: GBD 2019.

Key informant participants' feedback on mental health outcomes in children and adolescents: The most frequent mental disorders in children mentioned were neurodevelopmental disorders (8/13) (autism, ADHD, speech difficulty and IQ issues) followed by anxiety disorders, which was the second most frequent (6/13). Following this are behavioural disorders (5/13) and nocturnal enuresis (3/13). As for the least frequent disorders, they were trauma and stress-related disorders (2/13), disruptive, impulsive control and conduct disorders (2/13), and depression (1/13). For adolescent age groups, trauma and stress-related disorders (6/13) and behavioural disorders (6/13) were the highest frequent conditions mentioned, followed by depressive disorders (5/13) which are the second most frequent. The least frequent were obsession compulsion disorders (2/13), neurodevelopmental disorders (2/13), adolescent learning problems (2/13), and anxiety and personality disorders (1/13). The participants also mentioned that the suicide rate has increased after the conflict but with no documented national data on the need for urgent intervention (**Table 1**).

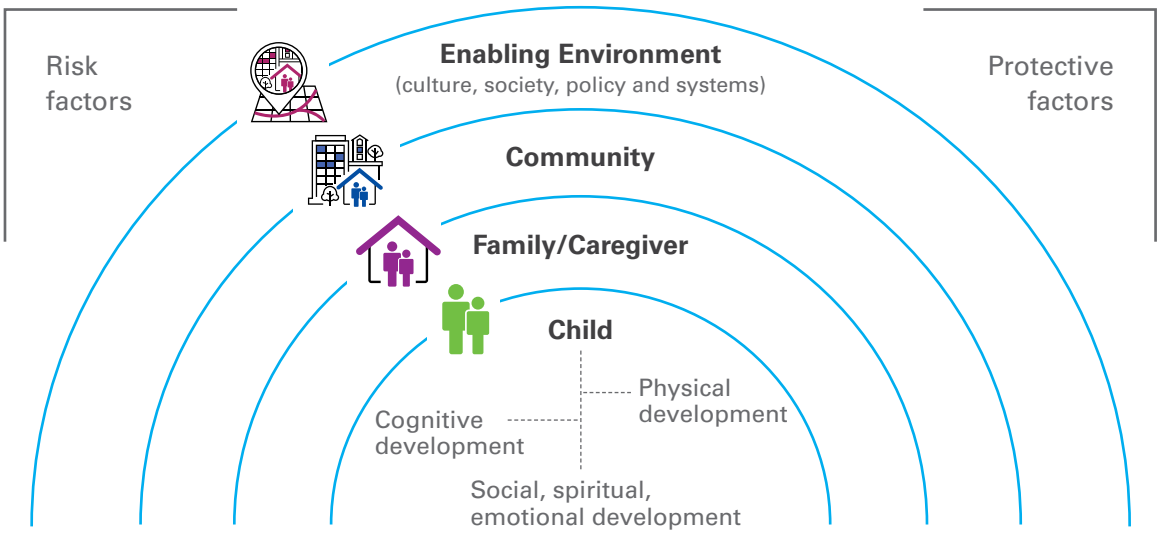
Table 1: Mental health outcomes by sector

Sector	Outcomes
Health	Developmental disorders (Autism, ADHD, hyperactivity, speech difficulty and IQ issues), depressive disorders, behavioural disorders, obsession compulsion disorders, disruptive, impulsive control and conductive disorders (oppositional defiant disorders and conduct disorders), trauma and stress-related disorders such as PTSD, and adjustment disorders.
Education	Anxiety disorders (such as phobias), depression, ADHD and learning disabilities
Social affairs	PTSD, stress and anxiety disorders
Youth	Stress and anxiety disorders

4.1.2 Mental health risks for children and adolescents

The global multisectoral operational framework for MHPSS of children, adolescents and care givers across settings has a social-ecological model that describes "the child at the centre surrounded by their family and caregivers, then their communities and finally society with its cultures and norms".[42] The 2021 UNICEF State of the World's Children (SOWC) report defines three spheres of influence that shape the mental health and well-being of children and adolescents, which are the "World of the Child" (individual assets, parents, caregivers and families), the "World around the Child" (safety, security and healthy attachment in school, communities and online) and the "World at Large" (social determinants, including poverty, disaster, conflict, discrimination and migration).[43] Childhood and adolescence are times of rapid change in social context and roles, and the timing and nature of exposures from the environment and immediate social context can shape mental health and well-being. Risks and protective factors are cumulative across the life-course and are often clustered – those who experience multiple adverse childhood experiences (abuse, neglect, violence or dysfunction within families, peers or the community) have the highest risk of poor mental health (**Figures 13 and 14**).[43]

Figure 13: The socio-ecological model has the child at the centre



Source: UNICEF 2021.

Figure 14: Three spheres of influence that shape the mental health and well-being of children and adolescents

World of the child
(individual assets, parents, carers and families)

World around the child
(safety, security and healthy attachment in school, communities and online)

World at large
(social determinants, including poverty, disaster, conflict, discrimination and migration)

Source: UNICEF, *State of the World's Children,* 2021.

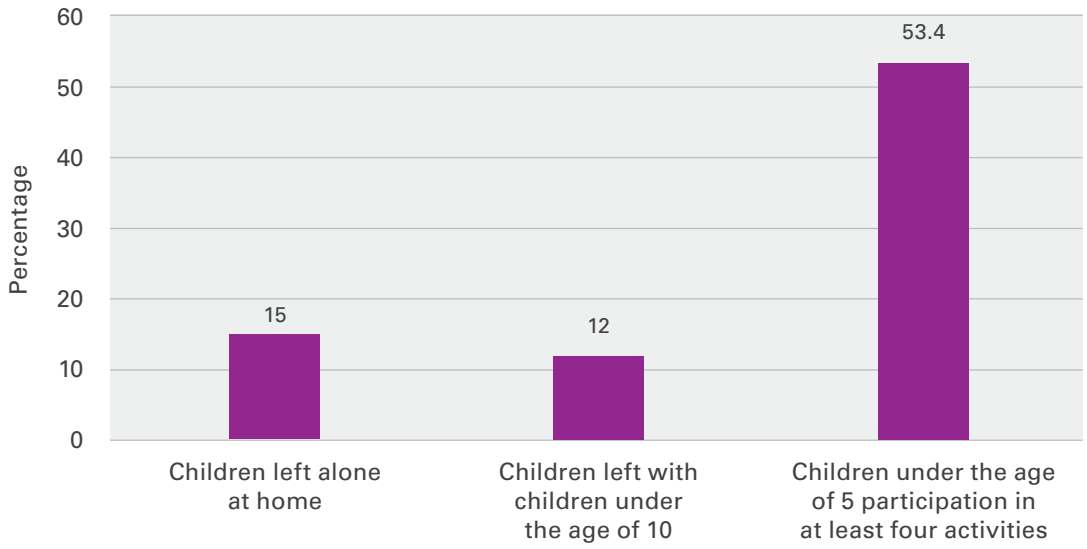
The world of children and adolescents

For early childhood, **healthy attachment with parents and other caregivers, nurturing and responsive care** are powerful determinants of mental health and well-being. Attachment refers to the emotional relationship between a child and their parents or caregivers that gives a sense of safety and protection, fostering the development of social and emotional skills. It is one of the defining influences on mental health and well-being during infancy and early childhood, however, it is also vital across later childhood and adolescence.[44] Furthermore, the mental health of parents (including adolescent parents) and caregivers impacts their capacity to provide responsive care and healthy attachment.[45]

National-level data describing attachment and the quality of caregiving in Libya are limited. According to the Libyan National Family Health Survey (LNFHS-2014), approximately 15 per cent of young children were left alone at home and about 12 per cent were left with children under the age of ten. Nearly 27 per cent of young children did not have protection when their mothers or their caregivers left the house and left them alone or accompanied by children under ten.[46] Of parents of children under the age of five, 53.4 per cent (53.6 per cent of boys and 53.1 per cent of girls) has participated in at least four activities as preschool preparation. This percentage increases when the child reaches 2 years of age or more, compared to those under the age of 5, and the participation rate increases with the increased wealth index (**Figure 15**).[47]

Healthy relationships with parents and carers are essential for the mental health and well-being of adolescents. GSHS (Libya 2007) has revealed that the percentage of 13–15-year-olds who reported that their parents never or rarely knew what they were doing in free time was 40.2 per cent (boys, at 42.2 per cent, were higher than girls, at 38.2 per cent). The percentage of those who reported that their parents never or rarely understood their problems was 51.3 per cent (boys, at 52.7 per cent, were higher than girls at 50 per cent) (**Figure 16**).[48]

Figure 15: Children with inadequate supervision and children with early stimulation and responsive care by adults

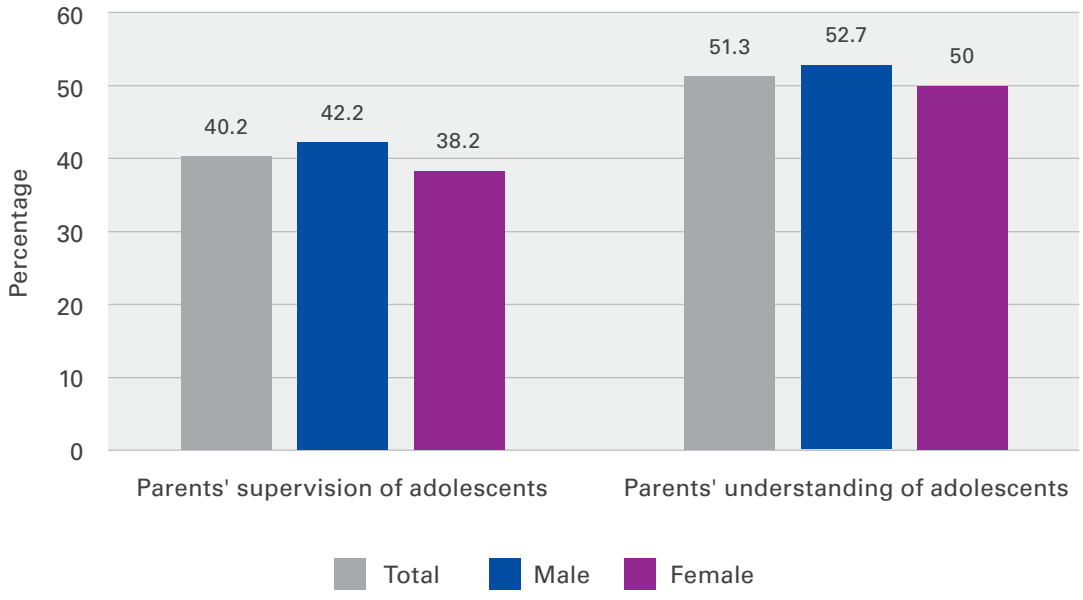


Source: LNFHS-2014.

[Text for the first two bars: Inadequate supervision, then below separate bar labels:

Firt bar: Percentage of children under the age of five years old left alone and
Second bar: Percentage of children left in the care of another child younger than 10 years of age for more than one hour at least once in the past week
Last bar: Early stimulation and responsive care below bar label: Percentage of children under the age of five with whom an adult has engaged in at least four activities to promote learning and school readiness]

Figure 16: Parents' supervision and understanding of adolescents

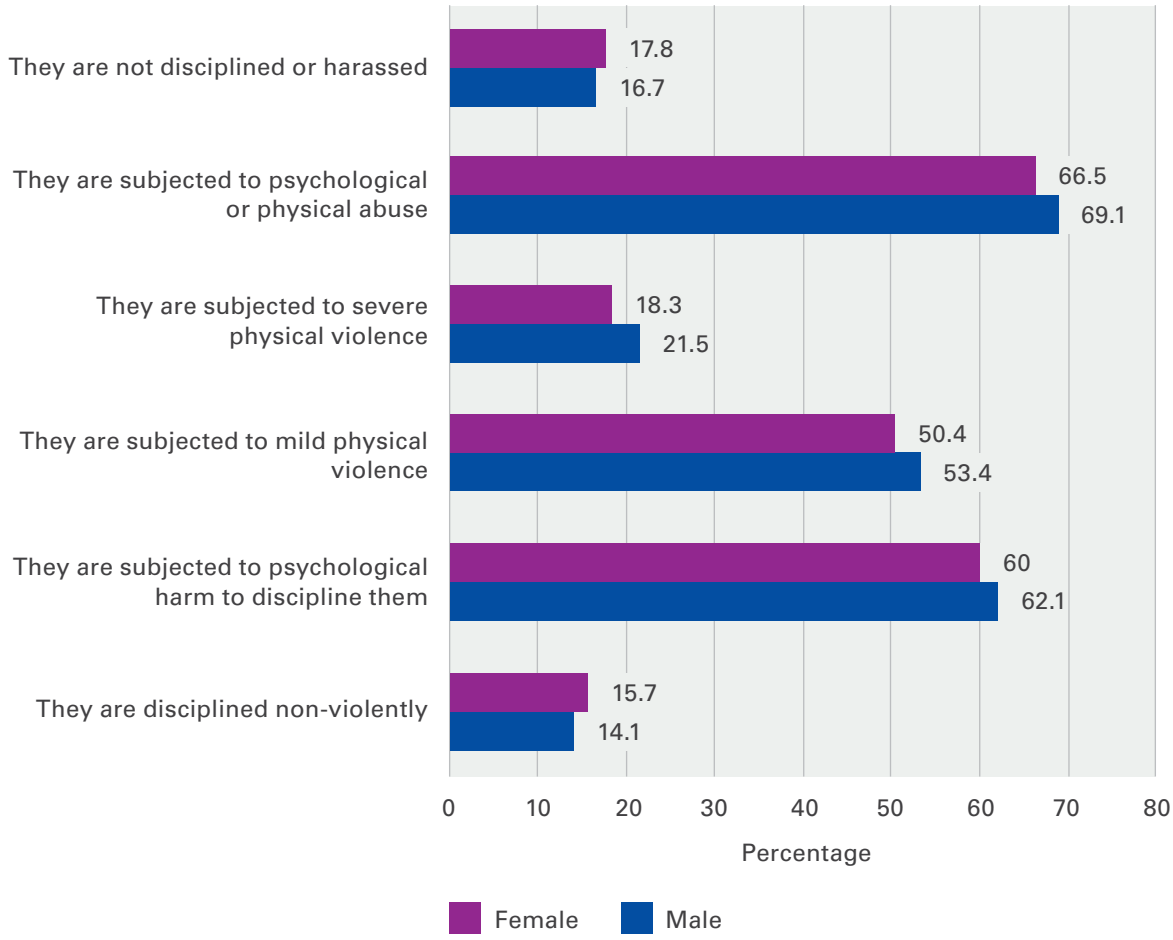


Source: GSH Libya 2007.

* Percentage of students aged 13–15 years whose parents or guardians never or rarely knew what they were doing with their free time, most of the time or always, during the past 30 days

** Percentage of students aged 13–15 years who reported that their parents or guardians, most of the time or always, never or rarely understood their problems and worries during the last 30 days

Figure 17: Percentage of children aged 2–14 years who have experienced any form of violent discipline (psychological aggression and/or physical punishment) at home in the past month, by gender

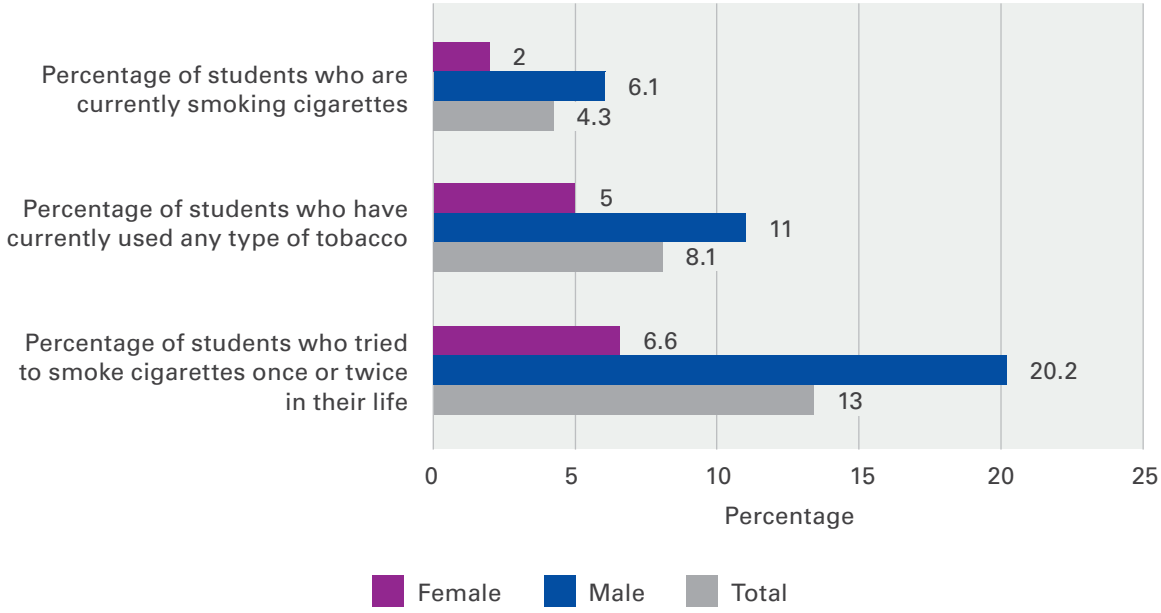


Source: LNFHS-2014.

