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Psychosocial Centre

Scoping report:

**INTEGRATING MENTAL
HEALTH AND PSYCHOSOCIAL
SUPPORT WITHIN NON-
COMMUNICABLE DISEASE
PREVENTION AND CARE IN
HUMANITARIAN RESPONSE**

An exploratory review

August 2021

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Please note:

The partners in this initiative wish to create an environment of trust and knowledge/lesson-sharing. Please do not hesitate to contact us with any comments, reflections, experience, concerns, or corrections to this scoping report.

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Abbreviations

ARCS	Armenian Red Cross Society
CBHFA	community-based health and first aid
CETA	common elements treatment approach
HLM	(UN) High-level Meeting
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IDP	internally displaced people
IFRC	International Federation of Red Cross and Red Crescent Societies
IRC	International Rescue Committee
KRCS	Kenya Red Cross Society
LMICs	low- and middle-income countries
LSHTM	London School of Hygiene and Tropical Medicine
M&E	monitoring and evaluation
mhGAP	mental health Gap Action Programme (WHO)
MHPSS	mental health and psychosocial support
MOOC	massive open online course
the Movement	the International Red Cross and Red Crescent Movement
MSF	Médecins Sans Frontières
NCDs	non-communicable diseases
PLWNCDS	people living with NCDs
PSS	psychosocial support
RCT	randomised controlled trial
UNHCR	United Nations Refugee Agency
WHO	World Health Organization

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1. EXECUTIVE SUMMARY

This scoping report is the concluding output of a year-long initiative by the IFRC Reference Centre for Psychosocial Support, the Danish Red Cross and the University of Copenhagen, which has explored whether and how mental health and psychosocial support (MHPSS) and non-communicable disease (NCD) prevention and care should be integrated in humanitarian response/settings. It is an exploratory, practice-based evidence building approach, using a variety of research methods to draw out the current state of play and prevailing opinions on integration: desk research (a grey literature review and the development of a scientific commentary), a series of key informant interviews, the development of four case studies, and a virtual roundtable event. The report takes the form of a suite of materials that, between them, form a knowledge base that can act as a launch pad for research, practice, and guidance into the future:

- The main body of the report first sets out the rationale for this initiative and the global context in which it takes place: the global burden of NCDs (including mental ill-health) and the growing realisation that this is highly relevant in humanitarian response. This is followed by a summary of the overall findings of the research, including the advantages of and barriers to integration and the impact of the COVID-19 pandemic, and provides a clear steer on key learnings that can direct future policy, guidance, and action.
- The first annex presents four case studies of MHPSS/NCD integration, detailing initiatives in Armenia, Jordan, Kenya and the Philippines.
- Annex 2 is a table of 16 further examples from around the world, demonstrating the broad array of approaches being taken to integration of MHPSS and NCD prevention and care.
- Annex 3 present summaries of eight key informant interviews, held in 2020/21 with experts from within the Red Cross Red Crescent Movement, from the London School of Hygiene and Tropical Medicine, the International Rescue Committee, the NCD Alliance and the World Health Organization.
- The fourth and fifth annexes briefly outline other outputs of the project: a grey literature review (undertaken by the IFRC PS Centre) and a scientific commentary developed by the project partners (led by the University of Copenhagen), which is currently seeking publication.
- The final annex is a meeting report of a roundtable held virtually in June 2021, bringing together 37 participants from 11 organisations from Europe, Latin America, Africa and Asia.

A clear conclusion is that there is widespread enthusiasm and support for the integration of MHPSS and NCD care and prevention in humanitarian response. The project partners hope that the new thinking and coordination that has been catalysed by the consultations and roundtable will continue, with benefits for people living in humanitarian settings across the world.

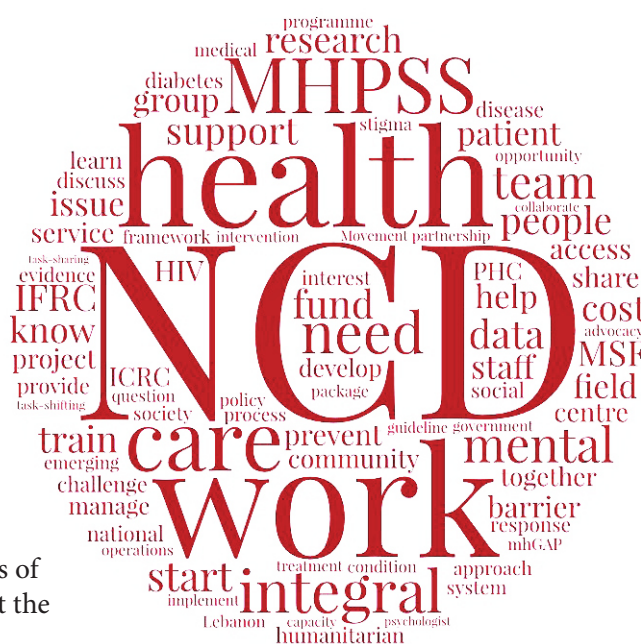


Figure 1: The main themes of the project, as discussed at the roundtable

2. INTRODUCTION TO THE PROJECT

2.1 NCDs and MHPSS in humanitarian settings

Noncommunicable diseases (NCDs) – including cardiovascular diseases, cancers, diabetes, mental-ill health¹ and chronic respiratory diseases* – are the leading cause of mortality globally and a major health challenge of this century. They account for three out of every four years lived with disability,² and mental ill-health alone accounts for almost 23 per cent of years lived with disabilities.³

Each year, over 72 per cent of all deaths (approximately 41 million people annually) die from NCDs, and over 85 per cent of these deaths occur in low-and middle-income countries (LMICs),⁴ where NCDs and associated risk factors have been steadily rising over decades. Together, the five major NCDs will destabilise already weak health systems, undermine attempts to achieve universal health coverage and cost the global economy US\$47 trillion in lost gross domestic product between 2010 and 2030.⁵

This growth in NCDs has been taking place in all countries currently experiencing humanitarian crises.** According to estimates from the WHO and UNHCR, NCDs accounted for between 24 and 68 per cent of mortality in the five most common countries of origin of refugees and migrants in 2017 (Syria, Afghanistan, South Sudan, Myanmar and Somalia).⁶ The traditional humanitarian response to managing the acute phase of an emergency, such as dealing with trauma, injury, sexual and reproductive health and infectious disease, falls short of the comprehensive approach and continuity of care needed to address NCDs. Chronic conditions that have been successfully managed in the past can rapidly deteriorate and lead to complications. But too often NCDs in crises are not prioritised, with mental ill-health seen as secondary even to other NCDs.

43% and 50% of all Syrian refugee households in Jordan⁷ and Lebanon⁸ respectively are reported to have at least one member with an NCD (primarily diabetes and hypertension).

Over one person in five living in an area affected by conflict is estimated to have depression, anxiety, post-traumatic stress disorder, bipolar disorder, or schizophrenia.⁹

Prevention of NCDs will also become increasingly important to avoid the deterioration of long-term health among the world's displaced and refugee populations: emergencies are becoming more and more protracted, with the average length of displacement being 20 years for refugees and more than 10 years for most internally displaced people (IDPs).¹⁰ Mental health and psychosocial wellbeing are threatened by exposure to violence, conflict and other risk factors for mental ill-health, such as increased poverty, lack of access to basic commodities and services, and social exclusion, discrimination and stigma including, for refugees, in host communities.¹¹

Mental ill-health and other NCDs are strongly interconnected, highly co-morbid and are linked by underlying behavioural risk factors and environmental and social determinants. They may occur at any age and frequently require life-long care. The interplay between physical and mental co-morbidities is bidirectional: people living with these conditions have poorer health outcomes, greater functional impairment, and decreased adherence to medicines, which drive a higher risk of complications and early death.

NCDs, including mental-health conditions, are responsible for the majority of the disease burden in many LMICs, and short-term, disease-specific responses to these multi-faceted and often co-morbid conditions are demonstrably insufficient. It is time for the humanitarian response to take this into account and ensure a holistic, integrated approach to these conditions that puts individuals at the centre of their own care.

* The partners in this initiative also recognise the importance of a range of other non-communicable conditions to the health of the world's poorest populations, including epilepsy, asthma and sickle-cell disease: see, for more detail, the 2019 report of the Lancet Commission on Reframing NCDs and Injuries for the Poorest Billion <https://www.thelancet.com/commissions/NCDI-Poverty>.

** Humanitarian settings are also present in higher-income countries, but this report focuses on LMICs because it is here that health services (both for NCDs and MHPSS) are likely to come under the greatest strain.

2.2 Why integration matters

NCDs, including mental ill-health, can be a result of accumulated or chronic stress. To some extent, these problems can be prevented from becoming chronic, with suffering alleviated. Supporting the process of facilitating resilience within individuals, families, and communities by connecting people to new forms of community and psychosocial support, or (re-)activating existing support, can aid recovery after the disruption of a crisis. **Where people are empowered to care for themselves and each other, their individual and communal wellbeing will improve, which has a protective, preventative, and promotional role for both physical and mental health.** Community-based psychosocial support can play a pivotal role in the restoration of social cohesion and structures, as well as addressing social stigma around mental and physical health conditions and addressing behavioural risk factors.

Everybody experiences stress, to some extent, in everyday life, but people who live through crisis events such as humanitarian emergencies may experience stress in an extreme form, with physical, mental, emotional, spiritual, behavioural and interpersonal implications. If the signs of stress are not identified in a health-care setting, this can lead to incorrect or missed diagnosis and inappropriate treatment – health-care providers need to be trained in the clinical consultation skills they need in active listening and psychoeducation for the patient and their family, as well as basic training in recognising the signs of more severe mental illness.

'Many of the refugees develop NCD conditions because of a psychological reason – because of inner sadness and all the incidents that occur in front of them, such as killing and destruction of property'

– Areti Hamagambo, NCD Officer, Dadaab Refugee Complex, Kenya Red Cross Society

Offering assisted coping and supporting positive coping mechanisms for those undergoing these stressors – for instance, by connecting patients to psychosocial support efforts in the community or (when needed) referring patients to more focused or specialised types of support – can help mitigate the negative effect of severe stress and its effect on physical and mental health outcomes.¹²

2.3 The rationale for this initiative

The IFRC Reference Centre for Psychosocial Support, the Danish Red Cross and the University of Copenhagen are exploring if and how NCD prevention and care and MHPSS should be integrated in humanitarian response/settings. Such integration can be bidirectional – with multi-level, multi-sectoral mental health and psychosocial support approaches being integrated into NCD prevention and care, or vice versa with NCD prevention and care approaches being integrated into MHPSS services – and delivered at community or health-care levels. However, an integrated approach is not yet standard practice, which suggests that there are challenges to operationalisation and gaps in knowledge, as well as opportunities for better practice, both within the Red Cross and Red Crescent Movement and beyond.

'Being auxiliary to the government in the Movement, representing and working in different forums, we should be the voice of the people and ensure that their needs are being taken care of. This should be our responsibility'

– Dr Mahesh Gunasekara, Sri Lanka Red Cross

This is not a new approach; rather, it consolidates principles to which the Movement and other humanitarian actors are already committed. The project aims to foster an understanding of how integration of MHPSS and NCD prevention and care in humanitarian settings can support the Movement's mandate to provide neutral and impartial protection and assistance to people affected by disasters and conflicts, and to share the learnings with the wider humanitarian and health communities. It capitalises on the existing momentum for integration (see section 3), strategizing it as an approach and further embedding it into humanitarian thinking. The partners hope that it will **contribute to practice-based evidence-building that is complementary to evidence-informed and -based practice:** guided by science but with the outcomes pointing the way towards further research and practice, reflecting the complexities of the practical implementation of humanitarian services in complex humanitarian settings.

This initiative also explicitly **builds on an earlier initiative** of the Danish Red Cross with the IFRC, the University of Copenhagen and NCD Free, with funding from the Novo Nordisk Foundation. This culminated in a 'bootcamp' meeting, held in 2018: 'Mobilising young leaders within civil society for advocacy on NCDs

in humanitarian settings'. This brought together 70 young professionals and established experts from more than 30 different organisations to inspire advocacy action on the challenge of NCDs in humanitarian settings and to develop policy asks. The discussion and suggestions at the bootcamp were clustered under six key areas: access to treatment; continuity of care – people on the move; addressing risk factors in the community; preparedness; research and evidence; and financing/resourcing and partnerships.¹³ Figure 2 presents some examples of ways in which the research for this report has demonstrated that these key areas of focus of the bootcamp map onto the case studies on MHPSS/NCD integration.

Two of the most important learnings from the bootcamp were the importance afforded by participants to prevention as well as care, and to integrating mental health and physical NCDs.* This, coupled with the extension of WHO's definition of NCDs to include mental health and neurological conditions (see section 3), provided the inspiration and impetus for the current project.

Ultimately, this initiative seeks to understand how an integrated approach can better enable us to address the needs of people living with and at risk of NCDs, including mental-health disorders in their communities as an essential aspect of humanitarian response worldwide.

Figure 2: The relevance of MHPSS/NCD integration to the 2018 bootcamp priority discussion areas

Key area	Why it matters	Examples from the case studies of relevance to MHPSS/NCD integration
Access to treatment	In humanitarian crises, access to treatment for NCDs is severely disrupted. This extends far beyond access to medication: it is about how health systems under serious stress can ensure continuing, affordable access to drugs/ diagnostic/tools, referral for specialist treatment, and health workers.	Covid19- had a very significant impact on treatment services for both NCDs and mental-health conditions. In humanitarian settings, as elsewhere, care was adapted, with support delivered online and by phone and with medication supplies provided for a longer period of time so that PLWNCDs did not have to attend clinics so frequently, and changes were made to support groups with, for example, the Armenia programme shifting to smaller groups meeting outside.
Continuity of care – people on the move	Ensuring a continuum of care for people living with NCDs is always a challenge because NCDs require lifelong support. In crisis situations, this is greatly exacerbated: displaced, transient populations often have to move between health facilities or humanitarian agencies, making it harder both to access and provide care.	The Dadaab refugee camps have been threatened with closure over a number of years, and PLWNCDs have generally not been prioritised with repatriation where it is clear that they will not have access to appropriate treatment in their new community. Even moving between camps as one is closed has been shown to impact upon access to care in the absence of reliable records.