Violence and neglect within households and families are the main risk factors for mental health conditions. LNFHS-2014 findings show that only 15 per cent of children are disciplined in an appropriate, non-violent manner, and the percentage increases with the age of the child, as in the Jabal Al-Akhdar and Al-Zawiya regions.[49] More than 67.9 per cent of children aged 2–14 years are exposed to psychological abuse and physical violence by parents with the aim of disciplining them. The results revealed that violent discipline is more common for boys than for girls (**Figure 17**).[49]

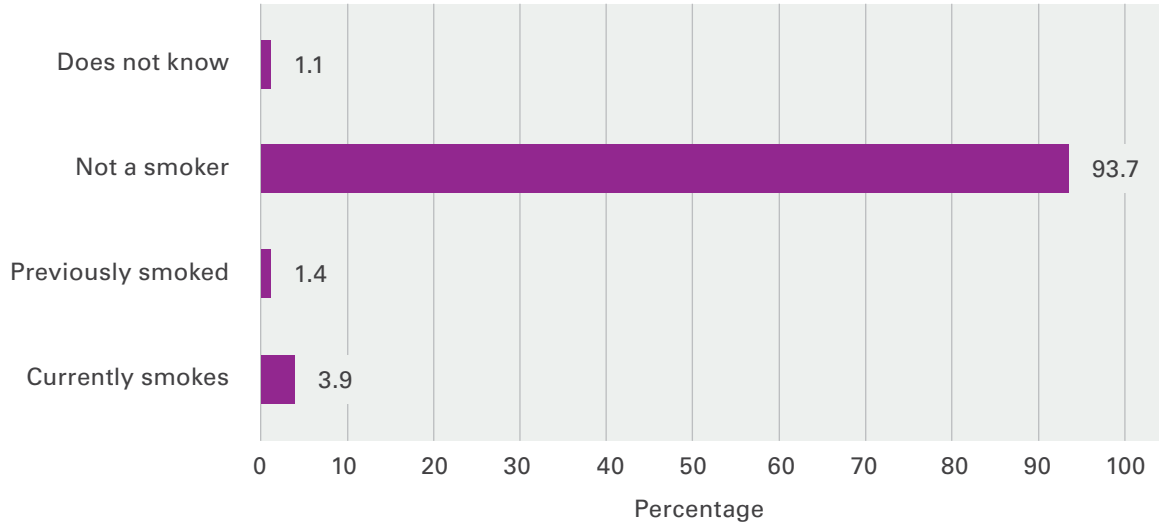
For older children and adolescents, **substance use and misuse** are considered key individual-level risk factors for poor mental health.[50] The Global Youth Tobacco Survey (GYTS) 2010 in Libya reported that 13.4 per cent of students aged 13–15 years had ever smoked a cigarette, and 8.1 per cent of students currently use some form of tobacco: 4.3 per cent currently smoke cigarettes, and 5.8 per cent currently use some other form of tobacco, being notably higher in males than females.[51] The GYTS was conducted in 2007 in all aspects of tobacco use.[52] This revealed that 4 per cent (6.7 per cent boys, 1.5 per cent girls) of students aged 13–15 years have smoked during once or more in the last month before survey, and 5.6 per cent (7.9 per cent boys, 3 per cent girls) of students used other types of tobacco, such as nargila (water pipe), once or more in the last month. During the last 12 months, 22.6 per cent of students (33.5 per cent of boys, 8.3 per cent of girls) have smoked cigarettes and tried to stop smoking.[53] Furthermore, LNFHS 2014 found that tobacco smokers aged 15–19 years comprised 3.9 per cent of this group. In this same age group, 1.4 per cent had previously smoked and 93.7 per cent never smoked (**Figures 18 and 19**).[54] All the findings of GYTS 2010, GSHS 2007 and LNFHS 2014 indicated that the percentage of current cigarette smokers was nearly equal. There is no available data on marijuana usage in Libyan surveys.

Figure 18: Percentage of students aged 13–15 years who currently smoke cigarettes, who currently use any type of tobacco or who have tried smoking cigarettes, by gender



Source: GYTS 2010 Libya.

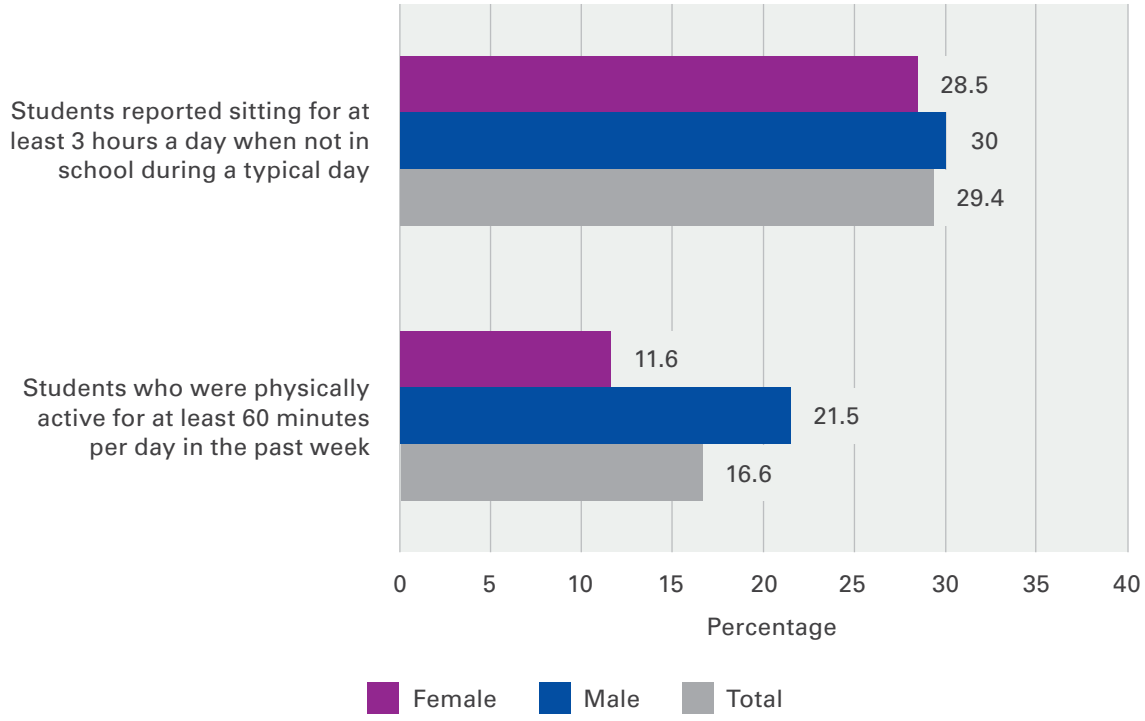
Figure 19: Percentage of adolescents aged 15–19 years who smoke, previously smoked or are not smokers



Source: LNFHS 2014.

Sedentary behaviour is considered another defining influence on psychosocial well-being. GSHS 2007 has reported that only 16.6 per cent of 13–15-year-old students were physically active for at least 60 minutes per day in the past week, with rates of physical activity among girls around half of those of boys. Around 29.4 per cent of students reported sitting for at least three hours a day when not in school during a typical day (**Figure 20**).[55]

Figure 20: Percentage of students aged 13–15 years by physical activity, by gender



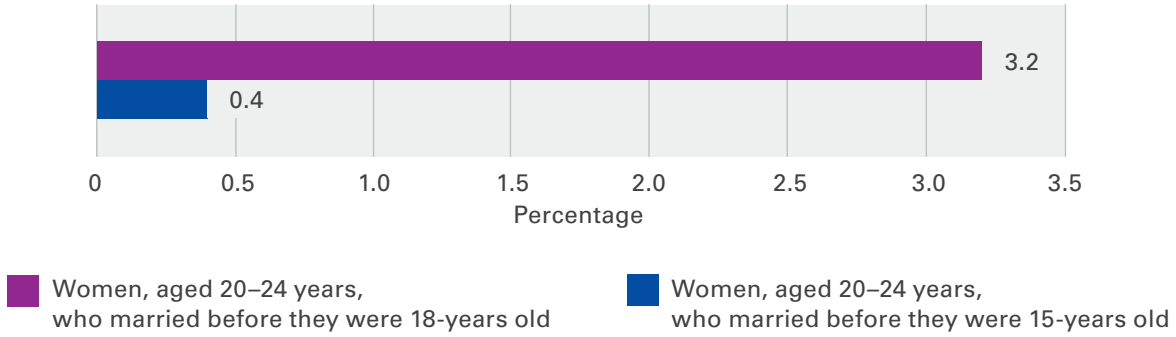
Source: GSHS 2007 Libya.

Children and adolescents with chronic illness and/or disability: Chronic illness or disability can undoubtedly lead to poor mental health and impair the quality of life of children who may also experience a higher burden of poor mental health (and/or exposure to risks, such as violence, abuse and neglect). According to LNFHS 2014, approximately 4 per cent of 10–19-year-olds have at least one chronic illness (such as diabetes and hypertension).[54] No national data is available on the effects of disability and chronic illness on the mental health of children and adolescents in Libya.

Children and adolescents living in alternative care, including residential care, are also at increased risk of poor mental health and exposure to risk factors, such as violence. Unfortunately, there is no national data describing mental health needs or risks for these children in Libya. However, research in many settings has indicated that institutional care can profoundly affect social, emotional and interpersonal development, and increase risks for exposure to violence, abuse and poor mental health.

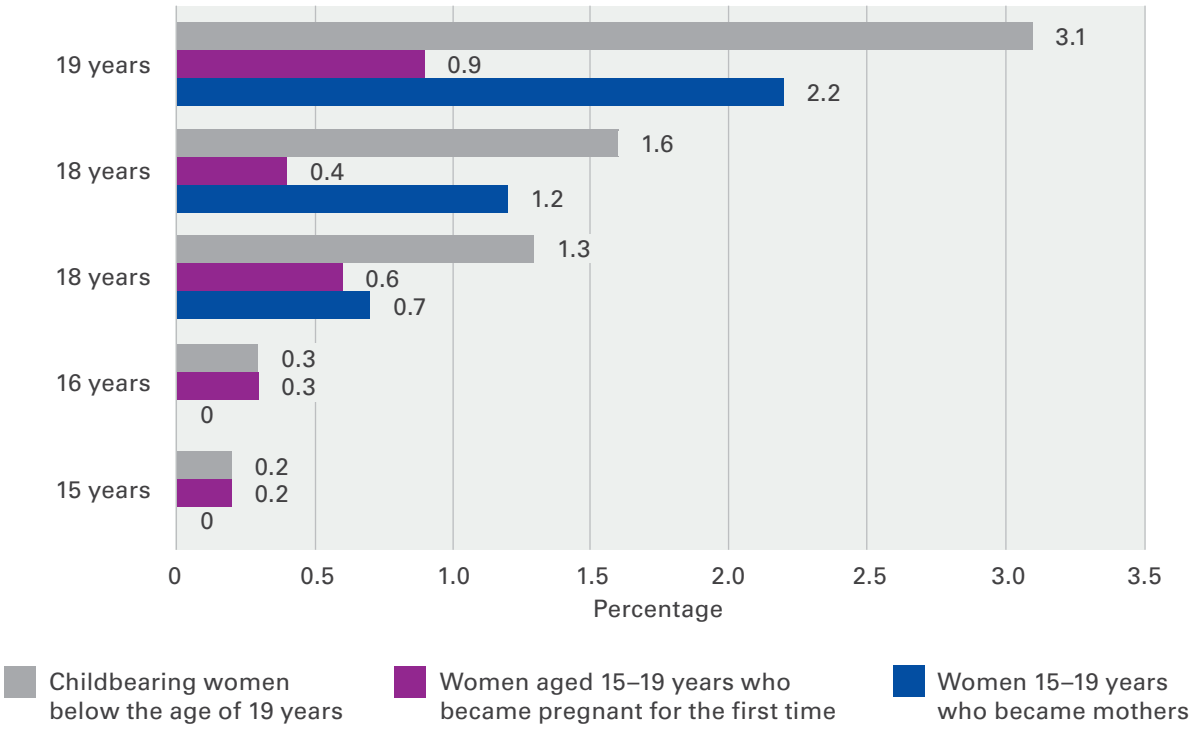
Child marriage and early pregnancy are also associated with poor mental health outcomes, including higher rates of perinatal depression and anxiety. According to LNFHS-2014, around 3.2 per cent of women aged 20–24 years were married before the age of 18 years and 0.4 per cent married before the age of 15 years.[56] At the time of the survey, the percentage of women who were pregnant at the age of 15–19 years was 35.6 per cent (**Figures 21 and 22**).[57, 58]

Figure 21: Percentage of women who married by the age of 15 years or by the age of 18 years



Source: LNFHS-2014.

Figure 22: Percentage of women aged 15–19 years who are mothers or pregnant for the first time and the total percentage of childbearing women younger than the age of 19 years[58]



Source: LNFHS-2014.

The world around children and adolescents

In addition to healthy parent/carer relationships, **peer relationships and connectedness** influence mental health and well-being, particularly during adolescence. GSHS revealed that 41.9 per cent of students aged 13–15 years answered that their friends were unfriendly and uncooperative during the last 30 days. Peer relationships were poorer for males (46.0 per cent) than for females (37.2 per cent).[48]

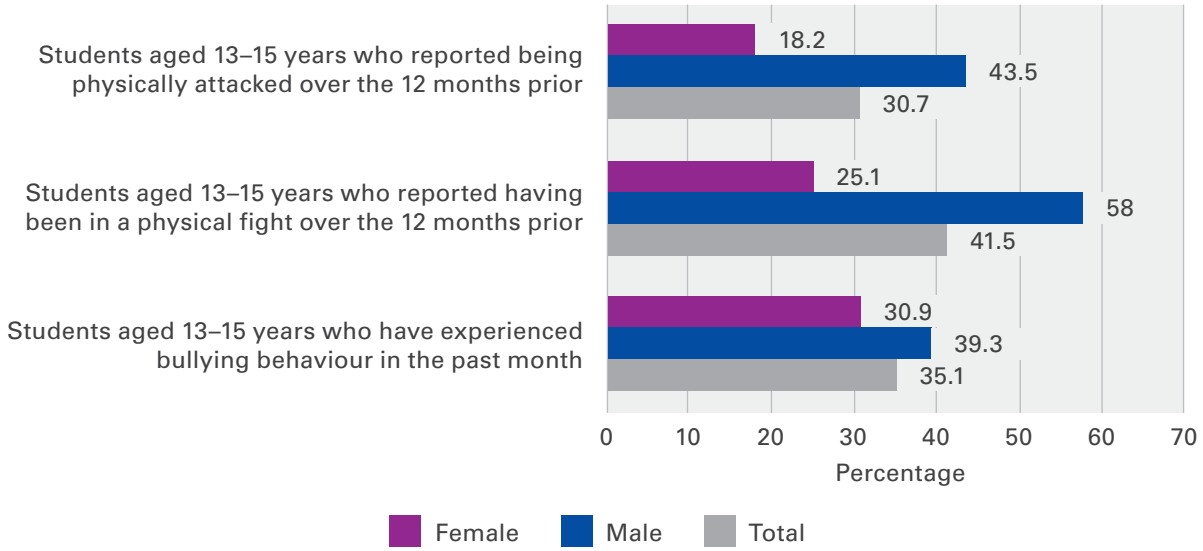
Exposure to peer victimization (bullying behaviour), harassment and violence in school is considered a risk factor for mental health and is highly prevalent among adolescents in the MENA region. GSHS in Libya 2007 has reported that 35.1 per cent of students aged 13–15 years have experienced bullying behaviour in the past month, with boys reporting being the victim of bullying more than girls (**Figure 23**).[58]

National-level data on cyberbullying are scarce. However, in 2019, UNESCO estimated that as many as 1 in 10 adolescents in the MENA region had been affected by online bullying.[59] The impacts of COVID-19 and the increase in remote learning and social media use are likely to have increased exposure to online harassment and peer victimization.

Witnessing, perpetrating or being the victim of **physical violence** in school settings is also common. In Libya, the available GSHS data indicate that 41.5 per cent of 13–15-year-old students reported having been in a physical fight in the 12 months prior, and 30.7 per cent reported being physically attacked (**Figure 23**).[60] The prevalence of violence was substantially higher among adolescent boys compared to adolescent girls.

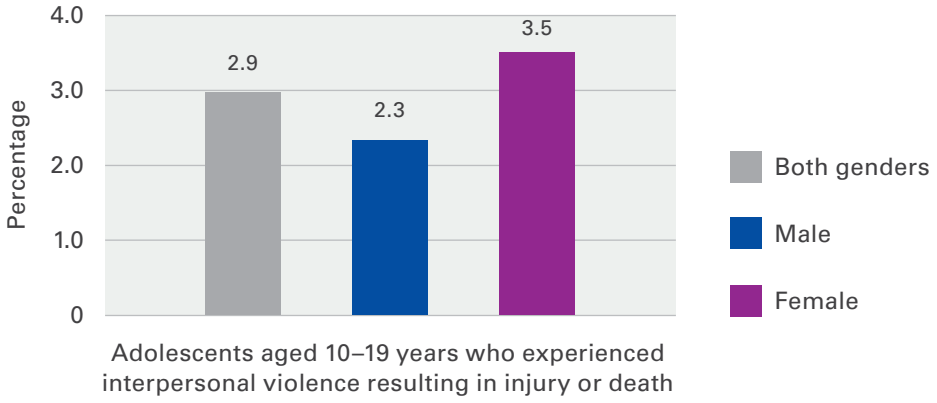
Modelled estimates of GBD have revealed that approximately 2.93 per cent of 10–19-year-olds experienced interpersonal violence (including sexual violence, violence with a sharp object, firearm, or other means) resulting in an injury or death in 2019), with interpersonal violence higher for girls compared to boys (**Figure 24**).[4]

Figure 23: Percentage of students aged 13–15 years who reported having experienced bullying, having been in a physical fight and/or having been physically attacked in the last 12 months



Source: GSHS 2007.

Figure 24: Prevalence of interpersonal violence resulting in injury or death among children and adolescents aged 10–19 years, by gender



Source: GBD 2019.

Sexual harassment, sexual violence and intimate partner violence are also important risk factors, most notably for adolescent girls. LNFHS-2014 revealed that among the women aged 5–49 years who were married or had a previous history of marriage about 8.2 per cent were exposed to violence in the last year,[61] and half of such exposure to violence was from their husbands.[61] Modelled data estimated that the prevalence of sexual violence among girls aged 10–19 years was 3.14 per cent in 2019, with around 1.65 per cent of boys also having experienced sexual violence.[4]

With data being scarce, **online sexual exploitation and abuse** are increasingly prevalent risk factors. According to the survey conducted by Lawyers for Justice in Libya (LFJL), it was suggested that the overwhelming majority of respondents to the survey perceive online violence among women to be a serious problem (96.3 per cent), with 97 per cent of respondents confirming that this form of violence is taking place in Libya. Moreover, 67.5 per cent of respondents said they had experienced online abuse on social media platforms.[62]

The world at large

Around 61 million children (one in three children) who are living in the MENA region are affected by ***conflict,*** with profound impacts on mental health and psychosocial well-being. Multiple studies conducted within the region describe a high prevalence of exposure to trauma among children in conflict settings and increased rates of PTSD and other poor mental health outcomes.[63] Since 2011, due to the political civil war in Libya, mental disorders are likely to become more prevalent in the Libyan population in the post-conflict period. The prevalence of severe PTSD in populations exposed to a high level of political terror and traumatic events was estimated at 12.4 per cent and the prevalence of severe depression was 19.8 per cent across six populations that have been affected by the conflict.[64] PTSD among Libyan children and adolescents has not been studied yet.[65]

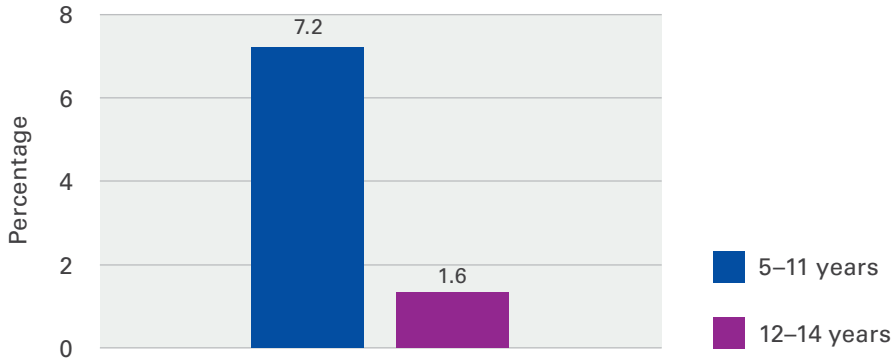
Refugee, displaced and stateless children are at increased risk of adverse exposure to violence, abuse and neglect; death or separation from parents; loss of connection to family, friends and community; insecurity and instability; and disrupted access to health, education and other services and support. Significant distress, mental disorders, substance use and exposure to violence among caregivers also impact the well-being of children and adolescents.[66]

According to the United Nations High Commissioner for Refugees (UNHCR) 2023, an estimated total number of 803,000 people in Libya are considered to be in need of humanitarian assistance. The registered refugees and asylum seekers in Libya accounted for 44,724, while the number of internally displaced people reached 134,787.[67] **The registered refugees and asylums seekers aged 0–17 years** in Libya included 14,485 children and adolescents, of which 6,190 were girls and 8,295 were boys.[67]

According to UNICEF, in 2020, **adolescents were among the internally displaced** in Libya.[68] The Annual Report of the UNICEF Libya Office recorded that there were 316,415 children who were internally displaced, and 567,802 returnees across Libya in October 2020. Migrant children in Libya are particularly vulnerable to abuse and exploitation, including in detention centres.[69] There are approximately 574,146 migrants and refugees (9 per cent are children, 2 per cent of which are unaccompanied) in Libya. Migrants and refugees face increasingly difficult living conditions. An estimated 2,000 refugees and migrants are being held in detention, 27 per cent of which are children, in inhuman conditions.[69]

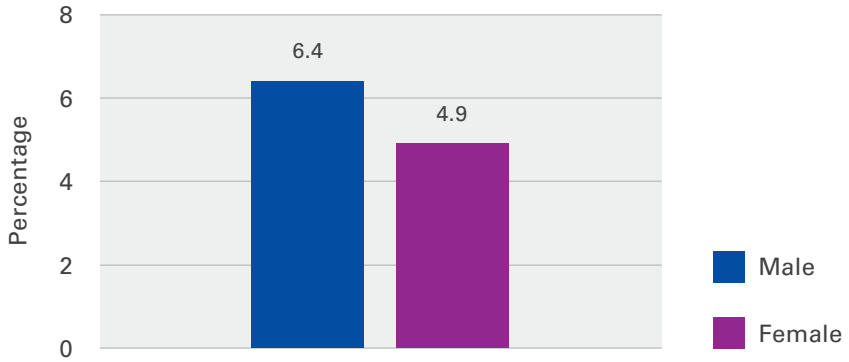
The condition **of non-Libyans in the nation – migrants, refugees and individuals on the move** – is extremely concerning. Several accounts state that refugees and migrants in Libya risk kidnapping, enslavement, torture, organized brutality and sexual abuse before crossing the Mediterranean Sea. OXFAM International (2017) reports stories of violence and sexual violence.[70] There is no data on children in refugees, but the mental impact on mothers will influence on their children and their care.[70]

Figure 25: Percentage of child labour for age groups 5–11 years and 12–14 years



Source: LNFHS 2014.

Figure 26: Percentage of child labour for the age group 5–14 years, by gender



Source: LNFHS 2014.

Child labour* is a determinant of mental health and well-being and is considered a major issue in forming the psychology of a child. It also has a negative effect on self-assets. According to LNFHS-2014, about 6 per cent of children aged 5–14 years are involved in child labour, and 5 per cent of this age group works outside the home (**Figure 25**).[71] Rates of child labour were higher among boys compared to girls (**Figure 26**). National data describing mental health needs among child and adolescent workers are not available.

Child trafficking for sexual exploitation, forced labour, forced marriage, or illegal adoption has been associated with severe psychological harm, trauma and mental disorders. In 2020, the United Nations Office on Drugs and Crime (UNODC) estimated that there were about 400 detected child victims of trafficking in the MENA region, representing around 20 per cent of trafficked persons. However, this proportion was as high as 30 per cent of the trafficked population in North African countries.[72] Sexual exploitation, forced labour and exploitative begging were the most common forms of exploitation, each accounting for around one third of the cases.

*Child labour is defined as a child who is a worker whose age ranges between 5 and 11 years and who works for any person outside the family, whether in return for a cash wage, in-kind, or without pay at all, or if they work for the family in commercial or agricultural work, their age ranges between 12 and 14 years, and they spend more than 14 hours per week in such work. If the child is between 5 and 14 years old and does housework, such as shopping, cooking, washing, taking care of children or the elderly, or bringing things to the family, and spends more than 28 hours a week in such work, the child is considered among working children. (LNFHS 2014).

Unfortunately, there is no national data on child trafficking in Libya, despite many reports of registered human trafficking, including children. Global studies have demonstrated that children from the poorest households are at increased risk of poor mental health and exposure to other risk factors, impacting their psychological well-being (such as family stress and violence, trauma, carer attachment, limited access to education, and stigma and discrimination).[2]

Stigma and discrimination are important contributors to mental health. Misconceptions and stigma associated with mental health are quite prevalent and highly contribute to poor access to MHPSS.[73] Stigma and discrimination are significant risk factors for all persons with mental health problems in Libya, for example, a girl from Tripoli might be sent to a mental health facility in Benghazi to avoid stigma.[74] Frequently, the patients' relatives and other caregivers attempt to manage the situation on their own. Thus, spiritual healers are a preferred option, as patients and their families opt for psychiatric services only as a last resort.[75]

COVID-19 was the most recent threat to mental health. In addition to psychological distress associated with the pandemic and illness, public health approaches that limit social interactions and movement have contributed to increased social isolation and loneliness, and disruption of mental health and other social services, education and employment, with acute impacts on mental health and well-being.[76] Increased social isolation and family and financial stress are also likely to increase exposure to family violence and conflict. Economic uncertainties and the projected socioeconomic inequalities will have long-term implications.[77] Crises, such as the pandemic, can also result in resources being diverted away from mental health services – combined with greater need, it can result in very limited access to services. Closure of schools and the pressures of remote learning were also described by families as significantly affecting children's well-being and socialization. In Libya, due to COVID-19, schools in Eastern Libya were closed from March to December 2020. As a result, children lost around eight months of education, and the opening of recreational spaces has added to stress after the 2017 conflict in Benghazi.[78] There is no data available to assess the mental health and psychosocial well-being of children and adolescents in the COVID-19 pandemic period but there are recorded cases of children with mental health and psychological disorders.[78]

A study on the psychological impact of civil war and COVID-19 on Libyan medical students in 2020 revealed that anxiety was significantly associated with living status and internal displacement. Suicidal ideation was present in 22.7 per cent of medical students. Thus, the study concluded that medical students in Libya are at risk for depression, especially under the current stressful environment of the civil war and the COVID-19 pandemic.[79]

Key informant participants' feedback on risk factors of mental health conditions among children and adolescents

The most frequently mentioned risk factors of mental health conditions of children and adolescents were associated with **country instability and security-related factors (mentioned 25 times in different sub-thematic titles)**. Stakeholders reported the following risk factors:

- Civil war and conflict: 9 of 13
- Internal displacement: 5 of 13
- Security concerns: 5 of 13
- Political instability: 5 of 13
- Demographic changes in the south of the country due to migrants of Chad and Niger affecting the children with different psychology and behaviours: 1 of 13

The second most-frequently mentioned risks were associated with **socio-economic factors (mentioned 15 times in different sub-thematic titles),** including the following risk factors:

- Economic stressors: 6 of 13
- Social stressors: 4 of 13
- Stigma issues: 2 of 13
- Daily stressors: 1 of 13
- Lack of employment opportunities: 1 of 13
- Poverty: 1 of 13

The third frequent risks of mental health conditions reported by stakeholders are associated with **the family (parents) (mentioned 13 times in different sub thematic).** The risks mentioned are as follows:

- Wide difference in the age of the parents
- Loss of parents' connections
- Lonely child
- Family separation and conflicts
- Parents' ignorance of their children's mental health conditions and parents' delay in seeking psychological consultation,
- Low education level of families
- Most new mothers have no appropriate knowledge of how to raise their children
- Lack of understanding of parent relationships
- Lack of pre-marriage education regarding inter-family relations

As the fourth most frequently mentioned risks were adolescent **substance-abuse disorders** (including cigarette smoking and drug addiction either in males or females), which were mentioned 9 times.

The least mentioned risks were **MHPSS service-related factors** (mentioned 6 times). These risks included:

- Lack of mental health awareness in the community: 2 of 13
- Ignorance of mental health either from the community or authorities: 1 of 13
- Lack of referral systems: 1 of 13
- Shortage of human resources: 1 of 13
- Lack of access to mental health services: 1 of 13

The other risks mentioned were:

- **COVID-19:** 4 of 13
- **Social media addiction and electronic games:** 3 of 13
- Spending long hours on electronic games: 2 of 13
- Sedentary life of mothers using social media for long time

Other risks that were mentioned once are genetic factors, dealing with breaking bad news in an appropriate manner, domestic violence, lack of educational opportunities, lack of official documents for work permits for non-Libyan migrants, and strict control in kindergarten, as this could have long-term effects on children's school performance.

The populations with the highest priority for mental health care, as informed by stakeholders, are as follows:

- Adolescents mentioned in different sub-thematic area: 9 of 13, as follows for highest priority:
  - Male adolescents: 4 of 13
  - Both genders of adolescents: 2 of 13
  - Adolescent victims of violence: 1 of 13
  - Adolescent victims of sexual and/or emotional abuse: 1 of 13
  - Adolescents who have been internally displaced: 1 of 13
- Victims of violence (all ages): 3 of 13
- Victims of sexual abuse (all ages): 2 of 13

4.2 Maternal mental health needs (outcomes and risks) for mothers

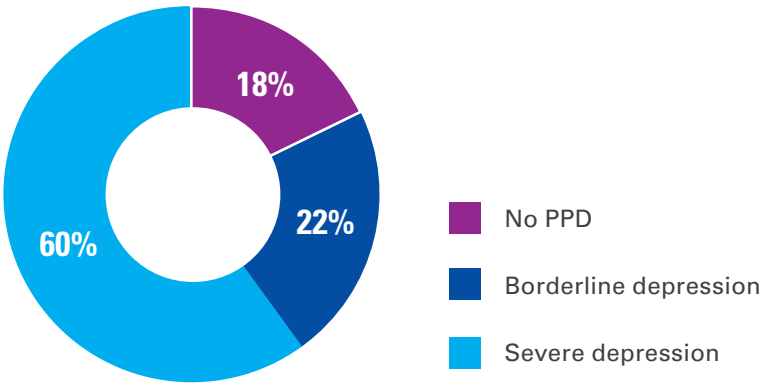
It is estimated that, in low- and middle-income countries, almost one in six women experience common perinatal mental health disorders (including depression and anxiety) during pregnancy, while one in five women experience common mental health disorders during the postpartum period experience.[80] Many women experience symptoms of psychological distress, loneliness, isolation and self-harm, with suicide estimated to account for 20 per cent of maternal deaths in the year following childbirth, globally.[81] Moreover, risk factors for perinatal mental health conditions include youth (such as adolescent mothers) experiencing intimate partner violence, lack of partner or family emotional support, and socioeconomic disadvantages. Having a previous history of mental health conditions increases the risk for perinatal mental disorders.[80] Higher rates of poor maternal mental health have also been described among migrant women, especially refugees and asylum seekers.[82, 83] Poor maternal mental health profoundly impacts not only the physical health of infants and children, but also that of caregivers (attachment, responsive care) and the cognitive development and mental health of children and adolescents.[84]

In Libya, there are currently no comparable national-level indicators or data describing mental health outcomes of women during pregnancy or in the 12 months following birth. As for **postpartum depression (PPD)** in Libya, reviewed literature (Saeed et al, 2022) has revealed that the prevalence of depression, measured on the Edinburgh postnatal depression scale (EPDS), was 60 per cent. Among mothers who delivered in the past 6 months, 22 per cent suffer from borderline depression.[85] In another study on risk factors of PPD (Gawass et al., 2009), it was revealed that 15 per cent of mothers had borderline depression (EPDS score of 5–9), while 42 per cent suffered from PPD (EPDS ≥10).[86] The study also showed a strong relationship between the development of PPD and giving birth to an unhealthy baby, experiencing neonatal death, previous bad obstetrics experience, low parity and higher level of education.[86] On the other hand, the relationship was weak between PPD and young age, history of infertility, delivery by caesarean section, history of hospital admission during the current pregnancy and presence of a medical problem. The presence of social problems did not seem to have any notable effect on PPD (**Figure 27**).[86]

Stress-related disorders are classified among the mental disorders that negatively affect pregnancy outcomes. According to the reviewed literature, there was a significant rise in the rate of deliveries involving preterm births (3.6 per cent versus 2.5 per cent) and low birth weight (10.1 per cent versus 8.5 per cent) in infants, and caesarean sections (26.9 per cent versus 25.3 per cent) due to the mental health impacts of civil unrest in 2011 compared to 2010 reported in Benghazi.[87]

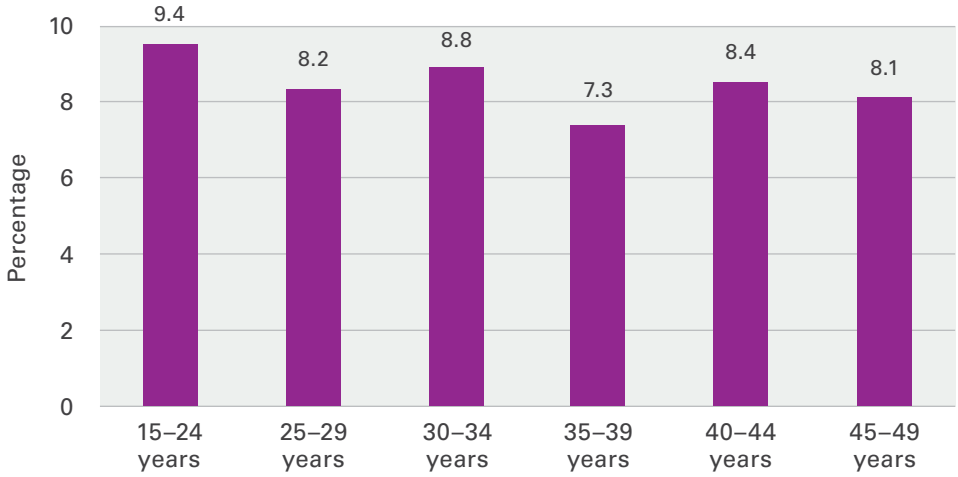
In terms of **violence against women,** the LNFHS-2014 revealed that among women aged 15–49 years who were married or had a previous history of marriage, about 8.2 per cent of them were exposed to violence in the last year,[88] 79.1 per cent of them were exposed to verbal violence, and half of this exposure to violence was from their husbands. In addition, 74.4 per cent of women suffer from depression as a result of violence (**Figures 28–31**).[88]

Figure 27: Percentage of women with postpartum depression measured by EPDS



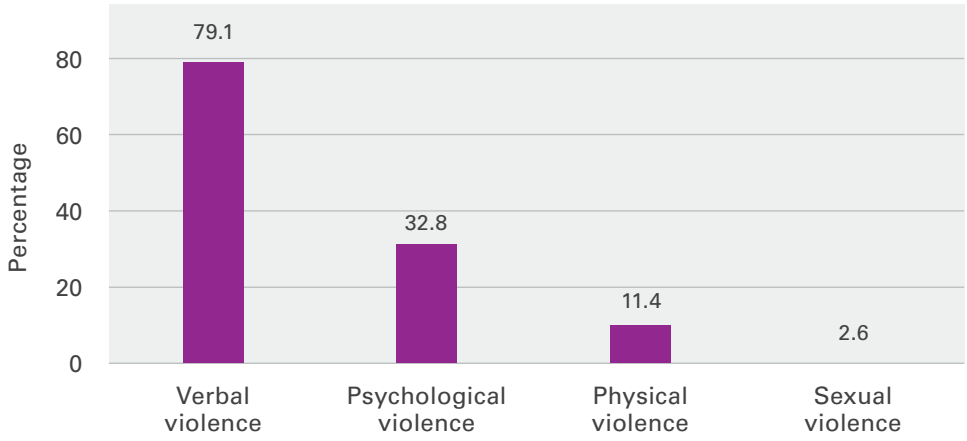
Source: Saeed et al., 2022.

Figure 28: Percentage of adolescent girls and women aged 15–49 years who are married or had previously been married and have been exposed to violence in the last year, by age group



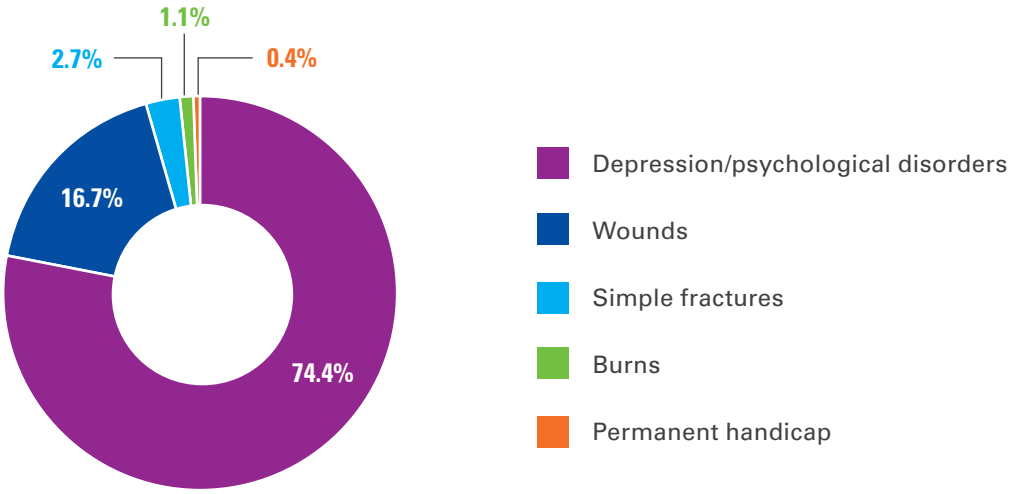
Source: LNFHS 2014.