* For more information on the 2018 bootcamp, see <https://www.rodekors.dk/ncd-bootcamp>

<p>Addressing risk factors in the community</p>	<p>As the acute phase of an emergency (during which provision of essential treatment is the priority) gives way to a protracted crisis, the longer-term challenges of living with and prevention of NCDs need to be addressed, involving patients, families and local communities.</p>	<p>Social support groups or ‘living well’ groups (such as in the Armenia and Jordan case studies) can provide support for PLWNCDs and their families, including nutrition counselling, health literacy and financial counselling, which together can improve self-efficacy of PLWNCDs and lessen the risk of not adhering to medication and further complications.</p>
<p>Preparedness</p>	<p>Rapid action in an emergency can save lives but is dependent on effective pre-planning. Emergency preparedness is action taken to address the risks, build capacity and prepare for humanitarian emergencies, to reduce the effects of any future crisis on the population. It should specifically address the needs of vulnerable groups such as people living with NCDs.</p>	<p>The WHO EMRO region has developed an NCD emergency kit (first-line NCD medicine and equipment, for 10,000 people for three months), which is now being adapted for use in both Kenya and the Caribbean (see table of examples). The Kit includes medication for mental-health conditions and health workers who will deliver it are also being trained in aspects of PSS.</p>
<p>Research and evidence</p>	<p>In many low- and middle-income countries, there is little reliable granular data available on NCDs – and this is magnified in humanitarian crises. Pragmatic, standardised data-gathering systems are needed that can be used in these fragile settings. Evidence is needed to identify, prioritise and advocate for effective interventions.</p>	<p>Implementation research can enable rapid learning about interventions and what works in particular contexts. An RCT is being established in Thailand by the IRC and partners to integrate a mental-health intervention into existing NCD care being delivered in a refugee camp. This will enable a comparison between an intervention and control group of health outcomes, factors influencing treatment compliance and costs.</p>
<p>Financing/ resourcing and partnerships</p>	<p>Innovative financing and new ways of working are required for NCDs worldwide, and particularly in humanitarian situations. A recent Lancet report has highlighted that ‘the notable lack of enthusiasm by global health donors has made it especially difficult for low-income, donor-dependent countries to even assess the size of the health burden’ for NCDs.¹⁴</p>	<p>Sustainability is clearly a challenge, particularly where partnerships are temporary and can leave ongoing programmes unfinanced and needing new partners (such as the Ministry of Health in host communities) to step in to fill the gap. Examples include MSF’s programme in Irbid and the Novartis Access support for PLWNCDs in Kenya’s Dadaab camps, where provision of medication has since been picked up by other partners.</p>

THE PROJECT PROCESS

This initiative takes an exploratory, evidence-informed approach using several different methods and with a number of interlocking outputs:

- Two literature reviews were undertaken: **a grey literature review** (done in-house by a consultant to the IFRC PS Centre) and a **rapid literature review** (undertaken by the University of Copenhagen). The learning from these were combined into a short **scientific commentary**, which has been submitted to a journal for publication. (See Annexes A4 and A5.)
- To complement the literature reviews, **eight key informant interviews** (see Annex A3) were held with experts from the Movement and beyond, and **four case studies** (Annex A1) chosen to be presented in detail in this report, to illustrate and inform the learning in this **scoping report**.
- The scoping report also draws on learning from a further output of the initiative: **a roundtable event**, held in June 2021 (Annex A6). This brought together around 40 participants from within and beyond the Movement, in two three-hour sessions (virtually, due to Covid-19 restrictions). This discussed and explored (day 1) whether and why an integrated approach to NCDs and MHPSS would be of benefit in humanitarian settings and (day 2) how this can best be achieved, building on the experience of all those present. It was an important and invigorating opportunity for knowledge exchange at a pivotal time for the concept of integration.
- A new [massive open online course \(MOOC\)](#), **“mas** on MHPSS/NCD integration has been developed by the University of Copenhagen. The course combines academic information with best practices/ challenges, to build knowledge, awareness and develop capacity of course participants. This is aimed both at country and programme managers (inside and outside the Movement) working with MHPSS and/ or NCDs in humanitarian settings, and at university students and others with interest in the subject. The course adds to an existing MOOC on Non-Communicable Diseases in Humanitarian Settings that was launched following the 2018 bootcamp, on which 4,000 learners have enrolled to date.

WELLBEING AND PSYCHOSOCIAL SUPPORT

IFRC, *eCBHFA Volunteer Manual, 2018*

https://pscentre.org/wp-content/uploads/2018/10/NC_MHPSS_VOLMANUAL.pdf

Wellbeing depends on many factors. The overlapping circles in the 'wellbeing flower' below suggest that individual and collective wellbeing depends on what happens in a variety of areas, that meeting at least some minimum level of need in each of these areas is necessary and that the areas are interrelated.

Social: refers to friends, family, relatives, social activities, sports/leisure groups and clubs, as well as support groups. Human beings are social by nature and a denial of access to social activities and social interaction can increase a person's distress levels.

Emotional: refers to how we are feeling. Our feelings have an immense impact on our wellbeing, and if you have emotional distress it can be difficult to ensure well-being even though you have all other parts of the wellbeing flower covered. One must feel at ease in order to truly experience wellbeing.

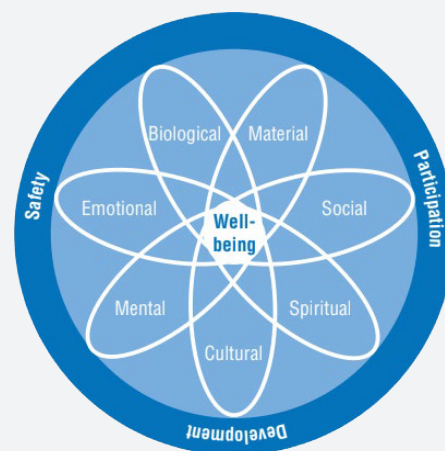
Spiritual: being free to practise one's religious or other spiritual practices is an important aspect of wellbeing

Cultural: culture involves learnt patterns of belief, thought and behaviour. It defines how things are supposed to be for us. Culture makes life and its stages more predictable and enables a society to maintain itself. A culture also develops, adopts, or adapts the tools, types of shelter, transportation and other physical items needed to maintain itself. It defines standards of beauty, both of things and of people, and prescribes acceptable and unacceptable ways to express emotion. It defines what behaviour is considered normal or abnormal. A culture evolves and changes over time.

Mental/cognitive: refers to thoughts and other related functions of the mind, which include problem-solving, learning how to learn, how to acquire information and how to be able to use it.

Biological: refers to the living organism. It is the physical health and the biological aspects of mental health as well as the absence of disease/disorder.

Psychosocial support: refers to the actions that address both the psychological and social needs of individuals, families and communities. Psychosocial support in the Red Cross and Red Crescent context is sometimes delivered through programmes specifically designed to address psychosocial issues. However, it is more common that psychosocial support is integrated within other activities and programmes, such as health programmes during emergency relief, assistance programmes to people living with HIV and AIDS and school support programmes in order to ensure a more holistic approach.



THE DEFINITION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THIS PROJECT

Mental health and psychosocial problems are common among adults, adolescents, and children in all humanitarian settings. The extreme stressors associated with crises place people at increased risk of social, behavioural, psychological, and psychiatric problems. The term ‘mental health and psychosocial support’ describes any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or treat mental health conditions.^a Mental health and psychosocial support is a response that involves multisectoral actions in support of people’s mental health and psychosocial wellbeing^b.

Mental health, as defined by the WHO, is a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community. ‘Psychosocial’ is a term used to describe the interconnection between the individual (a person’s internal, emotional and thought processes, feelings and reactions) and their environment, interpersonal relationships, community and/or culture (their social context). Psychosocial support, finally, refers to actions relating to the social and psychological needs of individuals, families and communities^c.

^a Adapted from IASC, IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

^b The Sphere Handbook (2018) <https://spherestandards.org/handbook/editions/>

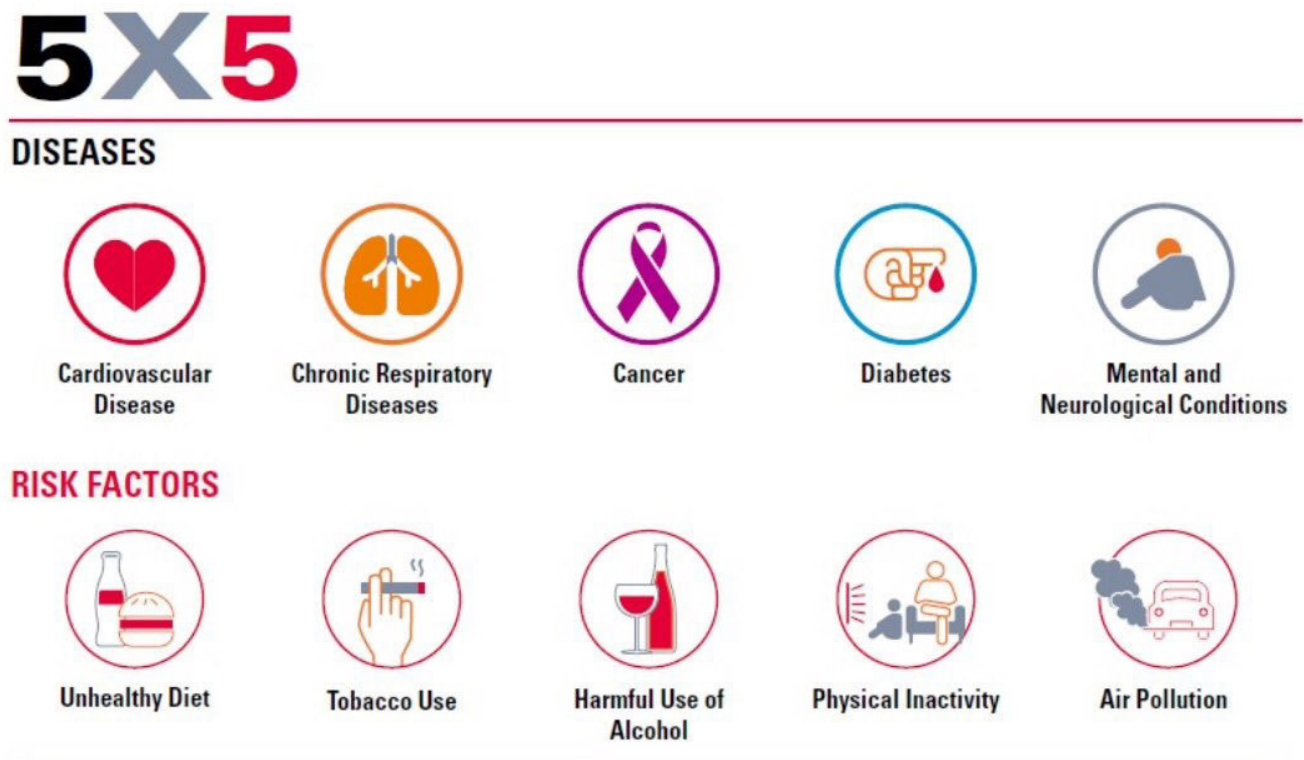
^c International Red Cross and Red Crescent Movement, Policy on Addressing Mental Health and Psychosocial Needs (2019) https://pscentre.org/wp-content/uploads/2021/02/Movement_MHPSS_Policy_Eng_single.pdf

3. GLOBAL CONTEXT

The development of understanding around MHPSS and NCDs in humanitarian settings is set out in the timeline below (Figure 4), both internationally and within the Movement. It is evident that support for integration of MHPSS and NCDs in humanitarian settings is growing, with the global context for integration more potentially supportive of integration than it has ever been:

1. The artificial distinction between ‘mental health’ and ‘NCDs’, which has made it harder to address them in conjunction, is being addressed at the highest level. Since 2018, the World Health Organization has extended its ‘4x4’** approach to NCDs to a ‘5x5’ approach,¹⁵ bringing mental health and neurological conditions under the NCD umbrella.** This is a recognition that the diseases are often co-morbid and that risk factors often cluster.

Figure 3: The ‘5x5’ approach (source: NCD Alliance)



2. Over the last few years – and particularly since the Syrian crisis, within which NCDs are more prevalent than infectious and other health issues – there has been an appreciation of the need for NCDs to be addressed in humanitarian settings (notably its inclusion in the Political Declaration of the UN High-level Meeting on NCDs, held in 2018): chronic, pre-existing conditions become much more visible in humanitarian settings. However, the case still isn’t fully made. The devastating impacts on mental health of humanitarian crises have been more fully understood for a longer period of time – notably the creation of the Inter-Agency Standing Committee (IASC) MHPSS Reference Group in 2007 – but also still do not receive the priority that their urgency affords.

‘When we introduced NCDs into Copenhagen University’s course on Health in Emergencies in 2009, the students liked it – but I was astonished by the pushback from journals, faculty, other organisations. We were told we were ‘naïve’ and that NCDs were not a priority, whereas to me it seemed entirely logical that this would become a problem as populations age. The reaction was beyond disagreement, it was real anger – and it was sufficiently upsetting that I felt unable to pursue it further’
 – Siri Tellier, external lecturer, School of Global Health, University of Copenhagen

* Four diseases (cardiovascular disease, diabetes, cancer and chronic lung disease) and four primary risk factors (poor diet, lack of physical activity, tobacco use and harmful use of alcohol).

** Along with the addition of air pollution as the fifth risk factor that is common to so many of the diseases.

An initiative that began in Armenia in 2016 on addressing diabetes among vulnerable populations rapidly identified a need for explicit PSS support. Social Support Groups were established, facilitated by Armenian Red Cross volunteers, with participants referred from health clinics to share their experiences and ask questions (see case study, Annex A1.1).

3. There is a **burgeoning understanding of the need to take account of the interplay between mental and physical health and the co-benefits of addressing them together** (rather than in vertical programmes). This was a clear message from the key informant interviews and the roundtable and is also reflected in the case studies, many of which began as NCD initiatives but expanded into inclusion of MHPSS as it became self-evident that to fail to do so would be to fail to provide appropriate care. Integrating MHPSS and NCDs can address the stigma surrounding mental-health conditions and better address morbidity and mortality through appropriately joined-up pathways.

'Looking at the aging population, rising obesity and so on, to me integration is a no-brainer – and from a health-systems perspective, we save time and money by addressing these issues early'
– Laura Archer, Senior Officer, Medical Services in Emergencies, IFRC Health and Care Department, IFRC

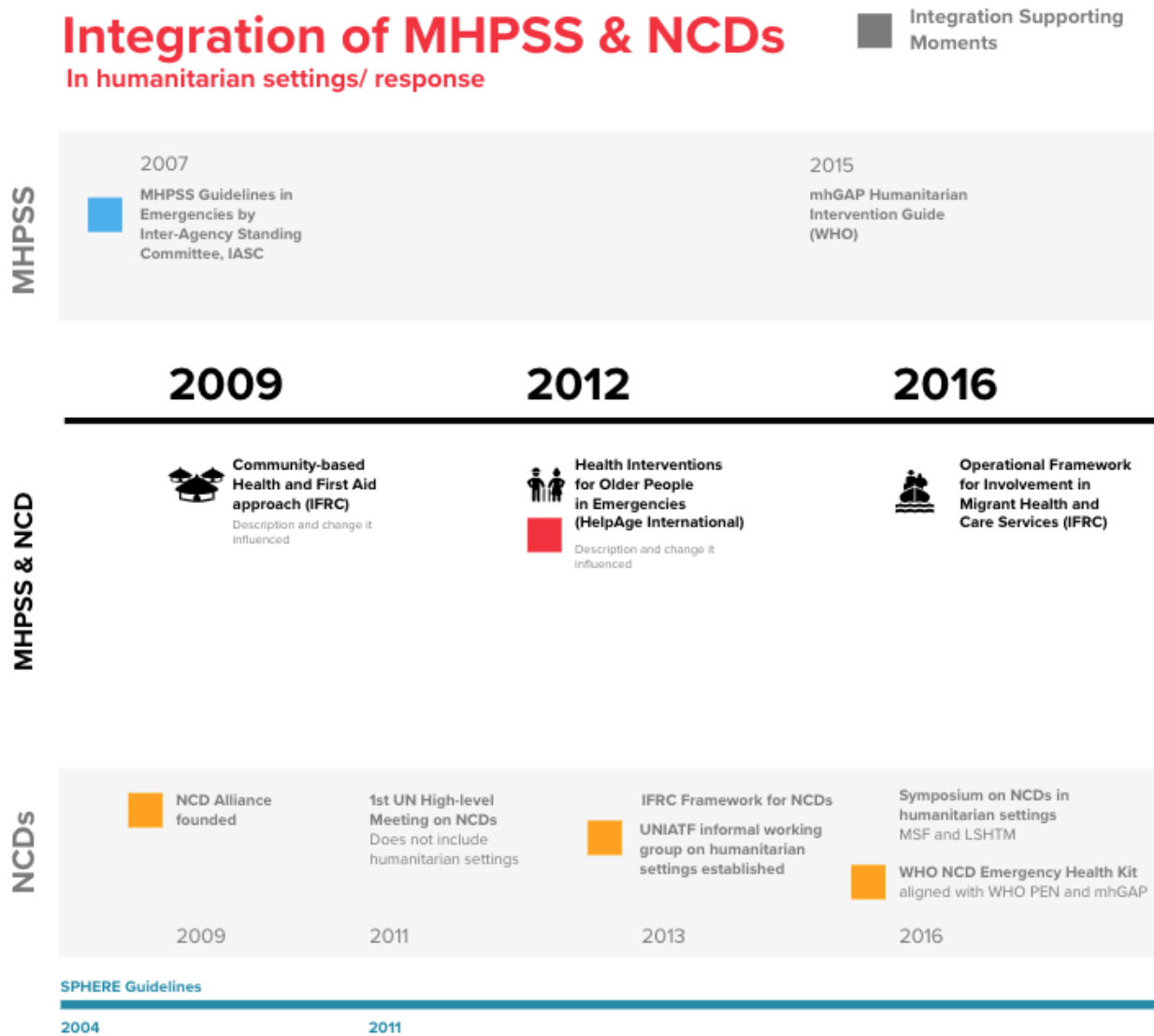
4. Finally, the **Covid-19 pandemic seems to have been a tipping point for understanding of the links between physical and mental health** – not just between infectious disease and mental health, but the physical co-morbidities that drive more severe Covid-19 outcomes. Covid-19 has had a very significant impact on MHPSS and NCD services globally¹⁶ – and this devastating impact is both a challenge (particularly so in resource-constrained and humanitarian settings) and an opportunity for integration to be part of the 'new normal'.