Figure 29: Percentage of women aged 15–49 years who are married or had previously been married and have been exposed to violence in the last year by the type of violence



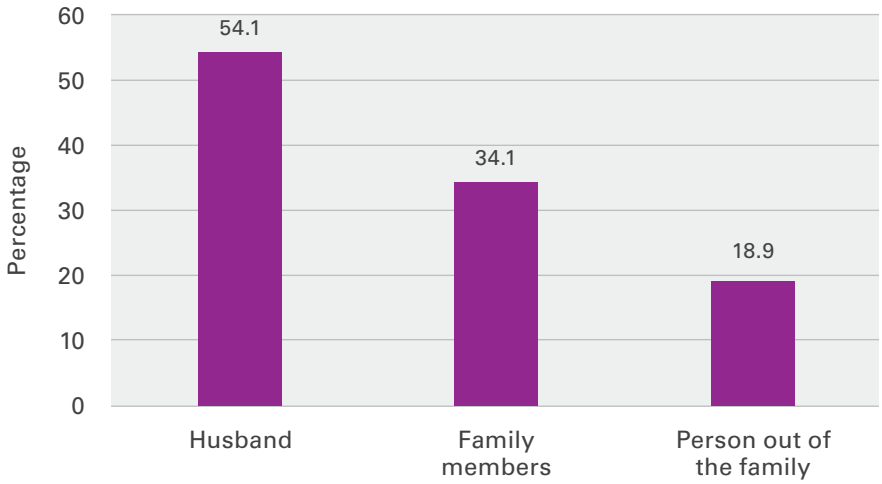
Source: LNFHS 2014.

Figure 30: Percentage of married women aged 15–49 years who have been exposed to violence in the last year by the effect of violence



Source: LNFHS 2014.

Figure 31: Percentage of married women aged 15–49 years who have been exposed to violence by the source of violence



Source: LNFHS 2014.

4.3 Current responses of MHPSS of children, adolescents and mothers

4.3.1 National mental health policies, plans, strategies and legislation

Libya has developed a mental health policy, but the date of formulation is unclear. Libya is considered one of few Arab countries to have a mental health act, which came into effect in 1975 but has never been reviewed. However, the mental health act is rarely used in practice. Rather, what occurs usually is dictated by the family's wishes. The common law has also been used to detain people against their will.[89]

There is no clear mental health policy or updated mental health legislation in Libyan health laws[11]

Table 2: MHPSS-related legislation, polices, strategies and plans

Name of document	Conceptual framework tier included	Extent to which specific actions are included for children and/or adolescents aged 0–19 years	Summary of key actions
Health Law (106) of 1973 Chapter 1, Section 1, Article 3[90]	Preventive and responsive care	The general preventive and curative actions provided for young people and new generations did not specify age groups.	"The Ministry of Health provides young people with all preventive and curative health services to achieve the physical, mental and psychological well-being of the new generation."
Health Law (106) of 1973 Chapter 3: Special provisions for certain types of treatment institutions and health facilities with respect to hospitals and places prepared for accommodating and treating people with mental illness. (Articles 60–64)[90]	Not mentioned	Not mentioned	The law is concerned with examining the procedures that must be adopted for the detention and release of people with mental illnesses inside hospitals and health centres.

Name of document	Conceptual framework tier included	Extent to which specific actions are included for children and/or adolescents aged 0–19 years	Summary of key actions
Implementation Report of the Health Law (106) of 1975 Chapter 8: Therapeutic medicine and therapeutic institutions, Section 2: Procedures to be followed in detention and release of people with mental illness[91]	Not mentioned	Not mentioned	The operational procedures related to hospital-based mental health care, which includes the detention, discharge and referral of mentally ill patients.
National Strategy Health For All and By All/1994 Decision of the Prime Minister No. (24) for the year 1994, Article 3[92]	Not mentioned	Not mentioned	Mental health is generally mentioned as one of the main services provided by primary health care (no detailed intervention).
The Arab Strategic Plan for the Development of Primary Health Care and Family Medicine (2011–2016) /2010[93] Programmes that achieve the first strategic objective: better mental health, adolescent health and reproductive health and the fourth, fifth and sixth strategic goals regarding primary health care Linkage between the Ministry of Health and the social sector at the Arab level.	Promotion and responsive care	Early detection and diagnosis of mental conditions. Enabling safe environment through community promotion and legislation, policy and strategy implementation. Strengthening health systems by enhancing the skills of health professionals and appropriate allocation of budget.	Mental health was addressed in general and no specific age group was mentioned. In adolescent health, it addressed priority issues, such as smoking and drinking. **Strategic objectives:** To improve mental health and accessible PHC services through: 1: Early detection and addressing mental disorders in health centres by fulfilling the need to implement this and developing a guide for identifying psychological disorders in their early stages. 2: Strengthening social services for dealing with cases of mental disorders by fulfilling the need to enhance social service, integrating female social workers in training courses and activating the transfer and coordination mechanism between social services and primary health care. 3: Raising awareness of community members to support the positive role in interacting with life circumstances. 4: Developing primary health care by strengthening cooperation and coordination between government sectors, the private sector and NGOs to provide primary health care services. 5: Allocating an appropriate budget for primary health care, in coordination with the Ministry of Health in proportion to the needs of the community. 6: Enhancing the efficiency and skills of health professionals by conducting the necessary training courses.

Name of document	Conceptual framework tier included	Extent to which specific actions are included for children and/or adolescents aged 0–19 years	Summary of key actions
Health Insurance Law/ 2010[94] Has not been applied yet, the medical services in the country are free of charge for all citizens	Not mentioned	Not mentioned	Health insurance services include diagnostic, therapeutic, investigation and admission services. They also cover family medicine services and medication and surgical procedures needed in public health facilities. Even though mental health services were not specifically mentioned, they were included through the mentioned services. The law demonstrates that non-curative health services are represented in promotional primary health care services, health awareness and education activities to promote healthy behaviour and chronic mental illnesses, and vaccinations covered by the general public fund.
National Centre for Disease Control Strategy/2012[95]	Not mentioned	Not mentioned	The NCDC Strategy outlines the national strategic directions in non-communicable disease care, including primary and secondary prevention (mental health is not specifically mentioned).
Decree for Reorganizing the National Programme of Mental Health and Psychosocial Support: MOH Decision 861/2012[96]	Not mentioned	Not mentioned	The decree outlines strategic directions of the national MHPSS programme. The decree gives authority to the Programme Committee to further develop policies. This may overlap with other departments at MOH, such as with planning and NCDC.
Proposal for Mental Health Policy Framework in Libya/2012[97]	Not mentioned	Not mentioned	It outlines a proposed mental health policy with a focus on primary health care and community-based services
Health Information System Strategy (2018–2022)/2017[98]			The strategy emphasizes the critical role of information pillar of health systems and indicates how essential multi-sector cooperation is.
Strategic Plan for Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) 2019–2023/2018[6]	Promotion and responsive care	All objectives of the strategy address children, adolescents and mothers	**Objectives of the strategic plan include:** **a) Establish mental health programmes in RMNCAH services by developing a National Mental Health Programme** that assesses MHPSS needs, develops a national mental health plan and strategy, conducts awareness activities, mitigates the shortage of essential psychotropic medicine, builds the capacities of health professionals, integrates mental health and substance abuse services, and allocates psychiatry beds in general paediatric wards in hospitals for children and adolescents. **b) Ensure the availability of a MHPSS package for children and adolescents in humanitarian settings, and for internally displaced and migrant children and adolescents.**

Name of document	Conceptual framework tier included	Extent to which specific actions are included for children and/or adolescents aged 0–19 years	Summary of key actions
National Strategy of Mental Health (2023–2025): First draft issued in November 2022[99]	Promotion and responsive and preventive care	Improve mental health services by providing paediatric psychiatric hospitals and addiction management centres	The National Strategy of Mental Health contains actions for each strategy of the PHC levers for the integration of MHPSS in PHC. It also improves services by providing the paediatric psychiatric hospitals and qualified workforces, and aims to improve the Health Information System (HIS) and financial support.

Name of document	Conceptual framework tier included	Specific actions for children/ adolescents aged 0–19 years	Primary health care
Primary Health Care Reorganization Decree by the Prime Ministry Office/2004[100]	Not mentioned	Not mentioned	Outlines strategic goals, services, facilities, components and governance of PHC. "Article 4 stipulates that mental health is one of the services provided by primary health care and that primary health care centres and units and group clinics shall provide this service in accordance with Article 5."
Health Care Planning Authority Establishment Decree /2004: Decisions of the General People Committee (Prime Minister) No. 66 of 2004[101]	Not mentioned	Not mentioned	Outlines the tasks, functions and financial arrangements of the Health Care Planning Authority.
Primary Health Care Institute Establishment Decree by the Presidency/2018.[102]	Not mentioned	Not mentioned	It outlines the administrative and financial autonomy of the PHCI and describes its mandate and functions.
Medium-Term Primary Health Care Strategy 2020– 2022/2019.[103]	Not mentioned	Not mentioned	It outlines the scope of PHC systematically and the needed interventions to strengthen all pillars to further improve access, coverage, efficiency and quality of PHC.

Name of document	Conceptual framework tier included	Specific actions for children/ adolescents aged 0–19 years	Non-health
Memorandum of Understanding and Cooperation between the Department of Social Services, School Health and Psychological Support of the Ministry of Education and the Primary Care Institute of the Ministry of Health[104]	Promotion, preventive care Strengthening systems, such as field surveys and enforcing workforce skills		1. Establish health awareness and education programmes targeting social workers, supervisors, health workers and psychological counsellors. 2. Implement joint programmes to spread health culture and raise community awareness of such. 3. Hold joint workshops, seminars and conferences on issues of interest to young people (health, social and psychological). 4. Issue brochures, pamphlets and magazines that are concerned with reducing health diseases, social and behavioural issues and mental disorders. 5. Conduct field surveys in the health, social and psychological fields.

Name of document			Legislation on age of work and marriage
Law No. (12) of 2010 regarding the issuance of the Labour Relations Law and its executive regulations.[105]			A person under 18 years of age may not engage in any type of work.
Personal Status Law No. "188" for the year "1959"[106]			The eligibility for marriage is met by reaching the age of 18. The court may authorize marriage before reaching this age for interest or as needed after the consent of the guardian. The judge may authorize the marriage of those who have reached 15 years of age if the judge finds it an extreme necessity that calls for such and is required to give permission to verify legal maturity and physical ability.

4.3.2 Overview of mental health system

Mental health has been neglected in Libya for decades. Many problems pre-date the conflict that began in 2011, including underdeveloped communities and a lack of specialized services, such as the lack of a skilled workforce, inadequate facilities, social stigma against those who suffer from mental illness and lack of funding.[107] The prevalence of people in need of mental health and psychosocial care is thought to have increased due to the ongoing and widespread violence in the country and COVID-19 lockdown measures, requiring a combination of short-term and long-term interventions.[107]

The Libyan health sector and Primary Health Care Institute (PHCI) position

Since its inception in 1951, when there were only a few health clinics and 14 hospitals, Libya's health care system has significantly advanced. The first Three-Year National Transformation Plan (1973–1975) emphasized every citizen's right to receive health services. From 1970 to 1979, community health facilities were created. Since 1980, Libya's government has offered free universal health coverage, adhering to the principle of "health for all". The public health sector is considered the main suppliers of health services. It is important to note that all citizens are entitled to free medical care, which includes preventive, curative and rehabilitative services. All levels of health care, except for hospitals and specialized facilities, are currently decentralized.[108]

The Ministry of Health is the top decision maker for the health sector in Libya. It is operated by a comprehensive central organizational system overseen by the Minister of Health, who directly supervises the following core institutions: Health Information Centre (HIC), National Centre for Disease Control (NCDC), National Council for Medical Responsibilities (NCMR), National Programme for Organ Transplantation (NPOT), Libyan Board For Medical Specialties, Medical Supply Organization (MSO), Centre for Human Resource Development, Authority of Ambulance Services, Hospitals and Medical Centres, Directorates of Health Services at the municipality level, and the Primary Health Care Institute (PHCI) that was established in 2018 as part of MOH.[102, 108]

At the district level, the District Health Officer (DHO) is responsible for providing comprehensive health care, free of charge according to Public Health Law No. 106 of 1973, to all citizens. DHO is currently responsible for overseeing only the primary health care facilities working at the municipal level. Functionally, PHCI deals with DHO at the municipality level.[108]

In Libya, a mixed system of public and private health care has been developed, rather than a state-run model. The health care delivery system operates at three levels. The first level consists of the primary health care units (providing curative and preventive services for 5,000 to 10,000 citizens); primary health care centres (serving from 10,000 to 26,000 citizens); and polyclinics, staffed by specialized physicians and containing laboratories as well as radiology services and a pharmacy. These polyclinics serve approximately 50,000 to 60,000 citizens. At the second level, general hospitals have been established in rural and urban areas where care is provided to those referred from the first level facilities. The third level is comprised of specialized hospitals and medical centres.[108]

Regarding mental health at the national level, there are mental health units/focal points in MoH, NCDC and PHCI. The MoH has a Mental Health Coordinator and NCDC has a Mental Health Department consisting of a multi-disciplinary team. PHCI also plays a vital role with its mental health unit, which deals with primary health care level.[109]

Total government expenditure on mental health: Due to the lack of clear mental health policy or mental health legislation, no corresponding budget or means by which to account for expenditure on mental health services has been allocated, resulting in very limited availability of services. The two psychiatric hospitals, one in Tripoli and the other in Benghazi, received 13 million Libyan dinars from the Ministry of Health's yearly budget in 2012, which was 0.45 per cent of the overall public health budget. Therefore, it can be concluded that there is no clear budget allocation for MHPSS services.[110, 111]

The health insurance system for mental health in Libya has been implicitly mentioned in Article 6 of the Libyan Health Insurance Law No. 20 of 2010 and in its executive regulation of 2019 through the family medicine services in primary health care services, as well as through its inclusion in the diagnostic, treatment and admission services for most health conditions in public hospitals. However, the health insurance system in Libya has not been applied yet, and health services are still provided free of charge by the state to all citizens according to Public Health Law No. 106 of 1973.[94]

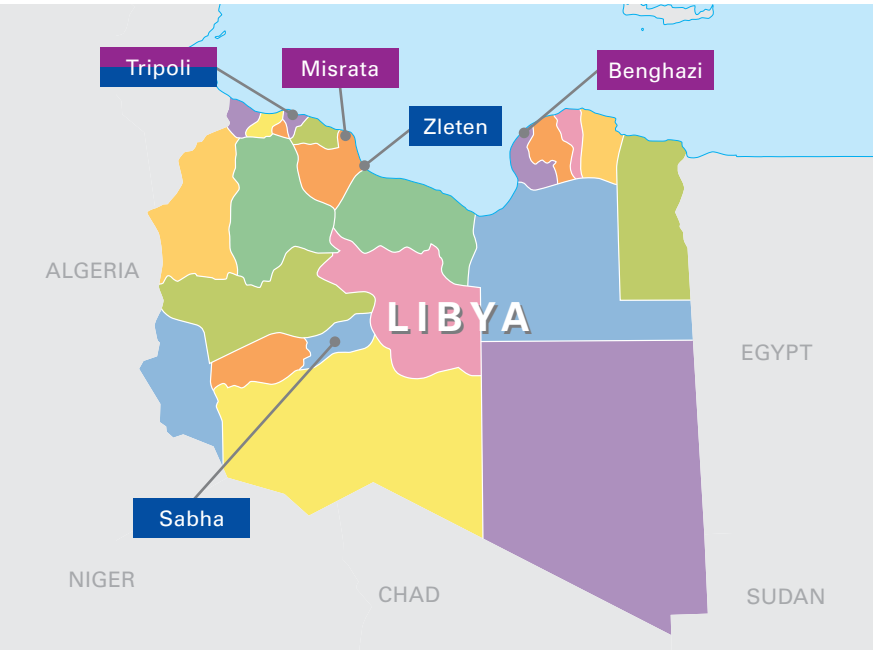
As for out-of-pocket payment services for all citizens, they are provided in the private sector when these services are not available in the public sector. Due to the devastating political and economic situation resulting from the conflict inside the country, the availability of diagnostic tools has been affected with interruption or irregular availability of medical supplies and equipment in the public sector. This is coupled with the stigma surrounding mental illness, especially in public psychiatric hospitals, forcing patients who are able to pay the fees to seek medical advice in the private sector, which is considered a high cost for most of the Libyan population.[94]

Mental health care facilities: Previously, the provision of mental health services in Libya was highly centralized, difficult to access and of limited quality. Now, these mental health services are provided by a few facilities. There are three specialized national hospitals with inpatient services: Al-Razi Psychiatric Hospital in Tripoli, Benghazi Psychiatric Hospital and the National Centre for the Treatment and Rehabilitation of Addicts in Misrata.[110] There are also three other hospitals offering outpatient services – Tripoli Central Hospital, Misrata Medical Centre and Zliten Hospital – and a mental health clinic in Sabha city.[110] The mental health clinic in Sabha is located in the Sabha Hospital, but is treated as a separate facility (**Figure 32**).[110]

There are four PHC facilities (mentioned in the SARA Report 2017), while the PHCI revealed recently that 32 PHC facilities played a significant role in MHPSS after mhGAP training, including children and adolescent MHPSS services (**Figure 33**).[110, 112, 113]

There are 10 private clinics that provide MHPSS services, three of which provide inpatient services, (such as Psy-Care Clinic in Tripoli, Eshraqat Clinic in Tripoli, and Alamal Clinic in Benghazi). The 10 private clinics are distributed as follows: five in Tripoli, two in Benghazi, one in Misrata, one in Zliten and one in Zowara.[114] It is also worth mentioning that people prefer private clinics, if they can afford these, to reduce or avoid stigma.[107] These facilities have a certain role but are still considered inadequate to meet the needs of six million people and are one of the barriers for MHPSS (**Figure 33**).[16, 17]

Figure 32: Geographic distribution of three specialized national hospitals with inpatient services (Tripoli, Misrata and Benghazi) and three national hospitals with outpatient clinics (Tripoli, Zleten and Sabha)



Source: Health Information Centre, 2017.