The case for integration and for health systems strengthening has never been more evident – and particularly in the parts of the world that are currently enveloped in a devastating humanitarian crisis precipitated by Covid-19 (see section 4.4 below).

'We won't be effective if [the Movement] do this alone – we need to collaborate and coordinate so we don't start from scratch, especially if we are working in the same location'
– Theresa Baylon, IFRC

However, there is still much to be done to lock in this new understanding. There are plenty of practical examples on the benefits of integration and many organisations are pivoting towards the integration of MHPSS and NCDs in initiatives on the ground (there are 16 such examples in Annex A2) – but, as the literature review for this project found, the peer-reviewed evidence is currently limited. It is time to gather together the stories and evidence that together can make the case for integration and embed it as part of business-as-usual.

Figure 4: Integration of NCDs and MHPSS in humanitarian settings /response



MHPSS & NCDs Moments

Key Integration Milestones

Key Milestones for MHPSS

Key Milestone for NCDs

2019

MHPSS Resolution and Policy
Red Cross Red Crescent Movement

OCHA's Global Humanitarian Overview
Includes first overview of global MHPSS humanitarian needs

2020

MHPSS monitoring indicators included humanitarian multilateral response plans
The WHO COVID-19 Strategic Preparedness and Response Plan, Global Humanitarian Response Plan and the UN Framework for the Immediate Socio-economic Support to COVID-19

2018

2020

2021



3rd UN High-level Meeting on NCDs

Includes humanitarian emergencies and extends to a "5x5 approach", including mental health and neurological conditions



Non-Communicable Diseases – Programmatic and Clinical Guidelines (MSF)

Bootcamp on NCDs in humanitarian settings

MOOC on Non-communicable Diseases in Humanitarian Settings
The University of Copenhagen and the Danish Red Cross

2018



Care in Communities (IFRC)



Managing Projects addressing NCD: Operational Guidelines for Field Staff (ICRC)

adapted from UNIATF 2018



Integrating NCD in Humanitarian Settings: An Operational Guide (IRC & UNHCR)

based on UNIATF



IFRC Roundtable on integration of MHPSS and NCDs

Lancet NCDI Poverty Commission and Network
addresses NCDs among the bottom billion, beyond the 5x5



Package of Essential Non-Communicable Diseases Interventions for Humanitarian Settings (PEN-H) (IRC et al.)

2020

Inclusion of humanitarian settings in the Global Diabetes Compact

2021

COVID-19 Pandemic

2018

2019

Ongoing

4. FINDINGS FROM THE INITIATIVE

This section combines learning from throughout the initiative: the literature reviews (both the grey literature review and the rapid literature review that underpinned the scientific commentary, see Annexes A4 and A5), the key informant interviews (summarised in Annex A3), case studies (Annex 1) and roundtable (Annex 6).

4.1 Should we integrate MHPSS and NCD prevention and care in humanitarian settings/response?

There is significant evidence for the need to tackle both NCDs and mental-health conditions in emergencies and other humanitarian settings, reflected in guidance from many humanitarian organisations and the WHO (see timeline, figure 4) – although it was noted at the roundtable that MHPSS advocacy and delivery in humanitarian settings is still more advanced than the integration of NCDs. However, the evidence on integrating the two is, to date, much scarcer; the grey literature review and the research behind the scientific commentary for this project found only limited published guidance and examples. Interventions tend not to foster bidirectional integration and integration is often not built into projects from the start.

However, the interviews and case studies for this report paint a very different picture. The key informant interviews were unanimous that taking an integrated, holistic approach is beneficial for end users and can lead to efficiencies – indeed, that this is particularly important in humanitarian response, because, although people living in such settings are often resilient and do well with their own coping strategies, in many cases the setting both precipitates MHPSS needs and exacerbates pre-existing mental-health and NCD conditions.¹⁷ This opinion was reinforced by the participants at the roundtable.

‘If we are serious about people, we must look at them as a whole, not as individual diseases’
– Grace Dubois, NCD Alliance

‘For real integration, the person must be at the centre, not the disease’
– Bhanu Pratap, IFRC

The research indicates significant and growing support for bidirectional integration as an efficient and effective course of action, with PSS support mainstreamed throughout any NCD initiative from the start, not added as an afterthought, and with stronger consideration for both mental and physical health and how these are interconnected. There are strong practical feedback loops, with better NCD care promoting good mental health, and psychosocial support contributing to better physical and mental health, for example through reduced stress and better adherence to treatment. Streamlining provision of services across MHPSS and NCDs can provide better, more efficient coverage for patients, simultaneously addressing barriers such as competition for funds and workforce burnout or attrition through task-sharing.

Placing the individual at the heart of their care reflects ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.¹⁸ There is often strong consensus on the right to health, so this can be a strong position from which to argue for integration, and to promote the understanding that ‘competition’ between diseases is unacceptable: care is best provided holistically, not in vertical silos. Some also voiced the opinion that MHPSS should be integrated not just as part of NCD or Covid-19 care, but across a much wider range of services, including all essential health services and logistics, so it becomes an embedded aspect of the duty of care.

In the past, vertical programmes were the norm, and one of the first indications that this approach was changing was after Typhoon Haiyan in the Philippines in 2013, after which the Movement promoted joint capacity-building across NCDs and MHPSS. Learning from the research suggests that, where possible, **MHPSS should be included as an integral part of community- and primary-level NCD services in humanitarian settings, taking a tiered approach that is responsive to individual need**: from basic MHPSS support for all, to PSS or peer-support groups for vulnerable populations, and individual counselling and treatment where appropriate.

The interviews also led to the identification of many initiatives where integration is already taking place, both within and beyond the Movement, 16 of which are presented in Annex A2, with four written up in detail as case studies in Annex A1:

- diabetes prevention and care among older people in Armenia;
- integrating MHPSS into an NCD initiative in Dadaab refugee complex, Kenya;
- delivery of an NCD programme for Syrian refugees and the host population in Jordan; and
- the Philippines Red Cross Haemodialysis Center Samaritan Programme.

Although the benefits of NCD/MHPSS integration are bidirectional, none of the initiatives identified began as exclusively mental-health initiatives and expanded to include other NCDs; all were either integrated from the start (e.g. the PRC dialysis support) or began as initiatives for physical NCDs and pivoted to introduced an MHPSS aspect as the need became apparent (e.g. MSF in Irbid, Jordan).

4.2 Advantages of initiatives that integrate MHPSS and NCDs

Integration reflects the reality shared by all of us: that mental health and physical health are inextricably linked right along the continuum of care from prevention and diagnosis to treatment and palliative care. An approach that recognises these co-morbidities and takes a person-centred approach is likely to be more effective for individuals living with the conditions. To deliver this effectively, **health systems need to be strengthened and adapted to deliver simplified and coherent treatment pathways, with an understanding of the synergies between co-morbidities – an approach that can, ultimately, be cost-saving.** Strengthening health systems and ensuring community- and primary-care access for everyone (including refugees and IDPs) is fundamental to delivery of universal health coverage, including for traditionally underfunded conditions such as NCDs and mental health.

Health systems that take a collaborative care approach deliver integrated care through a structured collaboration between community-based initiatives, primary care and specialised providers. Local providers or community health workers can improve community interactions, provide guidance on wellbeing, and improve health literacy to help to overcome reticence about seeking treatment for chronic conditions, facilitating referrals to more specialised care where required. Such programmes can be used to treat people with a wide range of co-morbid conditions, such as treating depression, anxiety disorders, bipolar disorder and schizophrenia among those with NCDs such diabetes and cancer,¹⁹ and are recommended to be used in primary care settings by the WHO.²⁰ In addition, where patients are empowered to self-manage, there will be less input needed by medical teams themselves, which can be cost saving.

This is about the continuum of care. You need to work on prevention as well as at primary care, and if there are complications then refer on to hospital or for rehabilitation. The continuum of care is essential, and helps with integration and working together, because we have to put the focus on the patient...to give the possibility of lifelong care'

– Sigiriya Aebischer Perone, ICRC and Geneva University Hospitals

The advantages for end-users include:

- **Improved care:** Providing psychosocial support for those living with NCDs can reduce anxiety, stress and depression and encourage greater adherence to treatment. In many humanitarian situations, individuals' health may be less of an acute concern than other, more immediate priorities such as poverty or fear for their loved ones. This is not just about the trauma of (past) conflict, but the stressors of everyday life in often fragile settings. Recognising that 'social suffering'^{**} is a major barrier to self-care and providing appropriate psychosocial support (including ensuring a supportive environment within health-care settings), can significantly bolster wellbeing and self-efficacy.

'It's important not only to provide access to treatment, but to deal with their needs and concerns – not only the reality of having a chronic disease, but the psychosocial impact of the disease, which relates to their economic status and the entire wellbeing of their family'

– Pred Morales, Philippines Red Cross

- **Reduced costs:** Chronic care can require considerable out-of-pocket expenditure, often for life. Providing free or low-cost medication can dramatically decrease the financial burden, often being the only way in

* See, for example, L. Maconick et al., "To die is better for me", social suffering among Syrian refugees at a noncommunicable disease clinic in Jordan: a qualitative study' (2020) *Conflict and Health* 14: 63 <https://doi.org/10.1186/s13031-020-00309-6>

which the treatment can be accessed (such as the case studies of dialysis in the Philippines and provision of medication in the Dadaab refugee complex). Even where care is offered from the same location (such as a clinic), it often requires people living with co-morbidities to attend on different days for different conditions; care is not fully joined up. Offering treatment for different conditions at the same time or even through online or telephone support reduces both travel costs and the time needed off work (or away from caring responsibilities) to attend.

- **Tackling stigma:** In many parts of the world there is significant stigma around NCDs (including mental-health conditions). Stigma can lead to treatment avoidance, delays to care and discontinuation of services: the case study of Syrian refugees in Jordan with NCDs found that although patients recognised the psychological dimensions of their illness, they were unwilling to attend clinic-based MHPSS services due to the fear of discrimination.²¹ However, where the fears of stigma are recognised – with care being provided in the community, in less obvious locations or is presented as being about ‘wellbeing’ rather than ‘mental-health support’ – take-up of support may increase. Opportunities are also being recognised to take a faith-sensitive approach, working with traditional healers to provide training in basic PSS skills, which can then complement the spiritual and emotional support that they provide within their communities.²²

One of the lessons learned from the MSF initiative in **Irbid, Jordan** (case study in Annex A1.2) is that greater engagement with NCD patients and providing patient-centred care would be of benefit because it would enable the co-creation of culturally appropriate programmes that better meet the population’s physical NCD needs and better anticipate their context-specific MPHSS needs. This cultural appropriateness should include consideration of the stigma attached to such support – for example, where psychosocial support services would benefit from being positioned as ‘living well’ support rather than explicitly about mental health. This could also be reinforced by situating the programmes in non-clinical settings, such as community halls or schools, to increase both their acceptability and accessibility.

- **Wider support:** Family, friends and the local community can be vital in supporting people living with NCDs. This is particularly the case soon after diagnosis to adapt to changes to lifestyles – and support is particularly important in a humanitarian setting where there may be many more barriers to care. Community health workers and Red Cross Red Crescent volunteers are particularly well placed to assist in delivering support, because they are at the heart of their communities and are known and trusted by those living with the conditions.

‘Support groups are an essential channel to provide mental health care support – they can give each other moral support, group and individual counselling is provided, and they are linked to further care that they need’

– Sylvia Khamati, Danish Red Cross

Better partnership working across all levels of service provision (including specialist clinicians, nurses, or community health workers) provided across all levels of care (from communities to health centres and hospitals) is at the heart of equitable, effective, and efficient care. This coordination enables integrated management of co-morbidities and provides more holistic care for people living with NCDs and mental-health conditions.

A learning from the case study in Armenia (Annex A1.1) has been the need to provide PSS support for family members as well as for the people living with diabetes themselves – and this reflects the RCRC MHPSS Framework, which includes family and community support.

MSF in Lebanon has implemented group sessions for adolescents with diabetes, providing peer-support and making use of a multidisciplinary approach that aims to improve adherence to medication and responsiveness to treatment and encourage better health. Sessions are run by different facilitators according to the subject matter, and cover illness literacy, physical activity, nutrition and stress management.

The medical social worker described in the case study from the Philippines (Annex A1.4) provides support for families of those on dialysis for treatment of chronic kidney disease, not only during treatment but also providing grief counselling should the patient die.

4.3 Barriers and solutions to integration

4.3.1 Knowledge and research

The research for this report identified a broad lack of knowledge about the need for, benefits of and most effective ways to achieve integration. Improving understanding of these benefits is the gateway to overcoming many of other barriers. This begins with an understanding of the basic concepts, including the prevalence and impacts of NCDs and MHPSS and the needs of people in humanitarian response, as without this understanding it is not possible to advocate for change. There needs to be an openness to learn and adapt – both at policymaker and agency level, and among those responsible for delivery of services on the ground.

‘The biggest gap is the understanding that integration is needed!’ – Bhanu Pratap, IFRC

The general lack of appreciation of the benefits of integration is exacerbated by inadequate information on demography, epidemiological data and co-morbidities in humanitarian settings, so it is not clear what the disease burden really is or how best to address it. Monitoring and evaluation (M&E) in humanitarian settings can be very challenging – which then makes it even harder to demonstrate the benefits of an integrated approach.

Monitoring should include both mental health and physical indicators – but there is a lack of well-established indicators, particularly indicators pertaining to integration itself. Having too many or differing indicators can be particularly confusing, especially when different donors require reporting on different indicators. There is a need to minimise and standardise the indicators that are used, while still providing the data that is required to build understanding and assess impact: coming to agreement on such indicators is likely to be a challenge.

‘When you can monitor what you are doing and reflect on achievements,

The Armenia programme (Annex A1.1) has found that centrally positioning a strong M&E framework, including MHPSS indicators makes it much easier to gather data at the start and to show impact during the course of the initiative.

‘it is easier to move the needle because you have a target to move towards’
– Lilian Kiapi, IRC

Studies comparing different approaches are welcomed as adding to the pool of knowledge and can then encourage others to follow suit. **Research should ideally be built in at programme planning stage,** ensuring that data-collection tools are appropriately designed, and that relevant data are collected before, during and after the intervention – but it is important to consider research capacity and be flexible in how the research is set up. RCTs can be difficult to implement in humanitarian settings, so alternative methods (such as quasi-experimental designs, including interrupted time-series analysis) may be more appropriate. It may be hard to establish causation when evaluating complex interventions, so triangulating novel statistical approaches with more qualitative findings may be of benefit. In particular, implementation research is essential: what works for whom, where and how.

The IRC is establishing a programme in a refugee camp on the Thailand/Myanmar border, which will test the effectiveness of integrating the common elements treatment approach (CETA) into care for NCDs including hypertension, diabetes and epilepsy – chosen for their prevalence within the camp and for their links with mental health. This RCT will enable a comparison of health outcomes and factors influencing treatment compliance and costs between the intervention and control group.

People living in humanitarian settings – both those responsible for delivering a proposed intervention and those receiving it – can provide valuable knowledge that can be tapped as part of the design of the intervention itself.

‘Co-creation is really important, working closely with teams on the ground to help design and guide the implementation of research studies to make them feasible and relevant and to maximise the uptake of findings’
– Éimhín Ansbro, LSHTM

An integrative approach is in its relative infancy as a priority in the humanitarian response, and more (and more diverse) examples of how integration can be of benefit would be welcomed. This could include better understanding of the impact of peer support on particular NCDs, of how PSS can address the impact of psychological impact of the physical complications of NCDs, and how NCDs beyond the five identified by WHO can be more holistically addressed (for example, epilepsy, mentioned by some of those interviewed as important to their humanitarian work).

Knowledge about integration can also inform and be informed by better guidance. Evidence-based guidelines and tools are beginning to be developed, but caution was urged because, if these are adapted from high-income countries (because of a lack of evidence from lower-income settings), this can lead to expensive and unnecessarily complex systems and a fragile continuum of care in settings with constrained resources.

‘Everyone involved must advocate for more, better quality and better-funded research’
– Éimhín Ansbro, LSHTM

One of the learnings from the MSF Irbid case study (Annex A1.2) is that integration of MHPSS into NCD policy of humanitarian organisations would be of significant assistance in embedding it and ensuring that a holistic approach is considered from the start. MHPSS is now included in the MSF OCA NCD policy and will be also included in the MSF-wide NCD policy as part of guidance for chronic care implementation (which is a collaboration among NCD, HIV, TB and mental health specialists).

4.3.2 Financing and resourcing

Financing is insufficient for MHPSS and NCD care globally, whether separately or integrated: just 1.8% (\$730 million) of development assistance for health in 2019 goes to NCDs,²³ and 'less than 1% of the emergency response budget is currently spent on mental and psychosocial wellbeing, even though over 20% of all reported health problems concern mental and psychosocial wellbeing'.²⁴ However, the shortfall is a particular challenge in humanitarian crises (where acute issues such as injury and infectious disease tend to get prioritised) and also in protracted crises, which may fall between short-term humanitarian funding and development assistance for health. There is still – despite the statistics presented in section 2.1 – an erroneous belief that NCDs are 'diseases of affluence' and will not be relevant in low- and middle-income countries, including in humanitarian settings. Using research to overcome this lack of understanding was cited during the consultation as being essential to establishing integration efforts.

The recent Covid-19 humanitarian crisis has demonstrated how a lack of funding threatens the ability of countries to implement both MPHSS and NCD plans. In a WHO rapid assessment of 116 countries, 89 per cent reported that mental health and psychological support response were part of their national Covid-19 response plans – but that only 17 per cent of these countries had fully ensured additional funding for these plans and 47 per cent had secured just partial funding.²⁵

NCDs, including many mental-health conditions, require the provision of long-term care and so are potentially both costly and complex – **making sustainability a particular challenge in protracted crises.** International donors are often unwilling or hesitant to fund chronic conditions in resource-constrained settings because of the timescales involved,²⁶ and where there is temporary funding there may be no exit strategy. And while there is an increasing awareness of the importance of taking an integrated approach to disease (not least because of the evident interplay between Covid-19, NCDs and mental health), it is not yet clear if this will translate into funding for integrated initiatives. In particular, prevention is rarely funded by donors, especially as part of humanitarian response, despite the prevention of disease being an important element of preparedness, which is at the heart of activities in the 'triple nexus' of humanitarian, development and peace. Donors commit to goals but are then unwilling to fund them*, and there are problems arising from competing financing streams rather than looking holistically across disease areas.

'The [traditional] approach was very vertical... so we started talking to government and other actors in different forums that this package should be person-centric and integrated'

– Dr Mahesh Gunasekara, Sri Lanka Red Cross

As was noted during the interviews, task-sharing, task-shifting and forms of collaborative care, peer support and group therapy and a holistic framing for MHPSS as part of NCD prevention and care all seem important and promising – but there is not yet the data to back this up. This is indicative of an urgent need to fund research, to provide better evidence of effective innovations and integration pathways and to encourage (and evaluate) scale-up.

While the addition of mental health and psychosocial support to a basic NCD package of care will inevitably initially add cost, **the return on investment may prove to be positive**, both for the programme through increased meds adherence and through broader returns such as ability to return to work.

'We hope that this study [in refugee camps in Thailand] will be able to demonstrate the small incremental cost of integration MHPSS in NCD care doesn't actually overall increase costs at primary health care programme level'

– Laura Miller, IRC

The private sector can also help to bridge the gap, including with enabling procurement of medications: for example, the Novartis Foundation's Access programme partnered with the Kenya Red Cross Society in the Dadaab refugee camps (see Annex A1.3). Partnership with the private sector should be transparent and with clear lines of accountability and responsibility.

* A gap identified by participants in the 2018 bootcamp on NCDs in humanitarian settings is that, although the WHO Global Action Plan for the Prevention and Control of NCDs has identified a menu of policy options known as 'best buys' for NCDs, these have not been specifically adapted to humanitarian settings. Combining with cost-effective solutions for mental health, and tailoring them to humanitarian response, could help to direct action and funding by governments and donors.

Funding and resources are often project-based rather than supporting a more structural approach, such as strengthening primary care, which can benefit both MHPSS and NCDs – although there may be possibilities to include funding for MHPSS and NCDs in other disease areas (such as for HIV) where there are clear co-morbidities. The Red Cross Movement may have more autonomy and flexibility than some organisations in its funding model, through disaster relief emergency funds and operational appeals, which may be available to be spent in more versatile ways.

4.3.3 National and systemic level

The failure to appreciate the depth of the need for NCD and mental health prevention and care extends beyond donors to governments – not just health ministries, but other relevant ministries including ministries of finance. There is often limited data on these conditions in lower-income countries even before a specific humanitarian crisis – and this lack of data is compounded in humanitarian settings, where people living with NCDs including mental-health conditions may be lost within the system and where people on the move are often entirely unregistered. In addition, in humanitarian settings, primary health care systems and the infrastructure for more specialist care are likely already to be under significant strain.

For NGOs and others interested in taking an integrated approach, **it may not be evident who is the best person within government to whom to introduce the concept of integration**. However, as was noted at interview, identifying this entry point is vital in increasing understanding (and potentially resourcing and support) – for example, in many countries mental health is nested within ‘NCD’ in the Ministry of Health, making an NCD department a good place to start.

There are further challenges when it comes to refugee populations, as the host governments have different approaches to their care in-country; some can include them on an equal footing to their own citizens, but others cannot or will not do so. Here, empowerment of refugees is important in ensuring that they get the integrated continuity of care to meet their needs.

The generally poor levels of data on NCDs, coupled with a lack of evidence on the specific benefits of integration of NCDs and mental-health conditions, can lead to low levels of political commitment to tackle NCDs and mental health. Many countries do not have policies (and fewer still have robust policies) or action plans in place for these conditions,²⁷ so they are likely to have even lower priority in a crisis.

Red Cross Red Crescent national societies have an **auxiliary role to government** in the countries in which they have a presence, so are well positioned to bring new ideas to bear, both as initial responder and in the longer term. This auxiliary role varies between different countries, depending on the need and on the specific national challenges faced. The Sri Lanka Red Cross Society has been taking forward a new approach that epitomises the ‘triple nexus’. This has developed out of the crises of the 2004 tsunami and the armed conflict of 1983–2009, with an increasing focus on prevention as well as more immediate crises. In this respect, the SLRC is a good example of how a national society can foster a more long-term and integrated approach – one that others can consider emulating. However, where good development work is begun by the Movement, growing out of the initial humanitarian response, this may not be picked up by funders, with significant challenges for sustainability.

‘We are trying to capitalise continuously on humanitarian and development settings, starting work from a humanitarian setting... [but] continuing and sustaining work is a challenge’

– Dr Mahesh Gunasekara, Sri Lanka Red Cross

‘We have to work on the whole environment and social determinants, including nutrition. It goes far beyond physical and mental health’

– Sigiriya Aebischer Perone, ICRC and Geneva University Hospitals

Advocacy by humanitarian actors, governments and civil society is needed to raise awareness and political will to tackle NCDs and mental health generally, and in humanitarian settings specifically. It is not just in low-income settings where integration struggles to be fully recognised – and there may be learnings to be drawn from examples from high-income countries – for example, how has advocacy made a difference in the recognition of and funding for of psycho-oncology .

As a recent paper on the MSF initiative in Irbid (Annex A1.2) notes, integrating within existing primary care services and strengthening health systems may be optimal, rather than providing a programme within a humanitarian setting that is then handed over to government control.

4.3.4 On the ground

Health workers and volunteers themselves will experience challenges to integration, not least because they will often be working in a system that is siloed and often meagrely resourced and fails to give opportunities to join up services: this lack of continuity makes it ineffective and inappropriate for person-centred care.²⁸ Even when services are theoretically available, **referral may be challenging** (particularly, for example, for refugees in host countries). Where mental health is not embedded in the primary care system, it is more complex and expensive to access – and less likely to be able to be integrated with NCD care as part of community-level provision rather than hospital-based care. There is a worldwide ‘human-resource-for-health deficit’ that is particularly acute in humanitarian settings: *‘the biggest gap is provider knowledge, ability and skills’*. A strong focus on the need for universal health coverage that reaches the most vulnerable and leaves no one behind can help to strengthen the case for services to reach forcibly displaced people and others. Too often, particularly in acute humanitarian crises, NCDs and mental health are lost – *‘we need to provide meds...but deprioritising mental-health support is not the way to go’* – with serious repercussions.

Significant stigma and discrimination against people living with NCDs, particularly mental-health conditions, can act as a significant barrier to accessing care, both on a personal level (with those affected being reluctant to seek care) and at a more structural level (where mental-health services are seen as a luxury and are not adequate for the needs of the population). Stigma may be rooted in cultural norms, and in many places mental-health support has been provided through family and religion rather than through the health system. Understanding traditional beliefs from the perspective of local communities themselves can help to inform how initiatives and research are designed, overcoming stigma and maximising uptake and impact. Improving the mental-health literacy of health workers can translate into community awareness-raising and individual peer-counselling to promote health-seeking behaviour among people with MHPSS needs and fostering better understanding among the general population.²⁹

NCD prevention and care are affected by (often pre-existing) shortages of human resources in humanitarian settings and high turnover of healthcare workers,³⁰ as shown in studies from Syria, Lebanon and Turkey.³¹ The suggestion of integrating a new element of care – such as incorporating MHPSS into NCD treatment – may sound impossible to already overworked staff and could dilute the levels of care that can be provided as well as adding to stress. However, there are recognised ways in which to redistribute the burden of care,³² which were evident in the research for this scoping report. This is vital in situations in which specialist expertise is in very short supply: in South Sudan, there are only three mental-health professionals for 12 million people, so primary care professionals or community health workers trained in the basics of MHPSS will be the only providers of care that most will ever be able to access.

- **Task-sharing:** team-based provision of integrated care for people living with chronic conditions, such as dividing diagnosis, prescribing of medication and psychosocial support to those most appropriately placed to deliver each.³³
- **Task-shifting:** delegating tasks to existing or new staff with either less training or narrowly tailored training. This can include training community health workers and volunteers to deliver psychosocial support and some aspects of NCD treatment, freeing up clinicians’ time to focus on more complex medical issues as they arise,³⁴ including in humanitarian crises.³⁵ For example, the Kenya Red Cross has trained community health volunteers at community level to refer patients through the system – a good model both of task-shifting and of integration of MHPSS into NCD care.

Ideally, task-sharing will take place, in which all the team work together to address the individual’s needs: this is the principle behind mhGAP and collaborative care models for NCDs. In practice, however, task-shifting is more common as it is less resource-intensive – but even this can face restrictions. In Jordan,

for example, there are strict rules on who may prescribe medicines, which limits the opportunities for task-shifting within teams treating the Syrian refugee community. A further brake on progress towards task-sharing/shifting is that clinicians may be protective of their own roles and not fully aware of the consequent benefits of this change, so both education and practical support are needed to deliver this approach.

The links between physical and mental health are often not fully appreciated – health workers and patients alike can be greatly affected by the physical and mental consequences of severe distress, for example – but to date the interconnections are not clear in much of the guidance. Mental health and NCDs tend to be siloed (such as mhGAP for mental health or the WHO’s Package of Essential NCD Interventions (WHO PEN) for NCDs), with little on disease co-morbidities and on integration itself.³⁶ An occasional mention of mental health in NCD guidance is not sufficient; it should be fully integrated throughout. **Too often, there is a mindset that mental-health support is about specialised care, rather than MHPSS being something that can be delivered by non-specialists to manage moderate mental-health conditions.** This is also complicated by the fact that situations vary dramatically: for example, MHPSS required by a patient who has had a limb amputated due to a traumatic event such as a war wound will be very different from that of a patient whose limb was amputated due to diabetes.

Even where clinical staff and community health workers have been trained on mhGAP (all the management modules of which include PSS elements) and on NCDs, **there is little support to integrate these services.** It was noted that it would be helpful if PSS training could include specific advice on NCD follow-up and also that those with NCD experience be trained in the use of mental-health medication. The latter has proved to be problematic for delivery of medication in the NCD Emergency Kit: sometimes the mental-health medication has not been used, either because of a lack of training in their appropriate use or because of restrictions on who can prescribe. And, while structured training is important, everyday interaction between a trained mental-health worker (such as a psychologist) with other clinicians can enhance other health professionals’ and community health workers’ understanding of the value of building MHPSS into wider NCD treatment.

However, **there are signs that this gap is beginning to be filled,** with recent MSF guidelines providing a range of options for humanitarian settings covering both mental health and NCDs, and also the IRC’s recent (2020) publication of the Package of Essential Non-Communicable Diseases Interventions for Humanitarian Settings (PEN-H), to which more insights will be added over time.

But even providing the tools, medicines, and training to deliver integrated care is not enough: **mentoring and ongoing supportive supervision is required** to enable health workers and volunteers to use the tools and prescribe with confidence: *‘training without supervision is entertainment’.* This support is an integral part of health-systems strengthening and capacity-building. The mental health of the responders themselves must also be considered, as traumatic experiences such as conflict, natural disaster and, recently, Covid-19 have long-term health implications for them, just as for the rest of the affected population.

‘It’s not enough just to do training: We need to provide a comprehensive package including mentorship and supervision; it’s not enough to ask people with a lay background to take on specialised tasks without equipping them to do so’

– Anouk Boschma, IFRC

A further challenge is, even where screening of patients for NCDs is feasible, there may not be an appropriate place to which to refer them. This is particularly problematic for diseases such as cancer or kidney disease (where chemotherapy or dialysis may be beyond the reach of the person being diagnosed – see case study Annex A1.4) as well as for mental health, with many countries still providing mental-health care through tertiary, hospital settings rather than in communities.

Disruption to health services is likely among displaced populations and refugees – and where people do not have access to their health records, continuity of care becomes particularly challenging. As the case study of the Dadaab refugee complex notes, for example, the government has closed camps at short notice, forcing people out of areas in which they can access care – and potentially right out of the system (Annex A1.3).

Where a programme is established by an NGO that provides integrated services that are not otherwise available within the national health system, it may then be hard to hand it over, should funding come to an end. In such cases, involvement and ownership by the local health authorities can be particularly important for continuity.