Figure 33: Geographic distribution of municipalities that have selected PHC facilities offering MHPSS services after WHO mhGAP training and United Kingdom cooperation with PHCI (DFID Project)

Source: Health Information Centre, 2017.

Tripoli's Al-Razi Psychiatric Hospital has a capacity of 220 beds (60 beds for acute patients, 120 beds for chronic patients, and 40 beds for forensic psychiatric patients). The Benghazi Psychiatric Hospital has 400 beds. These two hospitals together account for a total of 620 psychiatric beds,[109] indicating that there are about 0.01 psychiatric beds per 1,000 people. The number of long-stay patients in Benghazi Mental Hospital is about 80–90. There are no psychiatric wards in general hospitals.[109] Libya has no psychiatric beds for children or adolescents. Adolescents are treated in the wards for adults.

Benghazi had one addiction unit as a separate department within the hospital premises, but this has not been functioning since 2016.[109] The number of beds in the National Centre for the Treatment and Rehabilitation of Addicts in Misrata has approximately 50 beds, and at full capacity could expand to 120 beds.[114]

Mental health assistance for children and adolescents is very limited. There is only one child psychiatrist in Libya, and this psychiatrist oversees an outpatient paediatric clinic in Benghazi that is linked to a paediatric unit in the General Hospital.[109] In Tripoli, there is an outpatient department (OPD) for psychosocial support for children in a general hospital that was established by a paediatrician. However, the OPD in Tripoli is under threat of closing. Furthermore, adolescents above the age 18 years are usually treated in adult psychiatric services.[109]

Mental health workforce in Libya: The ratio of physicians to people in Libya in 2015 was 19.5 per 100,000 population. According to the Arab Board of Medical Specialties, there are only 30 psychiatrists in Libya. The number of senior psychiatrists in 2012 was 12, and the number of junior psychiatrists was nearly 20.[115] The ratio of psychiatrists is less than 1 per 100,000 people. This limited workforce provides services in multiple places, including their own private clinics.[16, 17] There is a relatively high concentration of social workers (estimated to be about 35–40) and psychologists (estimated to be about 50) involved in providing MHPSS services compared to other actors, followed by education staff.[115] The number of volunteers, case managers and community health workers are relatively underreported, and there are no occupational therapists in Libya. No accurate data has been collected on the exact number of MHPSS paramedic health workers.[16, 17]

Essential mental health medicine availability: According to the Essential Medicines Survey, 14 per cent of hospitals and 1 per cent of PHC facilities carry essential medicines for mental health. Haloperidol and phenobarbital injections are the most widely available mental health drugs in hospital facilities, at 23 per cent and 22 per cent, respectively. However, this still represents less than one quarter of all hospitals.[116] Fluphenazine injections (4 per cent) and lithium tablets (3 per cent) were the least commonly available mental health medicines in the hospitals. The mental health drugs in PHC facilities are essentially unavailable, according to the SARA 2017 survey.[116]

4.3.3 Current programmes and approaches for MHPSS of children, adolescents and mothers National MHPSS programmes

Primary Health Care Institution (PHCI): The WHO mhGAP training, supported by the PHCI and in cooperation with the United Kingdom, was launched in 2020 and completed in 2022. During the implementation, 300 non-specialized general practitioners (physicians) from 40 primary health care facilities in 18 municipalities throughout the country participated, and their training revolved around mhGAP version 2 related to mental health support services and treatments.[112, 113, 117] There were more than 500 doctors and nurses trained on psychological first aid.[112, 117] According to the Libya Herald, over 150 general practitioners in 30 PHC centres are now offering these services and transforming lives.[113]

Through mhGAP training, school health personnel were contacted in 30 schools, where 400 teachers, psychologists, social specialists and paramedics were trained on the early detection of mental and psychological disorders among students and were trained to refer suspected cases to the nearest PHC facility with mhGAP training.[112, 113, 117] In addition, six-months of mhGAP training shall be provided to 130 physicians. Twenty-five health workers have also been trained on community education, awareness of mental health and how to provide essential mental health drugs in targeted PHC facilities.[112, 117]

There was cooperation with the NCDC in forming the first draft of the National Strategy of Mental Health (2023–2025). It is also important to provide mental health indicators for the Health Information Centre to establish the DHIS-2 platform for mental health conditions, where registered cases in trained centres shall be followed up through KoboToolbox (a data collection software).[112]

National Centre for Disease Control (NCDC): The national programme for MHPSS has promoted mental health in the southwest of the country, including MHPSS promotion campaigns, primary mental health care diplomas for physicians (targeting 24 physicians), courses on mhGAP with involvement of 45 general practitioners and family physicians, and activating courses for psychiatric physicians who are involved in the training programme of Arab Board of Medical Specialities.[112, 114, 118] In 2013, a four-year mental health strategy to improve services was launched.[118]

MHPSS integration by organizations

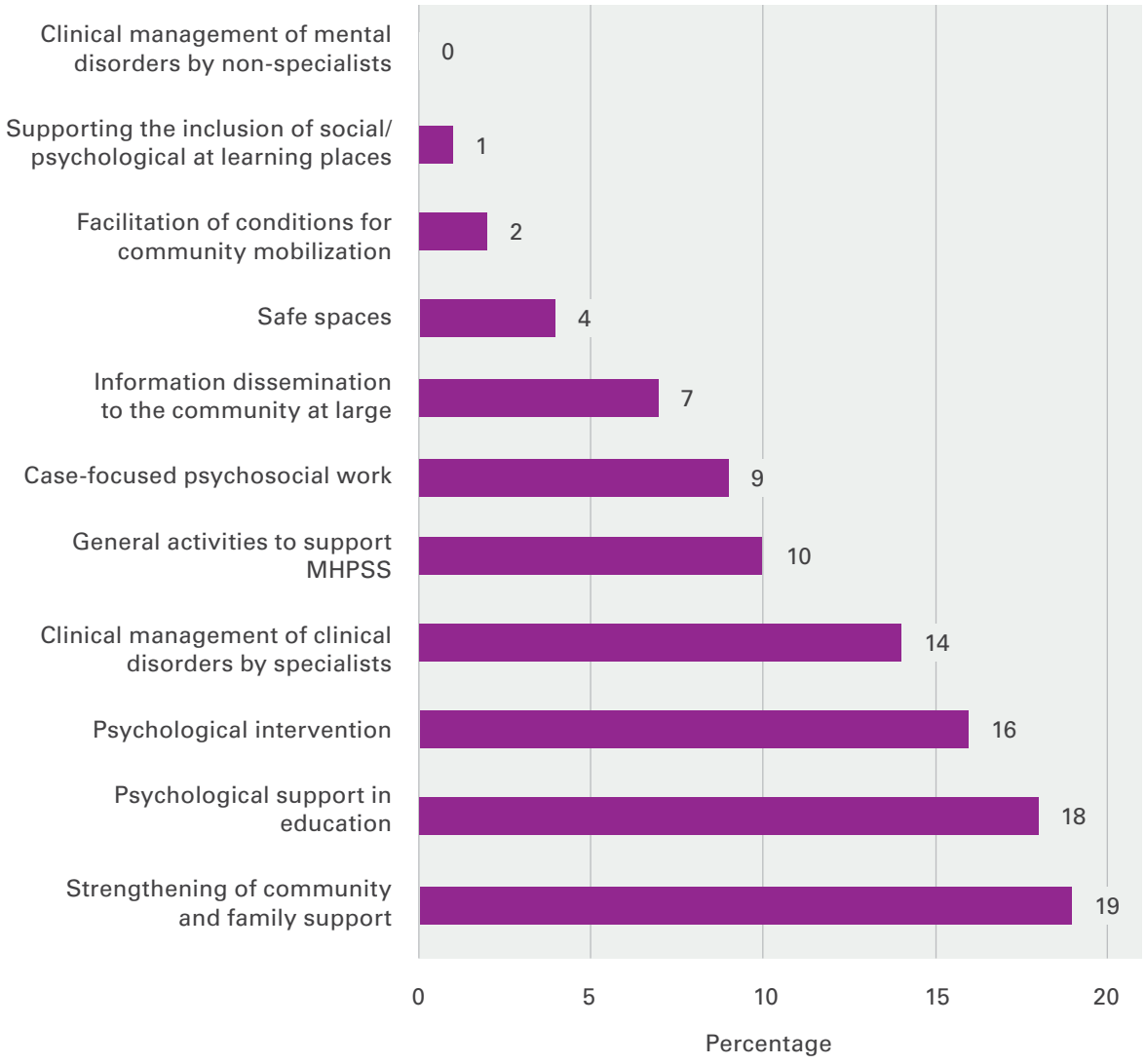
The Reali and Gagliato report *WHO is WHERE, WHEN, doing WHAT (4Ws) Report,* 2017, identifies **189 organizations that deliver MHPSS services,** programmes and activities across Libya, including 177 national actors and 12 international actors. The majority of organizations were associated with the government, such as the National Centre for Disease Control, health facilities and schools. A **total of 296 MHPSS activities** were reported, with the concentration of reported services in Tripoli (58 per cent of all activities).[118] The majority of MHPSS activities target children, adolescents, local communities and persons with disabilities. Activities targeting women, men, elders, caregivers, refugees, migrants and internally displaced people were also reported, but in low numbers.

Fifty-one per cent of the mapped services are community-focused interventions, such as safe spaces, community mobilization, information dissemination, incorporation of psychosocial considerations into other areas and psychological support in education. In addition, case-focused activities, such as psychosocial work, psychological intervention and clinical management of mental health, account for 40 per cent of the services provided. The remaining 9 per cent represent general activities that support MHPSS as training, supervision, research and psychological support of staff.[118]

The most frequently reported MHPSS services in Libya are related to strengthening communities and families, particularly group activities (43 activities), parenting (41 activities) and unstructured recreational activities (42 activities). These activities take place across Libya. In addition, 54 MHPSS services associated with educational and psychological support, most notably psychosocial support to classes or groups of children in school/learning settings, have been documented (**Figure 34**).[118]

Health facilities and private clinics primarily provide services related to clinical management of mental health disorders by specialists (such as psychiatrists, psychiatric nurses and psychologists working at PHC, general, and mental health facilities). In total, 41 events were reported throughout Libya. Included in these activities are pharmacological treatments for mental disorders.[118]

Figure 34: Concentration of MHPSS services by type of activity



Source: 4W report.[68]

Many organizations focus on improving access to PHC by incorporating MHPSS

International Rescue Committee (IRC): The IRC provides direct management care of mental health conditions by specialized and non-specialized providers in PHC facilities in Tripoli, Zliten and Misrata.[119] IRC offers MHPSS services in safe spaces in the Qasr Ahmed area in Misrata, where, so far, 138 people were directly served and 58 per cent of them were women. In Tripoli, IRC reached 105 people, where 45 per cent had depression, 11 per cent had PTSD and 10 per cent had an anxiety disorder.[119]

Through the IRC, three psychiatrists conducted a mhGAP training to seven general practitioners, during which participants learned more about mhGAP's goals, care principles and communication skills that must be acquired when dealing with mental health disorders in patients. They were also taught to identify the signs and symptoms of common and more complex mental health disorders and assess, manage and provide psychosocial and pharmacological interventions for depression, psychosis, suicide, self-harm and other serious mental health issues.[119]

International Medical Corps (IMC): Counsellors and psychiatrists from the International Medical Corps' Mental Health and Substance Use Services are providing in-person assistance to internally displaced persons, migrants, refugees and host communities at PHCs and polyclinics in Tripoli, Misrata, Benghazi and Sabha. Providers are a part of IMC's Mobile Medical Units (MMUs), which work to support the integration of mental health to PHC. In addition, counsellors provide educational seminars, one-on-one therapy and speciality care referrals.[119]

International Organization for Migration (IOM): The IOM implements a community-based MHPSS strategy to promote the resilience and psychosocial well-being of individuals and their communities. This strategy aims to improve access to MHPSS services and strengthen family and community care and support networks. The IOM MHPSS team provides a variety of services and activities to migrants and internally displaced persons in various urban locations in Tripoli and Zwara, including disembarkation points after rescue/interception operations at sea.[119]

IOM's MHPSS team offers individual counselling and psychological first aid, psychosocial awareness sessions, art-based psychosocial activities, support group sessions, facilitation of recreational activities for children and adults, psycho-education sessions, psychosocial assessments, remote counselling and psychosocial support through the IOM MHPSS helpline for migrants and referrals to protection, direct assistance and specialized mental health care services when needed. Apart from providing direct MHPSS services, IOM focuses on building capacity, mainstreaming MHPSS and assisting national coordination.[119]

Table 3: Current MHPSS service integration in PHC Facilities

Type of MHPSS services	MHPSS currently integrated into PHC
Tier of MHPSS action: **Responsive care**	
Early identification, screening and diagnosis of mental health conditions, including self-harm or suicidal behaviour (including standard guidelines and training for psychiatrist teams)	PHCI's programme, in cooperation with WHO and the United Kingdom, has targeted 40 PHC facilities and 30 schools in 18 municipalities throughout Libya. The results are as follows: 1. Setting a new protocol for mental health management in primary health care after consultation conference and awaiting the approval of the MoH. 2. Training of 130 physicians for 6 months to be trainers of the mhGAP Intervention Guide version 2 (IG V2) and other guidelines. 3. Training of 300 general practitioners in PHC with 6-month supervision on the mhGAP IG V2 Humanitarian version of the programme in over 40 PHC facilities. Practitioners being trained shall start carrying out their role in diagnosis and management. 4. Training of 400 teachers, social counsellors, social workers and psychologists on the mental health programme, in cooperation with the Ministry of Education, for early detection and diagnosis, and referral. 5. More than 190 trained paramedical staff in 30 PHC facilities.
Psychological first aid and emergency care	There are more than 500 doctors and nurses trained in psychological first aid.
Provision of care and management, and psychosocial support (including treatment plans and the psychosocial interventions)	PHC facilities selected by PHCI, WHO and the United Kingdom programme have been provided with essential mental health medications and shall start managing simple cases. Complicated cases shall be referred to psychiatrists in public hospitals. Treatment will be provided through the PHC facilities and the private sector, in cooperation with many organizations, as a form of MHPSS integration in PHC.

Type of MHPSS services	MHPSS currently integrated into PHC
Referral mechanism for specialized services	A referral mechanism will be established in selected facilities between the PHC doctors and supervisors who are specialist psychiatrists working in public hospitals.
Referral mechanism with other sectors	The referral between schools that received training on school mental health and doctors trained on (mhGAP V2) is established between 30 schools and primary health care centres in 18 municipalities.
Multidisciplinary care model	Not established
Care for parents and care givers	Only through intermittent NGO activities
Health information system for registering cases and mental health indicators	Indicators and data to be registered have been sent to the Health Information Centre and are yet to be included in DHIS 2 programme. Following the registered cases in trained centres (by PHCI) through KoboToolbox at this time.
Tier of MHPSS action: **Preventive care**	
Building individual assets and interpersonal skills programmes	Not available
Positive parenting care programmes	Through NGOs but there is a lack of sustainability.
Addressing the risk factors by identification, screening, intervention and referral, especially for substance use and violence	The Family and Child Protection Office of the Ministry of Interior shall provide activities and visits to schools and communities to raise awareness of risk factors, such as substance use and awareness of children and mothers regarding their rights against violence and abuse.
Safe and enabling learning environment	Not available
Tier of MHPSS action: **Promotion**	
Stigma reduction campaigns	National programme for mental health and psychosocial support to promote mental health in the southwest of the country (2012–2013), including the MHPSS promotion campaigns.
Awareness raising programmes to improve community mental health literacy	Training of 25 of community health workers for community education on mental health and their responsibility for education programmes in PHC and schools. Mostly through NGOs
Family and children and adolescent participation	Previously was available by Y-PEER network for 7 years (2013–2020) then stopped.
Linkage and coordination with other sectors	The only available coordination is between PHCI and the Ministry of Education through training programmes and referral pathways in 18 municipalities.
Policy and legislation	PHCI participated in the draft development of a national strategy of mental health, in cooperation with NCDC, MOH.

Key informant participants' feedback on the provision of current MHPSS services

Stakeholders have reported that most of promotion and preventive MHPSS services are temporary and not sustainable (**see Table 4**).

Table 4: Stakeholders' information on the provision of current MHPSS services targeting children, adolescents and mothers

Type of MHPSS services	Detailed MHPSS service provision targeting children, adolescents and mothers	Setting, poor access and referral coordination regarding MHPSS services
Responsive care	1. Treatment of mental health diseases through general psychiatric hospitals and private sector psychiatrists (the private sector is the main provider for MHPSS). 2. Provision of cognitive behavioural therapy for diabetic patients aged 0–35 years by psychologists. 3. Provision of early screening services in general hospitals, hotline services of NCDC and in the private sector. 4. Mobile clinics with mental health treatment services. 5. Conducting community zoom meetings and online services to diagnose suspected cases in outreach areas. Tele-consultation used by psychiatric doctors in Benghazi to cover the deficiency in most eastern areas, such as Tubrq city.	**The setting of MHPSS service provision:** the majority of stakeholders have reported that most services provided in private clinics are standalone mental health services and community outreach services in the form of a multidisciplinary mobile community team to support refugees and internally displaced persons. Two stakeholders reported that there were services provided in schools. The least mentioned MHPSS services are in universities and PHC facilities or related to hotlines. Stakeholders have reported that most of **MHPSS services are provided to** children (in schools as education programmes and recreational activities while raising the awareness of parents and children on sexual harassment and violence prevention programmes by the Ministry of Education), as well as to women and displaced populations. **Populations with the poorest access:** As mentioned by stakeholders, the populations with the poorest access are based in neglected areas (including rural and outreach areas, as well as the south of the country). It was revealed that the adolescent population has poor access, and that children, arrested persons, refugees and migrants suffer from severe mental health conditions. The displaced Tawergha population and girls are the least mentioned by stakeholders as those with the poorest access to MHPSS services.

Type of MHPSS services	Detailed MHPSS service provision targeting children, adolescents and mothers	Setting, poor access and referral coordination regarding MHPSS services
Preventive care	1. Facilitate learning and education programmes for students in universities during stressful events (such as displacement) to prevent mental problems and drug addiction. 2. Social workers have been newly appointed in universities to address the increase in psychological problems among students. 3. Provide sessions on fatherhood awareness. 4. Train families and parents on mental health. 5. Provide training services in life skills and parenting. 6. Raise women's and girls' awareness of violence. 7. Provide child protection services to children and parents. 8. Learning activity programme for girls progressed to small projects (sewing and crochet skills) in the south of the country through the education sector.	For **referral coordination,** most stakeholders (9 of 13) revealed that there are no organized referral systems and all are implemented in an unplanned manner. One stakeholder mentioned the referral systems, such as those supported by 4W mapping, or by the mhGAP training programme guidelines for referral. Other stakeholders emphasized that referrals are also conducted by organizations, in cooperation with WHO, to contact psychiatrists to deal with refereed cases.
Promotion	1. Provide education programmes to the community through public transport (by NGOs). 2. Focus group discussions (by NGOs). 3. Carry out recreational activities for children. 4. Raise awareness of sexual abuse prevention. 5. Health providers will link with boy scouts and the education sector for school awareness.	

Table 5: Gaps in high-priority MHPSS services provided by stakeholders

MHPSS care	Gaps in high-priority MHPSS services in each tier
Responsive care	1. Lack of MHPSS workforce specialists and multidisciplinary psychiatric teams, and shortage of psychiatrists, lack of clinical psychologists and other subspecialists. 2. Delay in early detection programmes in schools, weakness of school health programmes, absence of multi-sectoral standards of screening and early diagnosis, and unclear referral pathways for students in schools. 3. Absence of standard referral mechanisms between sectors. 4. Limited and unsustainable mental health medication supplies in PHC facilities. 5. Limited specialized centres for addiction management and rehabilitation and specialized hospitals for psychiatric paediatric admissions. 6. Limited psychological first aid programmes for acute conditions such as suicidal and post-conflict. 7. Lack of provision of sustainable MHPSS services in public clinics (provision does occur as part of private sector clinics).
Preventive care	1. Gaps in the provision of hotline services for MHPSS. 2. Lack of daily life skills, such as stress management; and lack of social and emotional learning awareness. 3. Deficiencies in parent-tailored programmes. 4. Absence of standards to address risk factors, such as substance use and survivors of violence (family violence, during war and for refugees and internally displaced persons), in terms of identification, intervention or referral.
Promotion	1. Absence of mental health law for children and adolescents, especially with those with physical and mental disabilities. 2. Absence of administrative systems and unified policies for service provision. 3. Lack of awareness of community members of the policy availability. 4. Stigma against mental health care (traditional healing methods preferred over medical consultations). 5. Diminished role of community participation in health promotion and stigma reduction programmes.

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5. Challenges and recommendations for strengthening the integration of MHPSS services in PHC

Leadership, governance and political commitment

In Libya, key informant interviews reported a lack of coordination and collaboration in governance, both at the national level (where there is a limited inter-sectoral and intra-sectoral coordination of policy and planning on MHPSS) and at the administrative and implementation levels.

The main challenge mentioned by interviewees was the availability of different high-level mental health departments/or units represented in MoH, NCDC and PHCI. Therefore, MHPSS must be placed as a priority and to be integrated in the primary health care and accordingly have its own department/unit with a multidisciplinary team at the PHCI. This team can take leadership while taking into account the interests of the whole country when integrating MHPSS services. The MoH, NCDC and PHCI should form a joint mental health committee with clear terms of references and responsibilities under the authority of PHCI's Mental Health Department, especially in light of current national stressors, including conflicts and displacements.

Stakeholders identified a lack of high-level multi-sectoral policy and planning coordination, even at the health-facility level. They also reported the existence of informal networks and relationships across sectors and subsectors due to the lack of clarity in roles, referral procedures between sectors and tools to support efficient referrals. The importance of modifying structural management to strengthen the system of governance was emphasized. The interviewees addressed the importance of inter-sectoral and inter-health sub-sectoral coordination in policy and planning actions, especially with relation to stigma, referral mechanisms and the approach to MHPSS. Interviewees also emphasized the need to increase awareness among non-health sectors of prioritizing the MHPSS with a primary sectoral focus and strengthen the structural management of PHC for mental health, which requires updating the older version of structural management and increasing the availability of psychiatrists at the polyclinic level of PHC facilities.

Key recommendations for leadership, governance and political commitment

1. Ensure national high-level policy governance coordination by the Mental Health Committee (jointly with MoH, NCDC and PHCI) to fulfil its responsibility in determining the terms of references under the authority of PHCI, which is responsible for mental health in PHC.
2. Under the authority of the Mental Health Unit in MoH, set a national multi-sectoral agenda, formulate policy, engage in planning and resource allocation, and monitor and evaluate national responses and health facilities, in coordination between different levels.
3. Form a high-level Multi-Sectoral Committee (including the health, education, social affairs, justice and interior sectors with engagement of community members, children, adolescents and parents) for mental health, established by the law and identify its key role in national level leadership to facilitate better collaboration and coordination with subcommittees regarding children, adolescents and mothers MHPSS.
4. The Multi-Sectoral Committee shall be responsible for cross-sectoral standards regarding referral mechanisms, early detection and screening, budget and resource allocation, and monitoring of the implementation of the multi-sectoral action plan on the mental health of children and adolescents and their protection rights.

5. The Mental Health Department at NCDC should fully play its role in the national development of mental health care and services should be clearly defined.
6. PHCI should play its role in policy and planning of MHPSS services for children, adolescents and mothers across the three tiers of MHPSS and monitor the activities being implemented in PHC facilities.
7. Increase the awareness among non-health sectors of prioritizing the MHPSS with their primary sectoral focus.
8. Strengthen the old version of structural management of PHC regarding mental health, which requires the availability of psychiatrists at the polyclinic level of PHC.
9. Improve the coordination at administrative and implementation levels, especially in referral systems by providing standardized referral procedures and tools.
10. Increase the awareness of MHPSS-related policies and legislation at the local level of each sector to facilitate implementation and coordination between sectors.
11. Adopt a multidisciplinary approach for each sector to facilitate the implementation process.
12. United Nations agencies, including WHO and UNICEF, should support national mental health programmes and plans.

Legislation, policy and strategy

In Libya, the Mental Health Law existed in 1959 and consists of 13 articles that were repealed and ignored, as informed by one stakeholder. Libya is one of the few Arab countries to have a Mental Health Act, which came into effect in 1975. However, it was never reviewed or put into practice, and is rarely used.[89] The current Mental Health Act No. 106 of 1973, consisting of six articles, addresses entry procedures to psychiatric hospitals and the detention process.

Currently, all legislation in Libya is in a transitional phase. The legislation of the former regime is no longer valid and new legislation is not yet available. Stakeholders have emphasized that a workshop was conducted in 2022 to present a proposal for a new mental health act with 12 articles, which has been postponed many times since the 1980s. This new mental health act focuses on the mental health of children and adolescents and their rights to protection.

The absence of effective comprehensive mental health legislation requires raising communities' and stakeholders' awareness of the importance of such legislation. It is also necessary to issue mental health legislation at every level of government across Libya and within each sector.

Stakeholders reported that the prepared draft of the mental health legislation is a separate mental health act that addresses all sectors and protects the rights of patients with mental health disorders. This separate legislation is considered more effective than a chapter in the general health law.

Challenges related to the legislation are the absence of job descriptions, legislative aspects regarding a para-psychiatrist team (psychologists, social workers, counsellors and occupational therapists), and the delay in legal procedures to facilitate the work of service providers who accompany psychiatrists.

Another challenge was the absence of legislation on budget allocation to MHPSS services provisions and providers, creating a gap in maintaining MHPSS activities and unsustainable financial support.

Stakeholders reported on the challenge presented by the absence of clear and comprehensive national mental health strategies or polices to implement the MHPSS actions. The first draft presentation workshop regarding the National Strategy of Mental Health was conducted in the November 2022 in Libya under the guidance of the National Committee for Mental Health, in cooperation with PHCI, the Mental Health Department of National Centre for Disease Control, MoH's Mental Health Unit and WHO. This national strategy contains seven goals as follows:

- establishing effective leadership and governance in mental health to develop a mental health policy, laws and programmes for the availability of the MHPSS services to children and adolescents,
- integrating MHPSS in PHC facilities,
- improving service delivery regarding addiction treatment and rehabilitation,
- ensuring sustainable and continuous availability of Mental Health medication supply,
- providing training and improving the qualifications of MHPSS human resource,
- enforcing the role of early detection and diagnosis with standard measures,
- improving the Health Information Centre and the role of researchers in engaging patients with mental health disorders in community activities.

This Committee developed short- and long-term strategies and action plans, started targeting 10 regions to open psychiatric clinics in PHC facilities, and trained general practitioners, nurses and psychologists on psychiatric programmes, as well as establishing remote psychiatry for consultation or training.

Key recommendations for legislation, policy and strategy

1. Put into practice a national mental health act by the Parliament that includes every level (promotion, and preventive and responsive care to protect the rights of children, adolescents and mothers), including MHPSS services for children, adolescents and mothers at a larger scale.
2. Increase community members' and stakeholders' awareness of the importance of mental health law availability.
3. Develop the mental health act to be a separate law and not a chapter in the general health law.
4. Dedicate separate sections to the mental health of children, adolescents and mothers in the Mental Health Act, with their rights protected at every level and in each sector in the country.
5. Determine the protection rights of children and adolescents with mental health conditions, as well as protection for those who are ignorant of such rights, and provide specific protection for children and adolescents to receive the least restrictive assessments and treatments possible, including protection from the use of physical restraints, involuntary seclusion and deprivation of liberty.
6. Enact rights for children and adolescents to receive mental health care to recover fully, with consideration of the best interests of children or adolescents.
7. Enact rights to participate in recreational activities, education and other support tailored to individual needs.
8. Facilitate finalizing the new National Strategy of Mental Health in Libya and start applying the action plan and engaging with other sectors, such as education, child protection, social affairs, interior and justice, as well as NGOs, community members, youth networks and private sectors.
9. Enforce the role of National Committee of Mental Health and NCDC for informing the next policies and strategies according to community needs.
10. Include mental health issues in all policies and recognize such action in each sector based on evidence.

Budget and financing

WHO reports that 2.1 per cent of national health budgets worldwide are allocated to mental health care programmes.[120] In Libya, the two national psychiatric hospitals account for 13 million Libyan dinars, or 0.45 per cent of the country's health budget (2012).[110, 111]

According to stakeholders in the health sector, **"the lack of government support poses the greatest obstacle to the MHPSS budget".** There is no data on the expenditures of other sectors on MHPSS-related services and programmes. An additional challenge, as identified by stakeholders, was the lack of legislation to improve government financial support and participation in the integration of MHPSS.

Stakeholders believe that the budget allocation for MHPSS should be increased and separated from other health services. They suggested requesting financial assistance from the state and from all ministries not only MOH. They also recommend, for example, that oil companies, charity organizations and external banks have the potential to be significant funding resources or indirect sources, such as through discounts for MHPSS providers as a form of incentive to support MHPSS integration. Furthermore, they recommend that expenditures on psychosocial aspects of mental health, such as mental health promotion, be increased.

Funding on mental health services in Libya should be the same as funding provided for all health services. However, due to the great shortage of human resources, it would be wise to consider some economic incentives for recruiting mental health professionals. The Parliament and Government must decide how the country's budget funds, insurance and out-of-pocket payments shall be used in the funding of health services, including mental health services.[121]

Key recommendations for budget and financing

1. Ensure separate sustainable allocation of budget to MHPSS.
2. Suggest financial assistance to be from the state or other ministries. Oil companies, charity organizations and external banks are cited as an examples of significant funding resources, or by indirect sources, such as discounts for MHPSS providers as a form of incentive to support MHPSS integration.
3. Decrease the out-of-pocket expenditure by improving MHPSS services in the public sector, especially in PHC facilities. These should be free-of-charge services according to Public Health Act No. (106). Maintain the sustainability of medical supplies and availability of diagnostic tools.
4. Study the feasibility of implementing the Health Insurance Act established in 2010 and its executive regulations in 2019, and assess the effectiveness of such in reducing out-of-pocket payments for citizens across the private sector.
5. Define the minimum essential package of MHPSS services, including child, adolescent and mother-centred MHPSS services at PHC (based on the tiered framework of actions) addressing responsive and preventive care and promotion. These can be costly, as they include defining the infrastructures, equipment, supplies, human resources and service delivery resources required by the PHC, and determine the required expenditure. UNICEF or WHO shall have a role in providing indicators to define the standard minimum service package required for PHC for integrating MHPSS of children and adolescents.
6. It is necessary to develop a financial strategy for MHPSS through a cross-sectoral budget by establishing a Sectoral Budget Committee for MHPSS as subset of the Multi-Sectoral Mental Health Committee.

Workforce

In Libya, the health, education, child protection and community sectors revealed a deficiency in MHPSS personnel (quantity of specialists in MHPSS and their qualifications) and an absence of para-psychiatric teams. One of the biggest challenges to integrating MHPSS in PHC is the limited role of service providers due to the lack of job classifications for psychologists, psychotherapists and occupational therapists in the country. Also, most qualified social workers or psychologists prefer working in the education sector rather than in the health sector.

Many stakeholders have emphasized the availability of the workforce, but the number of specialists in MHPSS service and their qualification is not sufficient. Therefore, they advised the mhGAP training to be expanded to include all physicians (including general practitioners or family physicians) in PHC facilities across all regions, and that all physicians be certified and integrated with other specialties to overcome the stigma issue. The majority of stakeholders indicate the need for providing training programmes for physicians and other specialties with upgraded learning programmes and issuing diplomas to raise their qualifications. It is also important to reactivate performance standards to monitor the MHPSS workforce (this includes the availability of psychiatrists at the polyclinic level of PHC) and provide specialized psychiatrists, such as paediatric psychiatrics and other subspecialties. For example, there is only one paediatric psychiatric physician available in the east of the country.

Stakeholders recommend reorienting newly graduated psychologists to be trained at least for six months in university hospitals and developing a national workforce strategy to include other specialists, such as psychotherapists, psychological counsellors, occupational therapists, psychology nurses and provide them with adequate training. There is also a need for social and psychological counsellors in maternal health and for counselling programmes before marriage and to tackle social issues during marriage.

Given that stigma is the main barrier for seeking medical help for mental health conditions and many community members opt for traditional or religious healers, many stakeholders emphasize the importance of educating these healers to refer suspected cases of mental health and psychosocial disorders as the first contact point due to stigma and enrolling healers in promotion services.

One of the stakeholders mentioned that nearly 200 trainees were trained in 2021–2022 in eight regions, adding to the total of those trained in last 10 years, accounting for 3,000 trainees as social workers and psychologists, especially for school health roles. Most trained personnel utilized diagnostic tools and private offices in schools to facilitate their work. The role of PHCI in the mhGAP training for physicians, psychologists and social workers in selected PHC facilities and schools must be enforced and maintained at all PHC facilities in the country.

Key recommendations for the workforce

1. Conduct detailed mapping of the PHC workforce and existing mental health competences to identify gaps in numbers, qualifications, skills and type of specialties across the health, education, social affairs, child protection and justice sectors.
2. Identify the needed roles and competencies, and develop a national workforce strategy for the mental health of children and adolescents.
3. Enhance the Community Health Workers Establishment Programme, which was launched by the PHCI; and build these individuals' skills to conduct basic screening, either in facility-based services through mother and child health or through community-based services.

4. There is a need for competent para-psychiatrists (such as psychologists, psychological counsellors, occupational therapists, social workers and psychotherapists) to be involved in pre-service training of new graduates at PHC facilities and to be able to work as part of available teams, either by having mhGAP training or undertaking another standard training programmes. It is important to provide job aids, tools and protocols to support key MHPSS actions (screening, referral, behaviour management and first aid) and private places for counselling children and adolescents, especially in school environments.
5. Standardize the MHPSS actions in each sector concerned with children and adolescents and provide a multidisciplinary team for all sectors.
6. Integrate mhGAP training in the undergraduate medical curriculum, post graduate training for all physicians and for other PHC providers, such as nurses and midwives, to provide care for children and mothers.
7. Strengthen mhGAP training in terms of child- and adolescent-tailored modules.
8. Establish supportive supervision programmes and performance indicators to monitor the MHPSS integration for children and adolescents in PHC.
9. Upgrade learning programmes like diplomas for the MHPSS providers with professional expertise as one form of incentives.

Infrastructure

Most stakeholders revealed that infrastructure in PHC facilities is available, but it is not specifically designated for the delivery of MHPSS services. It is mainly recommended to provide appropriate counselling rooms while providing the required diagnostic tools. Stakeholders have also emphasized the absence of safe spaces to assess and monitor the behaviour of adolescents through their activities. They strive to ensure that the infrastructure adheres to international standards, and emphasized the immediate necessity of opening addiction and rehabilitation centres.

Key recommendation for physical infrastructure

1. Define the minimum requirement standards regarding infrastructure availability in PHC for MHPSS integration.
2. Conduct mapping of the available PHC infrastructure while defining the minimum requirement standards in the form of buildings, availability of rooms with privacy, water, sustained electricity, adequate sanitation systems and diagnostic tools to facilitate MHPSS services. Also, create physical spaces that are comfortable and maintain privacy for individual consultation/assessment/therapy, as well as safe spaces for group activities (parenting programmes and group therapy).
3. Train MHPSS staff on updated diagnostic tools.
4. Ensure the availability of paediatric psychiatric hospitals and increase the admission wards in the hospitals.
5. Build or reorient some available centres, such as addiction and rehabilitation centres, for addressing substance abuse among adolescents. Consider the golden polyclinic level (upgraded polyclinic level of PHC to admit few patients) of PHC, based on the advice of specialized psychiatrists in this field.

Supplies (medical supplies and equipment)

One of the main challenges regarding MHPSS, as mentioned by most stakeholders, is the lack of availability of the majority of needed medicines (especially for chronic patients). In many cases, there is a shortage of affordable medications, particularly for children. Another challenge is the interruption of medicine availability due to the country's instability, coupled with a deficiency in paediatric medicine availability.

One stakeholder reported that cognitive-behavioural therapy and some medications are quite expensive, adding that "some MHPSS medications were prevented in Libya, which are considered as the best choice of treatments". Therefore, they were advised to prescribe a low-cost alternative based on guidelines and physicians' experience.

Key recommendations for supplies (medical supplies and equipment)

1. Mental health drugs should be included in the Essential Primary Health Care Medical Drug List and be available on a sustainable, regular and non-discriminatory basis.
2. Ensure drug availability based on evidence and community needs.
3. Enforce cooperation with NGOs and United Nations agencies, including UNICEF, to help ensure adequate supply of medications.