New technologies can be used to reach new audiences. In the **Philippines**, social media influencers were tapped through TikTok to advocate for mental health.

'Using them, we can make more of a difference, especially to young people. We need to be creative and innovative in reaching people who need the information' – Pred Morales, Philippines Red Cross

Realism was urged at the roundtable: integration is a process rather than something that can be fully implemented immediately, and how it will take place will depend on resources and local and national structures.

'It is important to acknowledge for the mental health of implementers themselves that this is a process, not something you implement straight away and tomorrow it's fine – we need to manage our own expectations'

– Sofia Ribeiro, IFRC

4.4 A confluence of crises: Covid-19

Humanitarian emergencies are not restricted to armed conflict or natural disasters; they are any emergency that to varying degrees overwhelm government (and civil society) systems, either for a short period of time or for a protracted period – as is the case with Covid-19. The pandemic has added a very significant layer of complexity to the humanitarian response, as well as leading to a 40% spike in the number of people worldwide needing humanitarian aid,³⁷ which will ebb and flow as outbreaks appear. Research by WHO from 2020 found that the effects of lockdown and economic constraints had major repercussions for both NCD and mental-health services worldwide.³⁸ **Covid-19 has dramatically illustrated the speed with which NCDs, and mental-health services are undermined in a disaster situation.**

In 2020, the Covid-19 Response Humanitarian Project by the **Kenya** Red Cross Society addressed the impact of Covid-19. It strengthened PSS support for some of the country's most vulnerable populations (including people living with NCDs – PLWNCDS) by provision of psychological first aid (PFA) training to MHPSS workers, who could then provide counselling to people affected by Covid-19. It also provided support for affected health workers.

The links between Covid-19 outcomes and NCDs, particularly in settings where basic hygiene and social distancing may not be possible (such as in refugee camps), are a source of stress and anxiety for people living with NCDs: *'There has been real anxiety [among colleagues] about the particular vulnerability of NCD patients to Covid (especially those with diabetes or cardiac conditions), and PSS is even more important as a result.'* The financial repercussions of lockdown have left many people living with NCDs without work and without the means to buy essential medicines – the supply chains for which were, in any case, disrupted by travel restrictions. Fear of contracting the virus meant many at-risk populations (including people living with NCDs) were reticent about clinic attendance and it became even harder to navigate an already fragmented system. In-person support groups could no longer meet. Medical workers themselves became sick – with repercussions for care where expertise is concentrated in one person and task-shifting is not possible. Research undertaken by the Kenya Red Cross Society confirmed that 'people living with pre-existing health conditions are at higher risk of experiencing negative consequences of public health measures put in place by countries and counties to reduce transmission of Covid-19'.³⁹

However, the case studies and interviews for this scoping report highlighted the **resilience of health systems and humanitarian workers in the face of Covid-19**. Local civil-society organisations have shown themselves to be more adaptable than many international organisations whose staff were unable to travel, making rapid, flexible changes to keep continuity of care going. The shift to remote or virtual support – through m-health (use of mobile technologies) or e-health – has been striking and is unlikely to be completely rolled back.

In the **Philippines** (Annex A1.4) telephone calls were used to stay in touch with kidney disease patients when meeting in person was not permitted during Covid-19. Where transportation for patients was limited, the medical social worker worked to contact local health officials and government representatives to assist in getting them to the dialysis centre for treatment.

In **Armenia** (Annex A1.1), Skype was used to keep nurses and volunteers connected in Armenia, and social support groups adapted their way of working to meet in smaller groups outside, rather than inside.

And, crucially for discussions on integration, **Covid-19 led to a global appreciation of the need to take a much more holistic approach to health**. The added burden of Covid-19 on health systems has meant that *'globally, everything is so slammed, we have to look at things more holistically'*. Health-systems strengthening and the need to move away from a siloed approach to disease prevention and care is now being discussed with renewed enthusiasm and seriousness, even by the Global Fund on HIV, TB and Malaria and the World Bank. Covid-19 provides an opportunity – albeit one that no one would have wished for – to mainstream mental health, promote wellbeing across a wide range of settings (in schools and local communities as well as health settings) and foster resilience and prevention. While appreciation and understanding of the benefits of integration of MHPSS and NCDs in humanitarian settings had already been growing, this could prove to be the tipping point that could benefit millions: **we are on the cusp of real change**.

5. KEY LEARNINGS AND NEXT STEPS

As a concluding step in this project, the partners in this project – the IFRC PS Centre, the University of Copenhagen and the Danish Red Cross – took the action statements developed at the roundtable (see box) and formed a series of asks, building on the insights of the whole project: roundtable, grey literature review, scientific commentary, and key informant interviews. These asks are presented here and, together, form both a summary of the project learning and indicate the potential direction of travel for future efforts to integrate MHPSS and NCD prevention and care .

Action statements

1. How might we.... recognise the benefits of integration of MHPSS and NCD prevention and care in humanitarian settings?
2. How might we.... increase investment in research to develop, strengthen and evaluate innovative, effective strategies to integrate MHPSS in NCD prevention and care?
3. How might we.... produce evidence-based guidelines for effective integration?
4. How might we devise sustainable financing mechanisms for integration?
5. How might we.... advocate to raise awareness to reduce stigma about seeking care for NCDs, including mental ill-health?

5.1 What needs to be created and advocated for?

More **awareness- and evidence-building** is needed to ensure a better understanding and recognition of the need for and added value of the integration of MHPSS into NCD prevention and care in humanitarian settings. Operational research on integration efforts in humanitarian settings, linked to advocacy efforts and policy frameworks, may be helpful in building practice-based evidence, which can then support future evidence-informed and integrated evidence-based interventions.

Tool and guideline development to direct the integration of MHPSS and NCD prevention and care in humanitarian settings could be one way forward – such as e-health options and practical guidance (for programme managers, MHPSS and health staff and community-level volunteers) on how to operationalise integration of MHPSS into NCDs. This could include integrated NCD prevention and care guidelines with a strong emphasis on training and on the job supervision of primary- and community health workers, as well as self- and peer-support groups: such groups are not just strengthening psychosocial support, they also have an important impact on NCD prevention and care management, including mental illness, awareness-raising and patient empowerment, with repercussions for adherence to treatment etc.

Such an exercise should start by collecting the tools that different stakeholders have already developed. As an example, there are tools and good practice to be found in the Red Cross Red Crescent Movement, with several different national societies and regional offices already having a strong track record in integration (including Armenia, Georgia, Kenya and the European regional office of IFRC). The development and operationalisation of such tools (such as on patient empowerment, a focus on agency and resilience in NCD prevention and care including mental illness) in a humanitarian setting where some capacity already exists (such as in Armenia or Kenya) could be a way forward. The goal could be to develop NCD service packages for humanitarian settings, with MHPSS fully integrated.

Lessons can also be drawn from the experience of the Red Cross Red Crescent Movement in communicable disease responses, such as the integration of MHPSS into the Ebola response, and also examples such as the HIV/AIDS home-based care toolkit and the Healthy Aging toolkit, which focus on

chronic illnesses and degenerative diseases, but which already include an MHPSS component.*

Implementing an effective person-centred approach is essential. It is essential to identify what is most important to people living with NCDs and MHPSS problems, their families, and caregivers in terms of treatment, care and broader support. The first step is to gather patients' views or personal stories about their health status/conditions, their social and cultural background and their beliefs and preferences. Based on this information, the best and most appropriate treatment, care, and support can be identified, and patients and families supported to set goals and think about actions to take to reach them. A participatory, co-creative, community-based approach is required for a truly person-centred approach, ensuring not only that the voices of people living with health conditions are consulted and heard, but that decision-making powers are shared with people with lived experience, their caregivers, and communities.

Further advocacy on task-shifting, task-sharing and collaborative care is needed, as there are still significant challenges to delivery of these approaches in humanitarian responses. First, tasks are delegated without appropriately extensive training to those who are supposed to implement them. Secondly, task-shifting requires supportive and technical supervision (albeit not clinical supervision) and mentorship if service is to be ensured. Next to a person-centred approach which may require (individual) case management, this may be costly, time consuming and not possible due to a lack of human resources for health (which is itself the primary impetus for task-shifting).

Vertical task-shifting may be feasible in humanitarian responses in the clinical system, but on a community-based level this may not be practical. It is easier to delegate tasks from higher-level physician-clinicians to lower-level physician-clinicians than it is to delegate the same tasks to non-physician clinicians.

For such approaches to be successful, **long-term political commitments must be made, coupled with appropriate financial resources.** Governmental, international, bi- and multilateral agencies, INGOs, NGOs, community-based organisations and other key stakeholders need to step up to collaboratively prepare health systems to implement task shifting/sharing and collaborative care models by ensuring that appropriate regulatory frameworks as well as training, management, supervision, and mentorship capacities are in place.

This project identified the need to **develop a better understanding** of the impact of peer-support groups, relative and caregiver psychosocial support and psycho-education sessions, and improved supportive supervision of volunteers and health-care workers dealing with NCDs including MHPSS needs. Successful delivery of this approach requires volunteer and health-care work capacity to be built in MHPSS as well as NCD prevention and care.

There is an urgent need to **increase investment in research** to develop, strengthen and evaluate innovative, effective strategies to integrate MHPSS in NCD prevention and care:

- The first step in accessing investment is to prioritise research and innovation in humanitarian settings. A research agenda based on the needs of these settings should be determined, which will best be achieved through the involvement of all relevant national and local stakeholders, including funders, national authorities and researchers.
- There is a need to promote policy coordination because these settings often have incomplete and fragmented research policy frameworks due to a lack of funding or human resources.
- Interventions should be designed in a way that ensures a long-term commitment from donors and stakeholders, which will maximise the long-term impact of the research. The interventions should also be tailored, based on locally available resources. Research should also be built in from programme-planning stage to ensure that data-collection tools are appropriately designed and that relevant, meaningful data can be collected before and after the intervention. The capacity of local researchers and related stakeholders should be built up through the engagement of senior researchers to share their insights or by using cost-effective tools such as e-learning (including MOOCs).
- Research production and management in these settings are hindered by the lack of appropriate information and communication technology, which may restrict the production, communication and

* *The new IFRC NCD in Care in Communities Toolkit, the launch of which is due around the time of the publication of this scoping report, also thoroughly integrates MHPSS concerns into community level NCD prevention and care.*

dissemination of research. A policy framework should be developed to institutionalise and coordinate infrastructure development in these settings.

- Finally, this all requires strong commitment on research investments from relevant stakeholders.

Several areas in which further research would be welcome were identified, including:

- impact studies to measure wellbeing as well as ill-health, illness and disease management and adherence to treatment, with a more central role for the concepts of agency and resilience. This will enable reflection on and understanding of physical and mental/psychosocial aspects of health, allowing for a more person-centred approach to evidence-building;
- the role of stress (and distress) in the onset of diabetes; and
- the impact of MHPSS in mitigating risk factors and on wellbeing and health more broadly. MHPSS should be integrated from the start, such as in NCD assessments in disaster/conflict situations.
- the role of peer-support groups, relative and caregiver psychosocial support and psycho-education sessions
- the role of improved supportive supervision of volunteers and health-care workers dealing with NCDs including MHPSS needs

5.2 What needs to be changed or removed?

There is an identified need to move into **programming that is more integrated and avoids siloed initiatives**. This includes addressing the separation by civil society of humanitarian and developmental work, as well as systemic health silos amongst MHPSS and NCD practitioners themselves. For example, in many Red Cross Red Crescent national societies, 'MHPSS' and 'Health' sit in different departments and, as a consequence, NCDs and MHPSS are the responsibility of different focal points. The positioning of NCD and MHPSS in national policies and health systems should reflect the need for integration: for example, in Armenia, psychiatric services but not psychological services are housed as part of 'health', and this separation negatively effects both referrals and capacity-building of staff.

Capacity-building of community health workers, midwives, nurses and doctors, together with social workers, psychologists and psychiatrists, is crucial. Exploring existing possibilities for task-shifting, task-sharing and multidisciplinary collaborative care models will enable a better understanding of the strong psychosomatic link between mental health and other non-communicable diseases. In humanitarian settings, m-health solutions are needed both for nurses and for patients/beneficiaries to support their work, and this may be particularly valuable in more remote settings where there is a lack of direct access to clinical-based care. Capacity-building of psychosocial support structures, which include the families of those directly affected, is equally important.

5.3 How can MHPSS and NCD prevention and care best be integrated in humanitarian settings?

Integration will best be achieved by **building capacity of health staff and/or key community actors through training, expanded education and on the job supervision**. This would require creation of the impetus to fund such programmes for the longer term through the development of policy commitments to collaborative working by all the stakeholders. No single stakeholder would be able to provide this integrated approach to the entirety of the (community) health-care workforce in a humanitarian setting: collaborative and well-coordinated advocacy, design, fundraising, implementation and monitoring and evaluation are needed.

Integration requires provision of NCD prevention and care with integrated MHPSS to affected communities by MHPSS or health staff (ideally, trained together on NCDs including mental health), or key community actors and volunteers. Their prevention and care support can be implemented by means of individual consultation, home visits or group support.

Initiatives such as the WHO/IFRC's community mental health toolkit, which is in the process of being

field-tested, hold great promise. Their value will be even greater if combined with other **low-intensity scalable MHPSS interventions that could be integrated into NCD prevention/care initiatives** or simultaneously or consecutively used to train community health workers and programme managers. The community mental health kit⁴⁰ is an integral part of WHO's mhGAP Action Programme, which aims to scale up services for people with mental-health conditions as part of the broader goal of achieving universal health coverage. The toolkit provides guidance for programme managers on how to identify local mental-health needs and tailor community services to match these needs. It offers practical information and necessary tools for community providers to promote mental health, prevent mental-health conditions and expand access to mental-health services.

E-mental-health interventions that are appropriate in terms of cultural acceptance and technological access and that are feasible given existing capacity can also be introduced and expanded to include persons who might not otherwise access services (for example, due to stigma).⁴¹ These tools are often developed for use in smartphones, and include self-help tools, guidance for community health workers, avatars with which users identify and that enable them to trust the messages and self-help tools provided, chatbots, access to medical professionals through chats, and algorithms that screen and alert for suicidal ideation. MHPSS is multisectoral in nature and can and should be made available through all existing humanitarian sectors, as per IASC MHPSS Reference Group guidance.⁴²

5.4 Final word

This initiative is the first time that the humanitarian community's views and ideas on how best to integrate MHPSS and NCD prevention and treatment have been brought together – and these are summarised in this scoping report. It is very clear that the time is now right to consider how best to act on this integration, which requires a fundamentally different approach: more holistic, person-centred and responsive to the many social and economic determinants of health in humanitarian settings, with a focus on prevention as well as treatment.

This project is not intended to scope the 'what's next' in detail, instead providing a knowledge base that can act as a launch pad for research, practice, policy and guidance in the future.

However, the partners hope that the new thinking that has been catalysed by the consultations and roundtable will continue, taking forward this nascent conversation and sparking new coordination between NGOs, humanitarian agencies, governments, and health professionals, with benefits for people living with non-communicable diseases, including mental health and psychosocial problems and needs, in humanitarian settings across the world.

A1: Case studies

Of the 14 examples of the integration of NCDs and MHPSS in humanitarian settings that are identified in Annex 2, four have been selected for detailed write-up. These were chosen for:

- the different approaches they have taken in bidirectional integration of MHPSS and NCDs, both within and beyond the Movement;
- their setting in current and post-humanitarian response or humanitarian emergency settings, across a broad spectrum of end users; and
- their geographic representation, namely the Middle East (Jordan), Europe (Armenia), Africa (Kenya) and Asia-Pacific (Philippines).

The IFRC requested detailed information from each case-study subject, including through detailed virtual interviews. Each case study was drafted and shared with those interviewed for comment, amendment and to answer any outstanding questions.

A1.1 Armenia: Diabetes prevention and care among older people in Armenia

A. Summary

The 'Prevention of diabetes and diabetes care among elderly [people] in Armenia' is currently being established by the Armenian Red Cross and the Danish Red Cross, with funding from the World Diabetes Foundation. It is the second phase of a programme that began by focusing on vulnerable populations more broadly than older people, and psychosocial support is fully embedded – through Self-Support Groups and Healthy Ageing Peer Groups. It intends to reach over 2,000 people with diabetes and over 6,000 of their relatives in 48 rural and urban communities in more deprived parts of the country, involving 300 Red Cross and community volunteers and over 200 health professionals. Psychosocial and NCD indicators are included in a detailed monitoring and evaluation framework.

The challenge of Covid-19 has delayed progress, but it is now under way again – and this case study describes both the current initiative and the learnings from the earlier phase.

B. Context and partners

Armenia is in the South Caucasus, bordering Georgia, Iran, Azerbaijan and Turkey – and conflict with both Turkey and Azerbaijan in recent years has meant economic hardship and political isolation.* Poverty rates remain very high, with a third of the country's population living in poverty and 16% classified as 'very' or 'extremely' poor. Diabetes prevalence is around 6.1% and premature mortality from diabetes is high, with around 27% of deaths due to diabetes occurring in the under-60s in 2019. Mental health is also a national issue: an estimated 40% of the population with mild depression and this is particularly concentrated in older age groups (almost 60% of people aged 65 and older).

The Armenian Ministry of Health has been increasingly concerned with increases in NCDs, and in 2011 approved national strategies on cardiovascular disease, cancers and diabetes. There is universal state funded primary health care for all citizens, but people with diagnosed diabetes often lack coordinated, continuous care, and struggle to access help.

The 'Prevention of diabetes and diabetes care among elderly [people] in Armenia' initiative is currently being established by the Armenian Red Cross Society (ARCS) and the Danish Red Cross, with funding from the World Diabetes Foundation. It aims to fill an important gap in the health-care system, by promoting and building skills for self-care of type 2 diabetes at community and health-facility level, reducing reduce the negative physical and mental repercussions of diabetes and promoting healthy living through a network of

* The regions in which this case-study initiative is being implemented are not themselves areas that are directly affected by recent conflict but are low-resource settings with significant barriers to both physical and mental health care.

trained volunteers.

It is phase two of an initiative that ran from 2016 to 2018 – ‘Diabetes prevention and self-care education for vulnerable [people] in Armenia’ – which addressed diabetes needs in the broader population and built up the capacity of ARCS to address this. Phase 2 is scaling this up further among a specific vulnerable group (older people), supported by the Ministry of Health and by the regional authorities, who are involved in the training and now have a strong sense of ownership over the project.

The initiative is taking place in 48 rural and urban communities in three of the more deprived regions of the country – Ararat, Gegharkunik and Aragatsotn, which have a combined population of 620,000. It is due to run from July 2019 to June 2022 and was formally launched in September 2019 with three regional events attended by local government and health facility representatives.

C. Integrating MHPSS within the NCD programme

The learning from the first phase of the diabetes initiative in these communities has informed the MHPSS/NCD integration aspects. The first phase coincided with a major World Bank programme to establish primary health centres in Armenia, which included screening for diabetes and access to a minimum package of medication. However, this was not coupled with provision of health education or patient support, and it rapidly became clear that PSS was a major unaddressed need. Phase 1 did include a small PSS component (psychological first aid training for volunteers), but this was found to be insufficient to provide the support needed for people with diabetes – who had many questions. The frustration of not being able adequately to address this need and answer the questions also affected the wellbeing of the volunteers themselves. Phase 2 acknowledges and addresses this gap, with PSS components now clearly articulated in the objectives and outputs.

The establishment of 120 **Self-Support Groups (SSGs)** are an integral part of the initiative. Each will have around 18 participants, who will meet monthly to talk about the challenges they face and the experiences they have had, as well as being an opportunity to receive information on diabetes and its complications. The groups aim to improve people’s psychosocial wellbeing by addressing common challenges of living with a chronic illness, including the anxieties about what lies ahead and the loneliness that many older people experience. Participants are identified by local primary care clinics, and the sessions were often (until Covid-19, see below) delivered in this health setting. The SSGs are run by ARCS volunteers, many of whom are retired nurses and so already have the basic training on which the SSG training can build. An SSG manual is provided to the volunteers that sets out a range of issues to discuss, including diet, medication and how to seek further help – although there is not a clear referral pathway, as many SSGs are in remote villages where specialised care is hard to access.

The support provided through the SSGs enable people living with diabetes to better manage the physical and emotional aspects of their condition, combining physical health monitoring – blood pressure and glucose levels are measured monthly – with lifestyle support. Cooking classes are held in every SSG (during which members share their recipes and support each other to make changes to their eating patterns) and each participant is provided with a diary containing health targets, which further motivates them to change. Each SSG will receive structured support from an Armenian Red Cross volunteer for a year, after which time each SSG will continue with support from local volunteers and nurses.

Materials to complement the SSGs are being planned, including on psychosocial support, along with provision of consultations with a specialist (psychologist, endocrinologist and dietician) for SSG members and their families, either by phone or online.

Family support is essential for the wellbeing of people living with diabetes – and **regular, open sessions** of the SSGs had been planned to enable relatives to attend and gain a better understanding of the challenges faced, facilitated by the ARC volunteers. However, these have had to be postponed due to the Covid pandemic.

A further way in which MHPSS and NCDs are being addressed is through the establishment of **Healthy Ageing Peer Groups (HAPGs)** across all 48 communities. Rather than taking place in health settings, these will be community based. They are led by older people themselves, who have the understanding and motivation to help to enthuse and support their older peers in living well and, as a consequence, preventing diabetes. The Group leaders will be supported by the Red Cross branch and project coordinator. The HAPGs will empower people to take charge of their own health and discuss issues of real relevance to their

everyday lives. It enables members to support each other and to tackle loneliness and depression, including through games and competitions, organising blood pressure and glucose level management days, and intergenerational activities and social events. It is also a mechanism to recruit further volunteers.

In 2019, as one of the first steps of the programme, **a six-hour psychosocial training module** was developed by the project psychologist. This trains participants in identifying, assessing, and supporting patients with common psychological problems, including diabetes distress. It also introduces Red Cross Red Crescent Societies PSS activities and psychological first aid (PFA) principles and their relevance in provision of health care, and also the importance of self-care when helping others, as volunteers themselves can be at risk of psychosocial stresses. Refresher training, with participation of the psychologist, was planned for the third quarter of 2020 – this will take place online, due to Covid-19.

Monitoring and evaluation of both PSS and physical impacts have been embedded since the start of the programme. A detailed M&E framework has been developed (with input from the project psychologist), which integrates indicators on patients' wellbeing from the Diabetes Distress Score. An initial baseline survey in 2019 found that 58% of those surveyed regularly checked their blood glucose level (every day or every week) and also that the majority had mild to moderate diabetes-related distress. The data was gathered using an app (Kobo Collect) on which 15 volunteers have been trained. A further survey will be taken at the end of the initiative. There is a quarterly review of progress (the latest of which details the impacts of Covid-19) and the mid-term review may include qualitative indications of the success of the initiative. Also, although regular monitoring and supervision of the staff and volunteers was not possible in-person during travel restrictions, project management remained in touch with the regional project teams by phone.

D. Project impact/reach

The initiative is at a relatively early stage, so data on impact is not yet available. In total, it aims to involve 90 doctors and 180 other health professionals from 40 health facilities, and 300 Armenian Red Cross and community volunteers. In total, over 2,000 people with diabetes and over 6,000 of their relatives will be reached, including through SSG membership.

By the middle of 2020, the second reporting period, the training of health professionals has been going well. 90 doctors have been involved through one-day meetings organised by the project coordinator and endocrinologist. 41 volunteers and 55 nurses have been reached with 'train the trainer' sessions over three days: two days with the endocrinologist and one day with the psychologist. Feedback gathered at the time suggests that the training was informative, practical, motivating – and enjoyable. Training of Armenian Red Cross volunteers has also led to an element of task-shifting, with the volunteers taking on what had been the nurses' role to follow up on clinical aspects of care with patients in the community, in between patients' visits to clinics.

Over 1,700 people with diabetes aged over 50 have been reached (and a further 168 aged 30–49), with were 388 people attending SSGs and over 1,000 family members involved. By the end of the first quarter of 2020, prior to lockdown, there were 24 SSGs (reaching almost 400 people – an increase of over 100 on the previous quarter). Covid-19 has slowed and pivoted the delivery of many aspects of the initiative, as detailed below.

Local government representatives have expressed willingness to provide further support to implement project activities.

E. Advantages/benefits of integration

The principal advantage of integrating MHPSS into diabetes care is that it treats the whole person, not just the physical manifestation of the disease. It was evident in phase 1 that many were struggling with depression and other mental-health conditions, often as a response to their diagnosis. The integration of PSS aspects has provided those diagnosed with a lifelong condition (and their families, who also have to adapt their lifestyles) with a valuable coping mechanism at a challenging time; peer-to-peer support has been vital in helping to understand and adapt to living with diabetes. The psychosocial support enables the target population to build resilience, to make new friendships and connections and to come to terms with their disease.

Integration reflects the WHO's inclusion of mental health as the fifth NCD – and as a cross-cutting NCD

that affects all the others. It is not possible to separate physical health from mental health, and there is co-morbidity between NCDs and depression. The impact of living with a chronic illness should not be underestimated and addressing diabetes care would not be complete without addressing affected populations' mental health as well, including relatives and carers.

F. Challenges

Challenges identified by the 'Prevention of diabetes and diabetes care among elderly [people] in Armenia' initiative include the following.

- The support that is currently provided to people living with diabetes does not address wider 'livelihood' issues, such as how to deal with the economic impact of having an NCD (which can be particularly severe if they or a family member have to give up work). This has significant repercussions for mental health – but there is not currently the capacity to provide training for the volunteers on how to navigate the system in the best way to overcome this financial constraint, or how to deal with the psychosocial repercussions.
- The people who are most vulnerable and in most need of support are also the hardest to reach. In particular, older people are often less mobile than younger patients with diabetes, so it may be difficult for them to attend in-person support groups.
- There is currently no 'how-to' guide to direct the establishment of an NCD programme that integrates MHPSS. A standardised guideline on how to work with NCD patients and the approaches to use, and how best to provide training/support would be very valuable.
- Phase 1 showed that the volunteers themselves would benefit from a support structure, within which they can ask questions and share their experiences.
- Sustainability is inevitably a challenge, as the formal support SSGs will continue only for a year. However, this is sufficient time for the SSG leader to cover all the issues in the manual, for healthier habits to be formed, and for new people to get involved within the community. Many of the SSGs are taking place in small, tight-knit villages, so informal support from volunteer or a local nurse may continue beyond the end of the project, and ownership of the initiative is high. As the branch director of phase 1 put it: 'I will [continue after the project] – I cannot stop even if I wanted to!'

G. The impact of Covid-19

Covid-19 has demonstrated the need to be flexible in programme provision in the face of unforeseen crises (in this case, a global as well as national crisis). Some aspects of care and support had to be postponed, with others pivoting to different forms of delivery, and new sources of funding sought for unanticipated expenses – such as glucometers to use at home rather than when at a group meeting.

Please note that this section will be updated following the roundtable, during a site visit by Danish Red Cross partners.

Impact on SSG participants:

- Once in lockdown, in all three regions the leaders of the SSGs remained in close contact with primary care practitioners, facilitating the delivery of medication and advice to SSG members where necessary.
- The SSGs were restarted in smaller groups (4–5 people) following the lifting of the full state of emergency in mid-July 2020. These took place outside and participants were provided with the appropriate PPE. However, it was not possible to deliver cooking classes during this period.
- Every member of SSGs in 24 target communities were provided with a glucometer and other materials need to track their own health status, funded by the Danish Red Cross and they receive telephone support from their SSG leader. The medication and devices were distributed through existing channels established by the ARCS, such as that established to provide food during the lockdown.
- Covid-19 has meant a delay in the establishment of the Healthy Ageing peer groups – although three groups have been established in Ararat, with a limited number of people (4–5 per session) and held outside. Their main concern has – unsurprisingly – been how best to protect themselves from the pandemic.

- Once the situation with Covid-19 is under control, peer initiative groups will also be established and awareness-raising activities among the older population – on healthy ageing and lifestyles – will be able to begin.

Impact on providers:

- In the second quarter of 2020, it was decided to continue activities for nurses and volunteers on online platforms such as Skype. Each discussion session involves around 10 people and is a forum to discuss the ongoing crisis situation and how best to deliver the required care. As already noted, refresher training, including with the psychologist, was planned online for the third quarter of 2020.

Impact on other stakeholders:

- During the first quarter of 2020, a series of meetings were planned with local public authorities and health facilities, and these could not take place.
- The planned establishment of a regional advisory committee, involving health and social care authorities, local NGOs and ARCS, has been delayed.
- Activities in the wider community – to build awareness about diabetes and the risk factors – have largely been put on hold.

Sources

Interview with Signe Frederiksen, Danish Red Cross, 17 February 2021

'Prevention of diabetes and diabetes care among elderly in Armenia', draft Q2 2020 report

IDF, 'Armenia – diabetes report 2010–2045', IDF Atlas 2019 (diabetes statistics) <https://diabetesatlas.org/data/en/country/9/am.html>

ARCS/Danish Red Cross, 'Implementation review: Diabetes Prevention and Self-care Education for Vulnerable in Armenia' (2018)

National Institute of health, Armenia Health System Performance Assessment 2017 (2018), p. 6 (mental health statistics) <https://nih.am/assets/pdf/atvk/81c7225c0595cc3dc4c86f6d1ca4534d.pdf>

WDF, 'WDF15-1308: Improving diabetes prevention and care in Ararat region, Armenia' <https://www.worlddiabetesfoundation.org/projects/armenia-wdf15-1308> (phase 1)

WDF, 'Prevention of diabetes and diabetes care among elderly in Armenia, WDF18-1636' (undated) <https://www.worlddiabetesfoundation.org/projects/wdf18-1636> (phase 2)

A. Tadevosyan, G. Sakanyan and A. Soghyan (undated) 'Report on baseline study of the project "Prevention of diabetes and diabetes care among elderly in Armenia"'

A personal story from Armenia

Astghik Shahbazyna is a maths teacher, whose husband was diagnosed with diabetes in late 2020 after returning from the recent war in Nagorno-Karabakh, in which around 5,000 Armenian men aged under 25 died. He worked at a factory in the region when the war began and helped to evacuate people from the conflict zone to shelters around Armenia at his own initiative.

But after he returned home, he fell ill and was diagnosed with diabetes within a couple of months. Astghik has no doubt that the anxiety and stress that he experienced during the war triggered the onset of his disease: 'He was fine before the conflict broke out!'

The psychosomatic link between psychological wellbeing and diabetes is well known by medical professionals and psychological distress can have severe consequences for diabetes management.

Astghik reports that, with her help, her husband has changed his diet and is making efforts to live more healthily – but his glucose levels still shoot up every time he hears news about the Nagorno-Karabakh conflict.

Both Astghik and her husband are now receiving support from the Armenia Red Cross: she joins the sessions for relatives supporting diabetes patients which are conducted by Red Cross volunteers and her husband is part of the support group for people living with diabetes. She now has more knowledge and information about the disease and knows where to go for help.



As told to Pia Lorentzen, Danish Red Cross, who also took the photo.

AI.2 Jordan: Delivery of an NCD programme for Syrian refugees and the host population in Jordan (Médecins Sans Frontières)

A. Summary

The NCD programme described in this case study was established by MSF Operational Centre Amsterdam (OAC) in Irbid, Jordan, in 2014, aimed at both Syrian refugees and the local host population. Initially it focused on delivering care for physical NCDs (primarily CVD, diabetes, asthma and COPD) and extended its remit in 2016 to integrate MPHSS, as it became clear that patients were in significant need of this support, and peer-support and individual counselling were offered.