Data, health information, research, monitoring and evaluation

Several needs related to data and information were identified. At the national level, timely reliable statistics on the prevalence of common mental health conditions, risks and service delivery data (disaggregated by age, sex, location) are required to inform policies and identify the priorities to support planning, implementation and budgeting.

In this respect, several stakeholders highlighted the need of including mental health indicators in the District Health Information System-2 (DHIS-2), which was implemented in Libya in 2018 to be used in data collection. DHIS-2 can be utilized for aggregate data and for routine data collection. This DHIS-2 was mainly designed for PHC, where stakeholders recommended including the private sector, given that services for mental health conditions are now available and are being used in private sector health care facilities. Other indicators can be included in school surveys, such as GSHS, which is considered a better option to monitor longer-term trends and progress, as this survey is not conducted annually.

In addition to national data, it is necessary to include subnational data for mental health indicators in the routine data collection in other sectors, such as in the education, social affairs, child protection, justice and interior sectors, as well as data collection efforts by NGOs and the private sectors, to be used in planning, implementation, monitoring and evaluating service delivery. This will further improve sharing of data within and between sectors to support follow up on high-risk children, adolescents and families.

Many stakeholders recommended conducting a rapid assessment with national surveys on mental health, including children, adolescents and mothers, in cooperation with WHO.

Some of the research priorities mentioned were to study children's and adolescents' needs, risk factors and barriers to determine the effectiveness of MHPSS interventions, including early diagnosis, referral mechanisms and the effectiveness of e-health, such as telemedicine and hotlines. In addition, the effectiveness of service delivery models and preventive and promotion programmes was also studied. Another recommendation was made for clinical studies and the effectiveness of their therapy.

One of the challenges is the funding to conduct research. The majority of stakeholders recommended providing the appropriate tools for researchers and funding support for research either at the national level or through sectoral activities. Funding support for research should be included in the sectoral budget.

Key recommendations for data, health information, research, monitoring and evaluation

1. Integrate mental health indicators for children and adolescents into the DHIS-2 of the health sector and in other sectors, if possible.
2. Unify multi-sectoral mental health indicators to facilitate the follow up of high-risk groups and to monitor the process of diagnosed cases. This can be supported with dashboard-updated data.
3. Establish data analysis teams across each sector and relevant subsectors to improve the mechanisms for analysis, reporting and inter-sectoral sharing of data, as well as sharing across sectors, to support the implementation of MHPSS actions and continue the care of those at risk.
4. Conduct national surveys on mental health needs, risks and service delivery, such as rapid assessment tools, in cooperation with WHO.
5. Activate research at national and subnational levels with funding support allocated to each sector, and build evidence for specific actions and effective implementation models.

Service delivery (models of care, fees, costs, provider incentives and technologies)

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According to the stakeholders' description of the current situation of mental health in Libya, multiple platforms can identify entry points for delivering MHPSS actions to be integrated in PHC.

Health platform: For addressing MHPSS, many services can be integrated in PHC. For responsive care, such services include early diagnosis, screening and treating simple mental health conditions, such as depression, anxiety and PSTD in accordance with guidelines from mhGAP training for general practitioners or family physicians that were integrated with other services such as child and adolescent health, and maternal health services, reproductive health and vaccinations. Also, identify risk factors, such as violence, substance abuse, physical and sexual abuse. All the interviewed stakeholders prefer that MHPSS be integrated through mother-child services, not as standalone mental health services in PHC, at least at the beginning of MHPSS integration in PHC, to overcome the stigma barrier. In addition to providing PHC facilities at the polyclinics level with specialized psychiatrists in each municipality, with standalone mental health clinics for severe complicated cases, and on-call psychiatrists for other PHC facilities in the municipality, they recommend standalone mental health services to be provided in separate units in general hospitals rather than psychiatric specialized hospitals. The main challenge related to this model of care is the loss of interest of trained personnel. To address this, many stakeholders recommend providing incentives to maintain the role of trained personnel.

Other services that can be integrated in the PHC are constant care and rehabilitation of treated cases, as well as education programmes for families, such as parent care and support in dealing with sick children or providing support through social skills to overcome challenges related to interpersonal relations. It is also necessary to have a Multidisciplinary Team or a (Psychiatric Team) in this sector, consisting of psychologists, social workers, psychology counsellors, occupational therapists and psychology nurses in addition to physicians.

Community platform: In Libya, there is lack of community-based structures, apart from PHC facilities, that are empowered by medical and paramedical teams. Community-based services are guided by NGOs to provide responsive care through screening and referral, as well as addressing risk factors through community-based and mobile services to improve accessibility. These services were mentioned by youth representative participants as members of an NGO, who considered that there was a lack of seeking treatment for mental health conditions due to stigma issues. This included refusal of families to seek help, which served as a barrier to accessing services for children and adolescents. Home-based services are difficult but can be provided as needed by the community to provide services for those who are unable to overcome the stigma barriers to get help outside of the home or for the continuation of care for diagnosed cases. In cooperation with NGOs and PHC facilities across each municipality, this model can be further facilitated and supported by the UNICEF or other United Nations agencies.

Other sectors can serve as platforms to help deliver the three tiers of MHPSS action for children, adolescents and mothers within communities. One of these sectors is the Social Affairs Sector, which can be involved in screening and early detection of mental health conditions of affected children, adolescents and mothers. This sector can also help in the identification and provision of care for parents who are at risk or who have diagnosed mental health conditions through a standard referral system tool. This also entails addressing risk factors and developing social programmes for children, adolescents and mothers in the form of parents' care, building self-awareness assets and interpersonal skills programmes. Many stakeholders recommend adopting positive parenting and family programmes before and after marriage to improve parenting skills with regard to parents' relationships with one another and with their children.

Schools and other learning environments: Schools are crucial distribution channels for MHPSS to reach a significant number of children and adolescents. However, "inadequate long-term planning and sustainable mental health and social service support were identified as the most significant barriers to the delivery of MHPSS services", as stated by an education sector informant. Focusing on improving early identification and screening, and contributing to the multidisciplinary team and continuation of care are some of the main challenges in learning environments. It is important to take the necessary actions to build individual assets and promote positive peer relationships to help create safe environment. The current school psychologist and social worker training programmes, led by PHCI, must be expanded to all schools while maintaining the delivery of MHPSS actions in cooperation with the Health Sector.

Accessible MHPSS services will be provided at least in one PHC facility in each municipality, providing MHPSS as integrated with other mother and child health services. It is essential to raise awareness of the population through awareness campaigns about MHPSS. Online services for MHPSS actions will be accessible for outreach, including in marginalized areas and to people with disabilities. These campaigns will work to overcome stigma barriers. As stakeholders mentioned, online services shall be in the form of hotline services to diagnose and refer cases, or as telemedicine to diagnose and help treat mental health conditions, or as call consultations to coordinate with specialists to help overcome the deficiency in the number of psychiatrists. This necessitates the availability of a psychiatrist at least in each region or high-density region for consultation by local general practitioners or family physicians in PHC facilities. All of these services were found to be effective in the far east of Libya when contacting specialized psychiatrists in Benghazi, in cooperation with general practitioners, in that region to further diagnose and treat complicated cases.

According to an informant in the youth sector, "We use the Speetar platform application as a digital technology to provide MHPSS...because it offers a high level of privacy and saves more time." This platform was widely used during COVID-19. It was accepted, less costly and secure for many populations. It was then approved by MoH in 2020 and is considered as the official e-health platform.

Peer delivery of MHPSS services have been provided by the Y-PEER organization in Libya for over seven years (2013–2020) to support community- and school-based delivery of MHPSS. One of the participating stakeholders noted that building adolescents' trust helps provide information to peers and facilitates identifying mental health conditions and/or addressing risk factors. The challenge here is parents' refusal to have their children engage in MHPSS activities because they believe that these activities can affect their educational qualification. Participation of youth and peer organizations in improving the mental health literacy and early identification and referrals is recommended as it benefits both providers and seekers.

Integrating MHPSS in a sustainable manner, as a free of charge service according to the Public Health Act No. 106), in PHC makes MHPSS action accessible to the population. The corruption in the political system after the 2011 conflict has negatively affected the availability of public health services, making those who are financially capable seek health care in the private sector with high-cost out-of-pocket expenditure on mental health. Therefore, it is essential to study the feasibility of applying the health insurance system to build a strategy for decreasing out-of-pocket expenditure for mental health along with other services.

Referral of acute cases should be made to specialized hospitals or to the polyclinic level of PHC, if applicable, depending on the availability of a specialized psychiatrist and the need for inter-sectoral coordination to refer cases according to a unified standard referral tool. The referral system can be improved or facilitated by telemedicine and e-health. All the platforms mentioned can be applied in each municipality to be accessible for the whole population.

Key recommendations for service delivery

1. Integrate MHPSS services into mother and child services, adolescent health, reproductive health, and vaccination services in PHC across the three tiers of action. In responsive care, these services include early diagnosis, screening and treating simple mental health conditions, such as depression, anxiety and PTSD. Preventive care includes identification of risk factors, such as violence, substance abuse, and physical and sexual abuse; and education programmes for families, such as training for parental care and social skills as well as participation in stigma-reduction and awareness-raising programmes.
2. Strengthen the integration of mental health into PHC services to increase accessibility by encouraging general practitioner/family physician training programmes and providing incentives to maintain their role.
3. Develop standard models of child and adolescent-centred health services for MHPSS across each sector.
4. Strengthen the role of community-based organizations and NGOs with youth networks with support from United Nations agencies, including WHO and UNICEF, to share in the community and promote mobile-based services, in cooperation with PHC facilities, for further responsive care and referrals of suspected cases.
5. Integrate the role of youth and adolescents in supporting the community- and school-based delivery of MHPSS to improve mental health literacy, early identification, first aid, referrals and attention to building their capacities.
6. Focus on the school-based model to support areas with a large population of children and adolescents by strengthening responsive care, mainly through identification of cases. Strengthen the preventive actions to be adopted through a standard of cooperation and referral tool with PHC facilities.
7. Raise the awareness of parents' care by detecting harmful parenting practices, addressing parental mental health, providing training and information on positive parenting practices, and education on interpersonal skills with specific programmes for pre-marriage education through the Health Sector: reproductive health, and mother and adolescent health in PHC; Community Platform and Social Affairs Sector. Awareness raising can be further applied across the School Sector for late adolescents by adopting standardized guidelines through a multi-sectoral system committee.
8. Evaluate online and digital services and determine the type of MHPSS action provided through standard protocols and which should cover the three tiers of MHPSS action, prioritizing children, adolescents, mothers and family care, asset-building services and interpersonal skills to be used in marginalized areas and in consultation calls.

Quality of care

Stakeholders in the health sector have indicated that the absence of practice guidelines for each mental health discipline is one of the main challenges to MHPSS integration in PHC in Libya. Therefore, it is necessary to conduct a high-quality assessment of quality assurance by PHCI and the MoH's Mental Health Department to further assess, monitor and test the operational procedures that reflect the new Mental Health Act and new strategies.

Stakeholders recommended designing guidelines for each MHPSS specialty provider (their responsibilities and type of services provided): psychiatrists, psychologists, social workers, nurses and occupational therapists. They emphasized the need for standardized tools for early identification and screening for common mental health conditions among children and adolescents across sectors, as well as standard protocols and operational procedures for referrals, management, preparation for release, maintenance and rehabilitation care.

It is worth mentioning that a set of treatment standards were required by stakeholders to follow the American Psychiatric Association and the Royal College of Psychiatry in treatment protocols, as well as standard management like electroconvulsive therapy, which is not used in Tripoli and is used in Benghazi. It is necessary to standardize the Diagnosis Classification according to the International Classification of Disease (ICD10) or Diagnostic and Statistical Manual of Mental Disorders (DSM 5th edition). It was also advised to provide standardized curriculum in universities to all specialties of MHPSS.

Recommendations were also made to unify the management of mentally ill patients who are inherently aggressive in an appropriate and humane manner, standardize effective affordable treatment types and ensure the nutrition of each patient using monitoring indicators to assess the effectiveness.

Stakeholders stressed that the new mental health plan should be developed according to the situation analysis and targeting the main gaps in MHPSS integration in Libya. This includes addressing the limited number of the MHPSS providers by raising the productivity of those present and maintaining their positions, and providing incentives and certifications for their performance, improving their distribution and striving to increase their number in long-term plans.

Key recommendations for quality of care

1. Define multi-sectoral indicators to monitor and evaluate the MHPSS performance by the MoH's Mental Health Department and PHCI's Mental Health Unit (for MHPSS of children, adolescents and mothers) to the three tiers of MHPSS actions.
2. Specialized psychiatrists and other para-psychiatric specialists should continuously evaluate and enhance MHPSS services of children and adolescents.
3. Standardize the tools for early identification and screening of common mental health conditions among children and adolescents to be locally adapted in each sector (formed by the Scientific Committee of Mental Health Specialists or through the NCDC and implemented by PHCI).
4. It is necessary to standardize protocols and procedures across sectors with regard to children and adolescents for referrals within and between sectors to ensure that each sector enables each child to exercise their right to be appropriately diagnosed and treated.
5. Develop the minimum standard requirements of MHPSS providers in PHC while monitoring their availability and quality.

Engagement of the community and participation

Mental health-related stigma and the lack of mental health literacy are major barriers to integrating MHPSS in PHC. Limited mental health literacy among children, adolescents and parents have also contributed to the delay in seeking care.

Engagement of communities and participation of children, adolescents and their families in the delivery of policies, programmes and services is essential to ensure that their needs are met. As mentioned by the youth representative from the university: "they should include the youth in policy forming and planning regarding mental health issues". This may include those who had previous mental health conditions to share their experiences and to set mental health as a high priority in designing policies.

Most key informant interviewees emphasized that community members have had no role to play in the past. However, one of the stakeholders mentioned that certain activities were carried out from 2013–2020 including education programmes on mental health, drug addiction and AIDS for children and adolescents, under the supervision of the Y-PEER network. They had positive responses in diagnosing cases; however, such activities were stopped due to families' and school stakeholders' refusal to continue such programmes out of fear of affecting students' performance.

One of the challenges in Libya lies in raising the family and communities' awareness of the importance of their participation. Providing opportunities for training, capacity building for youth leaders and counsellors to help in peer-led early identification, referral and support are one of recommendations made. In addition, there is a need for more formal mechanisms for linking the government agencies directly to communities, and for also linking with non-governmental support, such as civil society organizations and NGOs, in cooperation with WHO.

Strengthening the mechanisms for community monitoring is of high importance. Stakeholders recommended that each municipality should have a mental health office with community engagement and youth representatives to develop key indicators for monitoring progress and evaluating responses to MHPSS local needs. In addition, municipalities should cooperate with NGOs, UNICEF and WHO to identify the indicators and the process of monitoring and evaluating community engagement.

Key recommendations for engagement of community and participation

1. Build capacities and further engage youth and youth organizations to participate in MHPSS policy, planning and implementation support in addition to their participation in the administrative process.
2. Empower youth in policies, planning and implementation. Such initiative must come from parties who set the policies, be it a ministry, a committee of ministers, PHCI, or other agencies/departments, or through student unions, youth civil society associations, youth associations and other organizations.
3. Build the skills and capacities of community organizations on MHPSS, which is essential to screening, identification and referral to PHC.
4. Raise the awareness of family and community members of the importance of their participation, in cooperation between the PHC and local community organizations.
5. Strengthen feedback, monitoring and evaluation mechanisms.
6. Engage youth representatives in developing key indicators to monitor progress and evaluate responses to MHPSS local needs, with involvement from NGOs and United Nations agencies to identify the indicators and the monitoring and evaluation process.

6. Conclusion and overarching recommendations

Children and adolescents aged 0–18 years and mothers in Libya are exposed to a high burden of poor mental health, especially after the upsurge of political crises since the initial protests in 2011, leaving the mental health of the Libyan population significantly affected. With the outbreak of the COVID-19 pandemic, there were more unmet needs for services and inadequate support to respond to mental health conditions, prevent poor mental health and ensure safe and enabling environments for psychosocial well-being.

Libya is currently exerting effort to address child and adolescent mental health by providing mental health services and school-based programmes to support early identification and prevention of poor mental health, and to integrate of mental health services and support in PHC facilities through the mhGAP training by PHCI. MOH is striving to set new mental health standards to transform the institution-based approach to a community-based approach to mental health care to be available across the country. The MOH is also supporting activities that target promotion and awareness raising and activities on responsive care, in cooperation with PHC facilities and the private sector.

However, access to services is still far from universal and unmet needs remain prevalent. This report identifies significant gaps in the current MHPSS response in PHC facilities. There are a very limited number of services that cater to the mental needs of children and adolescents in PHC (that received the mhGAP training) and excessive dependence on tertiary, institutional-based care and the private sector that is coupled with the stigma barrier, which contributes to a significant number of unmet needs and delays in accessing services. There is also a lack of standardized early diagnosis tools for mental health, including for the detection of risks for self-harm and suicide. The absence of standardized referral protocols is a contributing factor to the delay in obtaining services and support, as most of referrals are made in informal ways. In addition, there is an absence of protocols for addressing risk factors, positive prevention care programmes and programmes for interpersonal skills. It is necessary to develop comprehensive and coordinated approaches to promote mental health in communities, especially given the shortage of MHPSS professionals. There exist significant gaps in programmes that cater to marginalized, out-of-school and migrant children and adolescents.

Challenges in the implementation of MHPSS-related programmes are the inadequacy of budgetary resources and inadequacy in laws concerning mental health for children, particularly for those with physical disabilities, and unclear unified governance, policies and plans for mental health services in PHC. Findings show that the main challenge in all sectors is the inadequate number of skilled personnel, which is a significant obstacle to implementation. This factor results in increased workload, prolonged wait times for care and inconsistent delivery of interventions.

Overarching recommendations

1. Put into practice a national mental health act by the Parliament that covers all three tiers (promotion and preventive and responsive care) of MPHSS, with specific consideration for the protection and rights of children, adolescents and mothers. The mental health act must be in a separate law and not a chapter in the general health law.

2. Increase the awareness of community members and stakeholders of the importance of mental health law availability, and increase awareness among non-health sectors of prioritizing the MHPSS within their primary sectoral focus.

3. Facilitate finalizing the new national strategy for mental health in Libya and start applying the action plan while recommending engagement of other sectors, such as education, child protection, social affairs, interior and justice, as well as engaging NGOs, communities, youth networks and the private sector.

4. Ensure national high-level policy governance coordination by the Mental Health Committee (formed jointly with MoH, NCDC and PHCI) and ensure fulfilment of their responsibility in determining the terms of references under the supervision of PHCI, which upholds the integration of mental health in PHC.

5. Develop standardized tools for early identification, screening, referral procedures and specific management of common mental health conditions among children, adolescents and mothers in PHC and a locally adapted tool for the health and other sectors.

6. Form a high-level multi-sectoral committee (including the health, education, social affairs, justice and interior sectors) with engagement of community members, children, adolescents and parents for mental health, established by the law. The committee must play a key role in national-level leadership for cross-sectoral standards on referral mechanisms, early detection and screening, budget and resource allocation, while ensuring the implementation of a multi-sectoral action plan on children and adolescents' mental health and their protection and rights.

7. Increase the government's budget allocation towards child and adolescent mental health services, defining the minimum essential package of MHPSS services, including for children, adolescents and mothers. MHPSS services for responsive, and preventive care and promotion should be costed, including defining the infrastructure, equipment, supplies, human resources and service delivery required by the PHC. Decrease the out-of-pocket expenditure by improving MHPSS services in the public sector, especially in PHC facilities (free of charge services according to Public Health Law No. 106) and maintain the sustainability of medical supply and availability of diagnostic tools in the public sector.

8. Integrate the MHPSS services in PHC into other services, such as mother and child services, adolescent health, reproductive health and vaccination services in PHC. It is necessary to develop standard models of child- and adolescent-centred health services for MHPSS in each sector in the three tiers of action: for responsive care include early diagnosis, screening and treatment of simple mental health conditions; for preventive care include identification of risk factors such as violence, substance abuse, physical and sexual abuse and education programmes for families, such as parental care and social skills; and for promotion include stigma reduction awareness programmes.

9. Strengthen the role of community-based organizations, NGOs and youth networks through support of United Nations agencies. WHO and UNICEF should engage in community initiatives and provide mobile-based services in cooperation with PHC facilities for further responsive care and referral of suspected cases, as well as support interventions to overcome stigma issues related to mental health care.

10. Conduct detailed mapping of the PHC workforce to identify gaps in numbers, qualification, skills and type of speciality. This should be undertaken across the health, education, social affairs, child protection and justice sectors. It is also necessary to strengthen the MHPSS workforce through:

    a. Integrating mhGAP training into the undergraduate medical curriculum and post-graduate training for all physicians and other PHC providers, such as nurses and midwives to provide care for children and mothers.

    b. Upgrading the learning programmes, such as diplomas for the MHPSS providers to help them acquire professional expertise as one form of incentive.

    c. Enhancing the quality of pre- and in-service training programmes for health care practitioners, social welfare personnel, justice sector employees, educators and other school-based staff to ensure that their roles and responsibilities regarding MHPSS are properly aligned.

    d. Developing job descriptions for identified roles across sectors and enhancing the role of multidisciplinary team.

11. Ensure unified drug availability based on evidence and community needs and recommendations on a sustainable regular basis, and include mental health drugs in the Essential Primary Health Care Medical Drugs List.

12. Conduct mapping of the available PHC infrastructure and define the minimum requirement standards for the availability of infrastructure in PHC for MHPSS integration in terms of the availability of equipped buildings and rooms, water supplies, sustained electricity, good sanitation systems and diagnostic tools to facilitate MHPSS integration. This also includes creating physical space that is comfortable and allows privacy for individual consultation/assessment/therapy, as well as creating safe spaces for group activities (parenting programmes and group therapy).

13. Reopen the available centres for addiction and rehabilitation for substance abuse, which can include addressing adolescents; and strengthen the old version of structural management of PHC regarding mental health that requires psychiatrists in the polyclinic level of PHC.

14. Integrate unified mental health indicators for children and adolescents into the DHIS-2 of the health sector and include other sectors to facilitate the follow-up process of high-risk groups and diagnosed cases. This can be supported with dashboard-updated data.

15. Conduct national surveys on mental health needs, risks and service delivery, such as rapid assessments, in cooperation with WHO. Activate research at national and subnational levels while ensuring funding support allocated to each sector and build evidence for specific actions and effective implementation models.

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Appendix

COUNTRY CONSULTATION AGENDA AND INTERVIEW GUIDE

LIBYA CONSULTATION WORKSHOP

ESTABLISHING THE FOUNDATIONS FOR THE INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) IN PRIMARY HEALTH CARE IN THE MIDDLE EAST AND NORTH AFRICA REGION

DATE: 3 December 2022

Objectives:

- Provide an overview of the research project objectives and approach.
- Present key findings from the desk-based review.
- Explore existing mechanisms for the delivery of MHPSS through primary health care, including challenges, linkages and opportunities,

Participants:

- UNICEF Office (Child Protection, Education and Benghazi Field Office)
- Ministry of Health (policymakers and stakeholders) at national and regional levels
- Health Information Centre (MOH)
- Representative of mental health service providers
- Ministry of Social Affairs (policymakers and stakeholders) at national and regional levels
- Ministry of Education (policymakers and stakeholders) at national and regional levels
- Ministry of Youth
- United Nations agencies: UNICEF, WHO, IOM, UNHCR
- INGOs: GIZ, MSF, ICRC, IRC, IMC, ACF
- UNICEF Bayti Centre INGOs (Cesvi, Intersos).
- UNICEF Bayti Centre CSOs (Future Makers and Friends of Cancer).
- Representatives for persons with disabilities

Agenda of the Consultation Workshop

Time	Activity	Facilitator
Session A: Introduction		
9:00 – 9:10	Welcome remarks and objectives of the workshop	UNICEF / Country TAG Chair Dr. Mawaheb Shelli Dr. Noureddin Bohelfaia (PHCI Representative)
9:10 – 9:20	Introduction to MHPSS and primary health care **Presentation:** Definitions of mental health and psychosocial well-being and common mental health conditions and risk factors Definitions and scope of MHPSS for children and adolescents, and maternal mental health The rationale for delivery through PHC and definition of the PHC system (including multi-sectoral linkages)	Country Lead: Dr. Maryam Zayid Saeid
Session B: Overview of Project		
9:20 – 9:30	Overview of project objectives, approach, and expected outputs **Presentation** of the project overview and objectives of the Workshop	Country Lead: Dr. Maryam Zayid Saeid and Dr. Khawla Alghazal
9:30 – 9:45	Key findings from the desk-based review **Presentation** of key findings: • Burden of mental health needs and risk factors and barriers to accessing care • Overview of the mental health system and implementation at the PHC level • Current challenges impacting the implementation Questions and discussion	Country Lead: Dr. Khawla Alghazal

Time	Activity	Facilitator
Session C: Mapping Existing Approaches to Deliver MHPSS for Children, Adolescents and Maternal Mental Health		
9:45 – 10:15	**Group activity:** • Break into small groups (organized by main sector, with youth representatives joining groups of their choice) • Each group to discuss questions below (nominate a note taker and someone to report to main group) **Questions:** • What MHPSS services are being currently delivered at primary health care or at the community level through your sector (consider actions in relation to care for those with mental health conditions, prevention of poor mental health and mental health promotion)? • How are these services delivered (in which settings/facilities and by which types of providers/ workforce? • What are the existing linkages with other sectors?	Country Lead and UNICEF to assign participants to groups prior to workshop (aim for one group per sector – if the health sector is too large, then groups can be separated into maternal mental health and child and adolescent mental health) Country Lead to explain the task and discussion questions If virtual, can use Zoom breakout and Jamboard (or similar) If in-person, flip charts and markers provided
10:15 – 10:30	**Group feedback and discussion** Each group provides feedback to the main group (5 minutes given for each small group) Identify any gaps in MHPSS	Country Lead to facilitate
Break (15 minutes)		
Session D: Challenges and Opportunities to Strengthen MHPSS		
10:45 – 11:20	**Group activity:** • Break into five small groups (can be mixed sectors) • Each group is assigned system-strengthening topic / lever: o Workforce o Governance and coordination o Financing o Participation o Service-delivery (models of delivery, guidelines, standards) • Problem tree analysis to explore current challenges that relate to this topic • Topics can be considered across sectors	Country Lead and UNICEF to assign participants to groups prior to workshop Country Lead to explain the task and outline the main system-strengthening topics If virtual, can use Zoom breakout and Jamboard (or similar) If in-person, flip charts and markers provided

Time	Activity	Facilitator
10:45 – 11:20	**Description of activity:** • Draw a large tree on a flip chart • Write the 'systems' topic on the trunk of the tree • Discuss the challenges that relate to this topic and write these on the tree roots (the 'root causes') • On the branches, write the impact of these challenges on implementation of MHPSS in primary health care • Choose one 'root cause' and discuss what could be done to address this challenge **Example: Problem Tree Analysis:** • Workforce is the topic (on the trunk) • Root causes/challenges could be insufficient numbers of health providers, teachers and/or counsellors; lack of MHPSS training; limited supervision; and/or heavy workloads • Impacts could be poor quality of MHPSS, lack of service availability, and/or over-reliance on referral to specialist care • Recommendation to address challenges could be improved pre-service training in mental health for all primary-level providers (health workers, teachers, etc.)	
11:20 – 11:45	**Group feedback and discussion** Each group feedbacks to main group (5 minute each per small group)	Country Lead to facilitate
11:45 – 12:00	**Questions and next steps** **Workshop closure**	UNICEF/Country Lead

Key Informant Interview Guide

Interviewer ID:		Date (DD/MM/YY):	
Start Time:		End Time:	
Participant ID:		Sector / Organization:	
Current Designation / Role of Participant:			
Age of Participant		Gender of Participant:	
Consent obtained?	YES / NO		

Thank you very much for agreeing to participate in this interview.

Today we will ask you to share your views and opinions about how to integrate mental health and psychosocial support services (MHPSS) for children, adolescents and pregnant / postpartum women, within the primary health care system in Jordan. This will include questions about your thoughts on the mental health needs of children and adolescents and maternal mental health, what role your sector currently plays in the delivery of support services and the challenges and opportunities to improve the delivery of MHPSS in primary care.

By MHPSS, we mean any services or supports to diagnose and treat mental health conditions to prevent poor mental health and thus promote mental health and psychosocial well-being.

This could include:

- Services for children, adolescents, or pregnant women/mothers who have mental health conditions (screening, clinical care, multi-disciplinary care and support, continuing psychosocial support to support recovery and rehabilitation)
- Preventive interventions to address risk factors for poor mental health or enhance protective factors (supporting social and emotional learning, addressing peer victimization and positive peer support, building parenting skills, prevention and response to specific risks, such as violence or substance use)
- Mental health promotion (efforts to reduce stigma and discrimination, or improve mental health awareness and literacy)

The session today will take approximately 60–90 minutes.

Participating in this project is voluntary. Kindly note that you do not have to answer any questions that I ask and we can stop the interview at any time. If you do not want to answer a question or would like to stop the interview, you do not have to give a justified reason for such. If you wish to withdraw from the project after our discussion, please do not hesitate to contact the study team and the information that you shared will be destroyed.

With your permission, I will be taking notes and recording today's interview to make sure we gather all your ideas. Everything you say will remain confidential. Your responses will not be shared with your manager or employer, and they will not affect your role or employment.

What we learn from this interview will be compiled with the responses from other interviews. A summary of the key findings will be shared with government representatives and UN agencies in this country and in Middle East and Northern Africa region. They will also be used to develop recommendations to improve the delivery of mental health support services in [**country name**] and the region. No personal information identifying you or your organization or employer will be included in any reports or other documents.

Please confirm the participant's consent to continue and have the interview recorded.

HEALTH SECTOR STAKEHOLDERS
Could include government as well as NGO and UN representatives focused on health

Theme	Questions
1. Mental Health Needs of Children and Adolescents	**I would like to start by asking what you think the main mental health needs or problems are of children / adolescents / mothers in Jordan.** • Children (<10 years) • Adolescents (10–18 years) • Pregnant and postpartum women (maternal mental health) • Are there particular groups who have worse mental health than others have, or are at increased risk? Why? (e.g., girls v boys, pregnant adolescents, refugees, migrants)
2. Current MHPSS Provided Through Primary Health Care	**I would like to ask you about the different mental health and psychosocial support services that are currently provided through primary health care.** **What types of services are provided and what mental health needs do they address?** • Children • Adolescents 10–19 • Maternal mental health Some **examples** to probe could include: • Screening, early identification and diagnosis • Triaging and assessment • Treatment and management of mental health conditions (including developmental disorders) • Continuity of care / multi-disciplinary case management • Mental health facilities / residential care • Screening and management of risk factors (exposure to violence, abuse, neglect, bullying, substance use, etc.) • Parenting support • Linkages with schools or communities for mental health promotion **How are these services currently being delivered?** • Who provides these services (which types of providers/workforce)? • How are they delivered - are they standalone mental health services (such as community mental health clinics) or integrated with other services (such as general outpatient clinics, maternal and child health, nutrition programmes, outreach services, school-based services)? • Who uses these services? • Are there any population groups that face additional barriers to access (rural families, refugees, displaced populations or migrant families)?

Theme	Questions
3. How Could MHPSS Be Strengthened	**I would like to ask you about what additional mental health and psychosocial supports or services could be integrated into primary health care.** **Are there any mental health and psychosocial supports or services that you think could be provided through primary health care that are not currently being provided? Can you describe these? (i.e., what services could be integrated into primary health care?)** Some **prompts** could include: • Additional services to identify or screen mental health conditions • Management (including multi-disciplinary support and case-management) • Services to identify and address risk factors (violence, bullying, substance use) • Parenting programmes and support • Outreach, community-based and school-based services Which of these would be the highest priority in your opinion?? How could these be delivered? • Integrated with existing services (if so, which ones)? • Establishing new services / programmes specifically for mental health? • Community-outreach or school-based? • Linkages with communities and community-based organizations • Who (which providers) should be engaged in delivering these services?
4. Linkages	**What are the existing linkages and referral mechanisms with secondary and tertiary- level care, including specialist mental health services? How could these be strengthened?** **What are the existing linkages and referral mechanisms between primary health care and other supports / sectors (schools, social welfare, NGOs)?** • How are mental health referrals to primary health care from schools, child protection, NGO or other services currently managed? What are the challenges? • What referrals are made by primary health care to other MHPSS supports (e.g. child protection, special education, social protection, etc.)? What are the challenges? • Are there any examples of coordinated programmes or services provided by primary health care and other sectors to address mental health and well-being? For example: o School-based screening, counselling, support o Multi-disciplinary case management of those with mental health conditions o Multi-disciplinary case management for children or families at increased risk **What role could other sectors (social welfare, social protection, child protection, education) have in supporting primary and community-based mental health for children, adolescents and their families?** **What would be needed to strengthen these linkages and coordination?**

Theme	Questions
5. Current Barriers and Enablers	**I would like to ask you about the current challenges in delivering or integrating MHPSS into primary health care** • What is **currently being done well** to address the mental health of children, adolescents and maternal mental health through primary health care? • What do you think could be improved or strengthened? • In your opinion, what are the main challenges in delivering MHPSS through primary health care?
6. PHC Levers	**I would like to ask you about some specific challenges related to integrating MHPSS through primary health care and your perspectives on how these challenges might be addressed** These are suggested prompts that could be explored in the sections above, or included here if not already covered. Please ask about challenges and recommendations in relation to: • **Political Commitment and Leadership** o What is needed to increase political commitment for MHPSS? • **Governance and Policy Frameworks** o What additional policies, strategies, or guidelines are needed to support implementation of MHPSS through PHC? o What legislative changes are needed (e.g. changes to mandatory parental consent for adolescents) o How could governance and coordination of MHPSS be improved – at national level and at sub-national level? o How could coordination be improved with other sectors (such as education and child protection)? • **Funding and Resource Allocation** o How is MHPSS through primary care currently budgeted for and funded? Who makes decisions about funding allocation? Are there sufficient resources to implement MHPSS? o What systems or structures are needed to improve coordinated budgeting and resource allocation? • **Engagement of Communities and Adolescents** o To what extent are children, adolescents and their families, engaged in designing, implementing, monitoring and evaluating MHPSS? How could this be strengthened – what role should they have? • **Models of Care** o How could MHPSS be more effectively delivered through primary care – what are the features of accessible delivery-models? o What are your perspectives about the accessibility and feasibility of stand-alone versus integrated mental health services? Are there other models (outreach, mobile, school-based, digital) that would be important? o Are there specific considerations to ensure equitable access (e.g. to improve access for unmarried adolescents, refugees, rural settings, out- of-school youth and marginalized people)

Theme	Questions
6. PHC Levers	• **Workforce** o What is needed to support a competent MHPSS workforce at primary care level? - Number of trained providers - Training needs (what skills do they need) – should this be through mhGAP or other training? - Supervision - Job aids / tools - Role of accreditation / professional associations o Is or could MHPSS be integrated into existing provider roles (e.g. as part of the role of MCH nurses) and/or are new providers needed to delivery these services? • **Infrastructure** o What infrastructure is needed to support delivery of MHPSS through primary health care? (e.g. private counselling rooms) • **Medicines and Other Supplies** o Are there any challenges in relation to supply of affordable medicines and other products for mental health? How could these be addressed? • **Private Sector / NGOs / UN Agencies** o What role does or could the private sector have in supporting MHPSS? What structural or systems changes are needed to enable this? o What role do or should NGOs have? o What role do or should UN agencies have? • **Purchasing and Payment** o Are mental health services included in UHC or national health insurance? o Do clients pay for user mental health services? In-patient? Outpatient? o Are there other indirect costs for clients seeking mental health services and support? o How could these be addressed? o Are there other incentives (such as provider incentives) that would improve delivery of MHPSS? • **Digital Technologies** o What e-health interventions are, or could be, provided for MHPSS? For example, crisis hotline. o Are there any challenges using these technologies for children, adolescents and their families?

Theme	Questions
6. PHC Levers	• **Quality of Care** o Are there national standards for mental health service delivery? How could these be strengthened? o Are there processes for accreditation or certification of providers and/or facilities that provide mental health services? o How is quality monitored and measured? How could this be improved? o What feedback mechanisms are in place for children, adolescents and families to register complaints or other concerns about quality of care? • **Research, Data, Monitoring and Evaluation** o What are the key knowledge gaps or research priorities to support delivery of MHPSS? o What routine health information systems data (and processes) would help strengthen implementation?
7. Final Recommendations	**Reflecting on the challenges and recommendations you have described, what do you think are the highest priority actions or next steps needed to support delivery MHPSS through primary health care?**
8. Any Other Issues	**Are there any other comments or suggestions you would like to raise that we have not yet covered today?** I will go over a summary of what we have discussed. if you would like to add or change anything you have said, please let me know.

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