Care was delivered through two primary-care clinics, with funding from MSF permitting 4,000 active patients to be enrolled. It has been studied through a partnership with LSHTM, outputs from which include a costing analysis and a paper on 'social suffering' among Syrian patients. MSF OAC has decided to hand over the project to local partners and close by the end of 2021, which has implications for sustainability, due to limited capacity among NGO and Ministry of Health partners.

B. Context and partners

The Syrian conflict began in 2011 and has, to date, internally displaced 6.7 million people within the country and a further 6.6 million into the surrounding region. 660,000 of these are currently in Jordan, of whom over 165,000 are hosted in Irbid, the country's second-largest city. Prior to the conflict, NCDs were the leading cause of death in Syria, accounting for 77% of deaths, primarily cardiovascular disease (CVD), with over 36% of these deaths occurring among people aged under 60.

People living with NCDs are at higher risk of mental-health disorders in any context, and for refugees this risk is exacerbated by the psychological impact of armed conflict, forced displacement and the ongoing stresses of everyday life as a refugee. Among this population, many people cannot separate their social and political context (which drives trauma and lack of self-efficacy) from their physical health – they are in a ‘state of entrapment’, with seemingly no way out. Given these serious comorbidities, there are ‘surprisingly few reliable studies’ on mental health and psychological distress among Syrian refugees in Jordan.

The MSF programme in Irbid was established in 2014 and continued until 2021, when the decision was made to close the programme in response to changes in the context (including a Ministry of Health policy reinstating subsidised healthcare for Syrian refugees) and other priorities in the OCA portfolio. Outcomes of the programme were studied in partnership with the London School of Hygiene and Tropical Medicine, using the RE-AIM framework (reach, effectiveness, adoption/acceptance, implementation, maintenance) to assess physical, mental and cost-effectiveness outcomes. It was established for the benefit both of the Syrian refugee population and also the host population, with the government requiring 30% of those enrolled to be Jordanian.

C. Integrating MHPSS within the NCD programme

The project was initiated in 2014 and took the form of two primary-care clinics in Irbid (eventually amalgamated in 2019), which provided new services that were not currently provided by or integrated into pre-existing services. The focus of the programme were the NCDs that were responsible for the greatest disease burden in the Syrian population before the war: cardiovascular disease, diabetes, asthma and chronic obstructive pulmonary disease (COPD) – but excluded cancer care. In 2017, around two-thirds of patients had hypertension, 60% had type 2 diabetes, 24% had CVD – and over 70% had two or more NCDs. The programme was financed entirely by MSF, with funding permitting around 4,000 active patients to be enrolled at any one time (over 5,000 patients were included during the period 2015–2017). Emergency cases were passed on to the Jordanian public health service and referrals for complications were made to other public, private or humanitarian providers.

Services were gradually extended as the need for other components became evident: in 2015, a family medicine specialist and a home visit service were added, and a physiotherapist in 2017.

However, what became particularly clear within the first few months was that patients’ mental health was affecting their self-care – and MSF felt that the quality of the mental-health services available from another international NGO in Irbid was inadequate (this is noted in the RE-AIM study in the sources). In response, a specific MHPSS strand was integrated into the programme in 2016, initially consisting of MHPSS counsellors who delivered individual counselling. This initially primarily focused on medication adherence but, over time, it became clear that there was an underlying additional burden of undiagnosed and untreated mental-health problems, including anxiety, psychosis and self-harm, and the service further evolved to address a wider range of issues.

The new service expanded beyond individual counselling to include ad-hoc psychoeducation sessions in waiting rooms, peer-support group sessions and a ‘living well’ sessions targeted at specific groups (such as young people with type 1 diabetes, helping them to adhere to treatment and improve glucose control), which focused on health education and psychosocial support. The peer-support groups have been assessed, but the living well sessions, to date, have not. In addition, a family medicine specialist was also trained to prescribe psychotropic medication (primarily antidepressants) and psychiatric input, as MSF identified a lack of quality referral options for patients with these needs. GPs were also trained in the WHO’s mhGAP programme. Referral of those identified as needing further mental-health treatment was initially limited to doctors, but referral rights were expanded to social workers and nurses.

Many concerns were common to both Syrian and Jordanian patients – poverty and unemployment – but others were more specific to the Syrian population – notably the collective suffering of their community, social isolation and fears for those left behind, vulnerability to exploitation, and working restrictions that exacerbated financial hardship and indebtedness.

*‘I say my diabetes is not because of food ...
Bad emotional status can increase the sugar level especially if one is always tired’
– male Syrian patient*

D. Project impact

Integration of MHPSS: One of the publications arising from the initiative has used the ‘social suffering’ framework to analyse how individuals describe and their own health, both mental and physical. The resulting publication is the result of 16 interviews with Syrian and Jordanian patients (all aged 60 or over and mostly with hypertension and/or diabetes) and 18 interviews with MSF staff. Poor finances were cited as restricting lifestyle changes (such as not being able to exercise or to afford to cook or eat healthily) and also as causing depression and anxiety, which themselves worsen self-care. The affordability and accessibility of the MSF-provided care was cited as helping to alleviate these financial concerns, even among the better-off in the study. There were challenges (see below) around stigma affecting enrolment and attendance – by in 2016 (when recording began), 66 group sessions were held, and 154 people attended individual counselling sessions.

In terms of the effect on NCDs, most patients (85%) continued to attend follow-up appointments six months after registering for the programme and valued the free medication and testing – and the medical outcomes are clear: the proportion of patients with hypertension achieving blood pressure control rose from 59% at baseline to 73% by six months. And, beyond the formal MHPSS groups and counselling, the supportive environment provided by the staff was appreciated by patients.

‘[MSF is] honestly caring about the patient, caring about his appointments even the medication availability. We have never come here and told us that the medication is not available. Their performance is great’

– female patient

Cost analysis: This study is one of very few to describe the costs of delivering primary-level NCD care in humanitarian settings, and the first among Syrian refugees in Jordan. Annual costs were calculated for the period 2015–17; there were no donations (drugs and other medical supplies were purchased locally, from MSF pharmacist-approved suppliers in Jordan) and, unlike in the Movement, volunteers were not involved in project delivery. The annual cost was considerable – rising from around INT\$4 million in 2015 to over INT\$6 million in 2017, as the programme grew in complexity – and by 2017, the annual cost per patient was over INT\$1,750. The majority of the expense were drugs and human resources, and a number of scenarios have been modelled to look for potential cost savings, particularly task-shifting. The costs did not include costs of external referral, as this expense is borne by the Jordanian health system.

However, to date the specific impact and cost of the MHPSS aspects have not been separately analysed – so these benefits of the integration of MHPSS have yet to be determined, despite the evident impact on patients’ wellbeing. Further crunching of the numbers to provide a better understanding would be welcome.

E. Advantages/benefits of integration

There have been a number of benefits to the integration of MHPSS into the NCD programme:

- It has been an ongoing opportunity to identify patients who would not otherwise seek mental-health care and could suffer poor NCD and MH outcomes as well, such as providing an element of psychoeducation to all NCD patients in the waiting room (reaching those not expressing/exhibiting current symptoms).
- ‘This is a blanket opportunity to improve MHPSS knowledge, personal skills and to minimise stigma’
– Éimhín Ansbro, LSHTM
- Medical and nursing staff have been trained in using specific tools to identify depression/anxiety that they would not otherwise have received.
- It has enabled a much more multidisciplinary approach. Although there was some initial resistance, over time the MHPSS and medical, nursing, and social work teams learned to work together to identify people needing MHPSS referral, leading to:
 - a. increased awareness of MHPSS issues among staff on the NCD initiative;
 - b. multiple opportunities across different patient–provider interactions to recognise symptoms among patients; and
 - c. empowering staff who initially felt overwhelmed and unable to deal with psychosocial issues arising

during physical NCD consultations.

The benefits of integration are evident from the patients interviewed for the study on social suffering, who consistently linked psychological distress with poor NCD control. Poor finances were causing depression and anxiety, which themselves worsen self-care – and the affordability and accessibility of the MSF-provided care was cited as helping to alleviate financial concerns, even among the better-off in the study.

'I feel relieved and comfortable since the first day I came here, I felt the difference in my disease. I used to take pills for diabetes and hypertension, but nothing changed'

– Jordanian patient

F. Challenges

In an effort to reduce costs and provide more person-centred care, task-sharing was adopted from 2016, with the intention of shifting responsibility for appointments for stable patients to nurses from doctors. However, this was met with only limited success: by the end of 2017, nurses were still performing only 6% of follow-ups and, because Jordanian law prevents nurses from beginning or adjusting medication, doctors retained responsibility for prescribing. Traditionally in Jordan, psychiatric services have been medication-based, delivered through specialists, rather than talking therapies delivered in primary care settings – and, perhaps as a consequence, MSF staff felt that doctors were sometimes distrustful of the effectiveness of the MHPSS services offered and felt that counsellors were 'encroaching' on their territory, resulting in lower referral rates.

A particular challenge, evident from the interviews with patients and MSF staff, seemed to be a reluctance to seek help from the MHPSS clinic, perhaps because mental-health issues were seen as being private: 'I do not think this [clinic] is a proper place [to seek help for psychological issues] ... these are personal things.' This is reflected in patients prioritising travel costs for medical consultations over those for MHPSS appointments, and also in initial distrustfulness of the medical team in the MHPSS services.

There is significant stigma around mental health among both the Syrian and Jordanian populations. Some doctors may have been unwilling to refer to the MHPSS service for fear of patients being stigmatised and MSF staff related patients' strong desire to be seen as 'normal' rather than 'crazy'. Research for the programme also suggest that this can be mitigated by providing interventions that focus on 'living well' and problem solving, rather than explicitly on mental health.

However, the primary obstacle for the project into the future has been its cost and, consequently, its sustainability following the withdrawal of MSF support. This, coupled with the ongoing lack of available MHPSS services for the wider population, threatens the longevity of the positive results shown and the dis-integration of what had been an integrated programme. Handing a complex care model over to national health services in a protracted crisis is proving to be a significant challenge – unfortunately, continuation of mental-health services cannot be guaranteed because of limited capacity among NGO and MoH partners (due to funding and existing service volumes). MSF is advocating for continued comprehensive care for the people who have been attending the Irbid clinic.

G. The impact of Covid-19

Covid-19 struck in 2020, as the programme was ongoing. new admissions were stopped in the second quarter of the year and, as soon as the first lockdown was announced in March, the team pivoted to home delivery of medications and telephone follow-up. This included individual MHPSS support, but group activities were suspended. Unstable patients resumed in-person follow up visits after lockdown, but group activities could not be resumed due to ongoing infection control measures.

Sources

É. Ansbro et al., 'Clinical outcomes in a primary-level noncommunicable disease programme for Syrian refugees and the host population in Jordan: a cohort analysis using routine data' (2021) PLoS Med 18(1): e1003279 <https://doi.org/10.1371/journal.pmed.1003279>

É. Ansbro et al., 'Delivering a primary-level non-communicable disease programme for Syrian refugees and the host population in Jordan: a descriptive costing study' (2020) Health Policy Planning 35(8): 931–40 <https://doi.org/10.1093/heapol/czaa050>

É. Ansbro et al., 'MSF experiences of providing multidisciplinary primary level NCD care for Syrian refugees and the host population in Jordan: an implementation study guided by the RE-AIM framework' (2021) BMC Health Serv Res 21: 381 <https://doi.org/10.1186/s12913-021-06333-3>

L. Maconick et al., "To die is better for me", social suffering among Syrian refugees at a noncommunicable disease clinic in Jordan: a qualitative study' (2020) Conflict and Health 14: 63 <https://doi.org/10.1186/s13031-020-00309-6>

WHO, NCD Country Profiles 2011: Syrian Arab Republic (2011) https://www.who.int/nmh/countries/2011/syr_en.pdf?ua=1

UNHCR, 'Syria emergency' (undated) <https://www.unhcr.org/uk/syria-emergency.html>

A1.3 Kenya: Integrating MHPSS into an NCD initiative in Dadaab refugee complex, Kenya

A. Summary

Since 2013, the Kenya Red Cross Society (KRCS) has been providing support and medication for people living with NCDs in the Dadaab refugee complex in Kenya. A partnership with the Novartis Access initiative enabled around 40 community health workers to provide NCD drugs and services to over 450 people, and patients were encouraged to join a support groups, each led by a community health worker, which provided health information, nutrition counselling and psychosocial support. Many more people were reached through community-based sessions, that include raising awareness of NCD risk factors and improving the community health system. The KRCS's work faces ongoing challenges: the funding from Novartis Access ended in 2019, but some support for medication is now provided by UNHCR, and the support groups continue to be run by the community health volunteers (CHVs), although monitoring is not now possible. The combination of Covid-19 and the threat of camp closure are also further affecting service provision, due to UNHCR budget cuts and high attrition of staff.

B. Context and partners

The Dadaab refugee complex is one of the largest in the world, housing almost 219,000 people in 2020 across three camps, Dagahaley, Ifo and Hagadera. The Kenya Red Cross Society's NCD programme was established in 2016 to address unmet needs of people living with NCDs: over 30% were estimated to have hypertension in 2017. In 2016 a partnership was established with Novartis's Access initiative to provide low-cost medication and to support training of community health promoters and community health workers – total funding was around US\$345,000 over three years. Other partners included representatives of the NCD Division of the Ministry of Health and the UNHCR. The Ministry of Health's county health teams provided supportive supervision of training of NCDs among health workers and CHVs, and quarterly stakeholder meetings were held between the partners, Ifo camp management and the host community.

The initiative was initially delivered in the Ifo 2 camp, but this camp was closed in 2018 and the initiative shifted to the Ifo 1 camp – both camps had a population of over 60,000 people.

Following the end of the Novartis Access support in 2018, the NCD programme and support groups have continued, with UNHCR stepping in to provide support and continuity of care, despite the Covid-19 pandemic and ongoing government threats of closure of the camps (ostensibly due to security concerns about Al-Shabab insurgents and influenced by an ongoing border dispute with Somalia on the coast).

C. The integration of MHPSS and NCD care and prevention in Dadaab

NCDs have been a focus for the KRCS since 2013, with community health workers supported to do basic screening for early detection of NCDs (including for hypertension and diabetes) and with high-risk individuals then referred for treatment. The Novartis Access programme ensured that laboratory services could be offered for blood sugar testing and liver and kidney function tests, and NCD medication was made available (at a cost of \$1) from a portfolio of drugs including insulin and metformin, procured through the KRCS procurement system.

From an organisational perspective, the Kenya Red Cross Society is well placed to deliver integrated initiatives, as the same person within the KRCS has responsibility for both NCDs and MHPSS, making it

easier to co-programme – and there is a strong understanding that mental-health conditions are both an NCD and a risk factor for other NCDs.

'Most patients when diagnosed go through a process that is more emotional than physical'

– Sylvia Khamati, Danish Red Cross

Integration is a logical step and was reflected in an important MHPSS strand of the NCD programme, which was built in from the start: monthly patient support groups for 10–20 people with diabetes and hypertension. These are organised by community health volunteers and are chaired by 'block leaders' (the camps are divided into blocks for management/service delivery purposes, with leaders from each acting as a link from their community to KRCS/UNHCR), with meetings synchronised with clinic days to minimise travel.

Participants are provided with health information (including on self-management) and nutrition counselling (from a Ministry of Health nutritionists), as well as psychosocial support to better cope with the conditions and to address the denial and stigma (both self-stigma and community stigma) that can follow diagnosis. The support groups are a forum to provide counselling and improve understanding about the need for compliance with medication: reasons given for non-compliance including lack of understanding about conditions, a desire to avoid side-effects, forgetfulness, and an assumption that being asymptomatic means that they no longer have the condition.

The support groups have been given advice on income-generating activities (IGAs) to support their families. Patients are encouraged to start small businesses, such as shopkeeping and tailoring, presenting their business ideas and, where appropriate, are supported by KRCS to identify the most feasible IGAs based on the available market. The group contribute money that is lent to members as a loan at a low interest rate. This new source of income can then help patients to bridge any gaps in availability of free medication, giving access to drugs from chemists.

The refugee patient support groups also link up with national patient support groups, which are a strong voice in calling for appropriate policies and guidelines. This is done through the Kenya NCD Alliance Kenya, membership of which is open both to patients and NCD organisations. The the support groups highlight challenges and gaps in services that can then be escalated to national level through the participation of KRCS in technical working groups, thereby informing policy development.

In addition, there are community-based sessions to ensure better understanding of the community health system within the camps, with a particular focus on NCD risk factors and early detection. These are run by influencers within the community, such as religious leaders, safe motherhood promoters and youth group leaders, who have been sensitised by KRCS. Sessions are also held at primary schools, at which children are taught how to identify symptoms of NCDs and about healthy behaviour such as physical activity and not smoking.

The active involvement of people living with NCDs in the support groups and as community health volunteers also helps to decrease the stigma around NCDs Protection gender and inclusion (PGI) was mainstreamed during implementation of project activities.

Until 2018, there were monthly data review and feedback meetings for the CHVs and others, an opportunity to review community health data related to the project. The M&E team in KCRS HQ has also assisted with quarterly data verification on both NCDs and MHPSS. An electronic patient information-management system was piloted, and UNHCR is currently developing an electronic medical record (EMR) system.

'Integration of MHPSS and NCDs provide new opportunities for a more holistic, collaborative and person-centred response to NCD prevention, treatment and care'

– KRCS team member

D. Project impact

In early 2018, in the Ifo 2 camp immediately before its closure:

- NCD drugs and services were provided to over 450 people: 313 receive treatment for hypertension, 78 for diabetes, 23 for asthma and 16 for CVD;
- there were 17 active patient support groups with 410 members, with a roughly even gender split;

- around 1,900 people had been reached by the most recent quarterly community outreach session headed up by community leaders;
- 30 community health volunteers had been trained to identify individuals at risk of NCDs and provide information on healthy lifestyles;
- 20 community health workers had been provided with training on how to educate peer-educators (who could be community leaders, block leaders, young people, mothers etc.), who then provided wellness support to over 50 people in the camp; and
- 10 primary schools (with around 60 pupils each) had been visited for NCD sessions.

In the Ifo 1 camp, screening for cervical cancer has been integrated into NCD interventions (for both refugee and host communities), with the auxiliary nurse in the clinic also providing women with NCD messages.

The community health promoters and community health workers trained by the Novartis Access programme continue to work in the camps, which means that interventions can continue, including the support groups for PLWNCDs. The portfolio of NCD drugs provided by Novartis Access is no longer available, and UNHCR now supports the procurement of NCD drugs (although this is not optimally done, as some patients cannot change their drug regimen as most of the drugs are unavailable). Screening interventions continue, although the demand-creation strategies that had been included in the Novartis funding means that demand has fallen.

Lessons from the initiative continue to be shared at a monthly meeting, headed by UNHCR and involving all health-implementing partners from the camps: KRCS, Islamic Relief Kenya, the International Rescue Committee, MSF and UNHCR. The meetings are on health more broadly, with NCDs as an agenda item.

E. Advantages/benefits of integration

Integration of NCDs with MHPSS has greatly improved the management of both NCDs and mental health in the camp. It led to the formation of comprehensive support groups, which have assisted in reducing stigma, as supportive messages can be widely shared through the new integrated approach. Integration has increased the sense of belonging of both NCD and mental-health clients, and community awareness and understanding of the conditions has significantly improved compared to prior to the integration.

Integration of MHPSS and NCDs provide new opportunities for more holistic, collaborative, and person-centred approach to NCD prevention, treatment and care.

'NCD patients go through a lot of stress due to fear of death and the fact that these are lifelong conditions and are financially draining. It's therefore critical to integrate MHPSS interventions for the patients, in order to help them to be able to deal with the stresses' – KRCS team member

F. Challenges

In 2021 the camps are home to around 400,000 people, who are facing a confluence of crises: the underfunded burden of (often undiagnosed) NCDs including mental-health conditions, Covid-19 (which itself causes significant stress and anxiety) and the threatened closure of the camps. The fragility of the system has already been starkly demonstrated with the closure of the Ifo 2 camp, and consequent collapse in continuity of care for many refugees, and with further imminent closures possible. In March 2021, the government issued an ultimatum to the UNHCR to provide a plan and timeline for the camp closure – although in April Kenya's high court ordered a temporary stay. In the past, refugees living with NCDs have not been repatriated, as no health facility has been identified by the UNHCR in Somalia that could provide people with NCDs with the access to treatment that they need in their home country. Voluntary repatriation disrupts treatment and can lead to complications.

Throughout the initiative, the NCD department has been understaffed, with inadequate nurses, auxiliary nurses and volunteers. Task-shifting to CHVs was attempted, but there were no digital blood pressure machines or glucose strips that the CHVs could easily use at household level, and there were relatively few CHVs available. There was also a lack of medication and tools, including blood pressure machines, and no standard BCC materials for community members in a refugee context.

Project funding came to an end abruptly, so not all planned activities were implemented but the NCD

programme, including the support groups, has continued with UNHCR support. However, inadequate supply of drugs and (in particular) lab equipment such as glucometers, has led to an inability to adhere to med regimes, and subsequent complications. In addition, funding limitations mean that it is no longer possible to monitor or evaluate the impact of the support groups or know who is reached by them. Patients returning to Somalia with no proper referral and without sufficient supplies of drugs may also then find themselves unable to access medication; if they then return to the camps to get treatment, they may already have developed secondary complications because of significant disruption to treatment.

The KRCS has recently undertaken an assessment to understand the range of challenges faced by the refugee community in Kenya, including NCDs and mental-health service delivery. It is clear that there are significant gaps in terms of service access, policies and guidance, as refugees fall outside the government's MHPSS and NCD programmes. NCD indicators are now, however, captured in the data health information management systems, implemented by the Ministry of Health almost three years ago.

G. The impact of Covid-19

During lockdown, NCD patients were given stocks of medication for two months with close follow-up by CHVs. The support groups continue because they are linked to clinic days, so as patients come for review, they can also meet to discuss their issues. Ministry of Health guidelines stipulated that there should be no gatherings or trainings of more than 15 people. Subsequently, this affected any planned training or review meetings that are normally organised for the CHVs. However, to ensure continuous supportive supervision, the KRCS project staff followed up the CHVs by telephone to ensure that all was well, including addressing any challenges that face at community level.

The Kenya Red Cross Society has also studied and published on the impact of Covid-19 on NCD programmes in Meru and Nairobi counties.

Sources

Interviews with: Sylvia Khamati (Danish Red Cross), March 2018; Dorothy Anjuri (KCRS), Sylvia Khamati and Dorothy Mwari Nkonge-Ngumbau (Danish Red Cross), March 2021; Sylvia Khamati and Dorothy Mwari Nkonge-Ngumbau, April 2021.

Danish Red Cross and KCRS, Case Study Report on Non-Communicable Diseases and Covid-19 in Meru and Nairobi Counties, Republic of Kenya (August 2020), supplied from KCRS and with accompanying videos at https://youtu.be/iEdSrgB_hUQ

Human Rights Watch, 'Closing camps won't solve Kenya's refugee problem: government should protect refugees, not send people back to dangerous conditions' (13 April 2021) <https://www.hrw.org/news/2021/04/13/closing-camps-wont-solve-kenyas-refugee-problem>

KCRS, 'Press release: Kenya Red Cross Society and Novartis join forces to combat non communicable diseases' (19 August 2016) <https://reliefweb.int/report/kenya/kenya-red-cross-society-and-novartis-join-forces-combat-non-communicable-diseases>

KCRS, Access Project Y1 report (January–December 2017) and quarterly reports (January–March and April–June 2018), supplied from KCRS

UNHCR, 'Dadaab refugee complex' (undated) <https://www.unhcr.org/ke/dadaab-refugee-complex>

A1.4 The Philippines: the PRC Haemodialysis Center Samaritan Programme

A. Summary

The Philippines Red Cross (PRC) Haemodialysis Center in Manila is part of the PRC Samaritans programme that provides access to otherwise unaffordable care. Five of the 15 dialysis spaces are reserved for recipients of the programme – and from its inception the programme has recognised the importance of psychosocial support in understanding and living with diagnosis. A full-time medical social worker is part of the package provided to patients and their families by the PRC. He monitors patients and meets with them regularly, offering practical advice on issues including finances, the practicalities of returning to work, and how to navigate the system to ensure access to further medication. If a patient on the programme dies, the

bereaved family continue to receive grief counselling and support including assistance with burial or funeral services.

B. Context and partners

The World Health Organization's 5x5 approach focuses on five major non-communicable diseases and these are the primary focus of the current IFRC PSS Centre initiative. However, there are many other NCDs that require long-term care, including chronic kidney disease. The Philippines Red Cross Samaritans programme enables people to access what would otherwise be unaffordable care – with one part of this programme being Samaritans Dialysis, which provides vulnerable patients with the lifesaving renal dialysis that they need and supports them during dialysis and kidney transplant, where this is required.

The PRC Haemodialysis Center in Manila has space for dialysis for up to 15 people, with five of these places reserved for Dialysis Samaritan recipients. 26 people are currently receiving regular dialysis through the programme, a key aspect of which is psychosocial support from a medical social worker, trained in the needs of renal patients.

Fundraising is ongoing for the Dialysis Samaritan initiative, which is funded by the PRC through donations including from private donors and the private sector (for example, the Tokushukai Medical Group donated the dialysis machines). The initiative covers the cost of the dialysis and other emergencies (such as emergency transportation and blood supplies if a patient is hospitalised) and the support of the medical social worker. Dialysis Samaritan does not, however, cover the costs of any other medication that may be required by the patient for co-morbidities.

'Unfortunately, the reality is that not everyone with NCDs can be provided with support from the Ministry of Health or others – most of the time, their needs are neglected'

– Pred Morales, Philippines Red Cross

C. The integration of MHPSS within the Samaritan programme

Patients themselves contact the PRC to access the programme, as there is not a formal referral system from the national health system. To be accepted, their family must be a recipient of the 4Ps (the Philippine government's social welfare programme) and each patient who applies is formally assessed by a PRC doctor to ensure that they meet inclusion criteria. This includes an assessment of the socioeconomic status and financial capacity of the family (which is verified by the patient with formal documentation including a social case study report from the local Social Welfare and Development Office and a copy of the income tax return of the main provider in the family), which is compared with the required frequency of treatment (as estimated by a physician) and consequent total cost.

From the inception of the programme, the PRC has recognised the importance of delivering psychosocial support in addition to physical care. Kidney failure requiring dialysis is a long-term and lifechanging diagnosis with repercussions for mental as well as physical health: both patients and their families can benefit from support to understand and live with the diagnosis. The centrality of this support is reflected in the access of all patients to a full-time medical social worker as part of the package of support provided by the PRC, who monitors the situation of the patient and helps, where needed, with referral to the National Kidney Transplant Institute (the leading government-owned hospital offering this procedure), as transplants are not offered by the Centre. There is close liaison between the medical social worker and nephrologist to ensure that patients actively participate with the process.

The psychosocial aspect of case management begins with an initial welfare assessment by the medical social worker, with ongoing lay counselling then provided throughout the treatment period. Patients are monitored to ensure that they are attending regularly, are successfully managing their condition to avoid complications and that they are compliant with treatment, because non-compliance will lead to disqualification from the programme. The medical social worker may meet with patients during treatment itself, particularly if it is proving painful.

Patients may also struggle to access medication not provided as part of the programme, so additional advice from the medical social worker on financial issues and ways in which to navigate access medication is an essential part of the role. This includes support in negotiating access to services to which they are entitled from local government or other partners, and careers advice to enable patients to remain in work. In addition, support on lifestyles and psychoeducation is offered, including advice on 'healthy coping',

such as nutrition, physical activity, alcohol, and smoking cessation. The medical social worker provides a sounding-board for patients' fears and frustrations, coupled with practical advice tailored to patients' individual circumstances.

Medical personnel (the nurses and physicians/nephrologist) include patient education as part of their activities in the Centre, and the medical social worker is currently planning to include health promotion / prevention of kidney disease as part of the activities offered by the Centre.

If a patient on the programme dies, the medical social worker continues to provide grief counselling and support to the bereaved family, including referral to social services and assistance with burial or funeral services.

D. Project impact

Feedback from the dialysis patients makes clear how important is the lay counselling provided by the medical social worker, and how valuable it is that relatives are also involved, addressing their emotional reactions, anxiety, and fears around the long-term treatment for the disease and enabling them to navigate the complex service delivery system.

'I am very thankful that I was referred to your programme, knowing that we already exhausted our financial resources due to the surgical operations I had undergone where my left foot was amputated'
– Melvin Dominguez (patient), during a home visit in 2019

The project is evaluated through case management done by the medical social worker. The cost of one year of treatment for a patient on the Dialysis Samaritan programme costs in the region of P655,200 (about US\$13,500), including 156 dialysis sessions and the PSS support.

E. Advantages/benefits of integration

By introducing the psychosocial support provided by the medical social worker, patients are supported through a difficult transition in their lives as they move to long-term clinical care for their chronic kidney disease. For those who are accessing the programme through the Samaritans programme, the support includes navigating the wider health system (for example, accessing for medications not provided by the PRC as part of the Centre's offering), which can relieve some of the stress surrounding the further expense of co-morbidities.

Patients have provided positive feedback on how well the social worker relates to them and their families: that it helps them to 'feel better' and eases negative impacts of treatment.

F. Challenges

The PRC Dialysis Samaritan Program is donor dependent, so sustainability of these donations is an ongoing challenge. It can also only be offered to those who meet all the eligibility criteria – and eliminating those who are in need but are not eligible is distressing for the medical social worker.

The financial situation of patients can make it difficult for them to adhere not only to the dialysis programme but to other medication that is not provided by the programme, without which they will not be able to control their disease. This may make them particularly dependent on the access to dialysis three times a week.

There is generally a lack of understanding among patients and their family members about chronic kidney disease – and addressing this is part of the role of the medical social worker.

G. The impact of Covid-19

Covid-19 has inevitably had an effect on the activities delivered through the Centre, both on provision of the dialysis support and MHPSS support, and there have been difficulties in communicating with patients and families as communications channels may be poor. Some patients were transferred to facilities nearer home and there was turnover among the medical personnel (but provision was sustained).

Rather than home visits and meeting in person, the medical social worker moved to virtual support, particularly during lockdowns, using phone calls, which is both cost-saving and much safer during the pandemic than face-to-face interaction. Their health and family situations are discussed, and some have

been referred to local PRC chapters for provision of food assistance.

Some patients and their families have had Covid-19 and in March 2021 the medical social worker himself contracted the virus, which meant that other social workers temporarily assisted until he was able to return.

Sources

Interview with Prednison Morales and Juliet Bendicio, PRC, 16 April 2021, and later correspondence

Manila Bulletin 2019 'PH Red Cross appeals for support of its Dialysis Samaritan Program' (31 March 2019) <https://mb.com.ph/2019/03/31/ph-red-cross-appeals-for-support-of-its-dialysis-samaritan-program/>

Manila Times 2020 'Dialysis beneficiary thankful to Gordon, PH Red Cross' (7 February 2020) <https://www.manilatimes.net/2020/02/07/public-square/dialysis-beneficiary-thankful-to-gordon-ph-red-cross/680676/>

Official Gazette, 'Pantawid Pamilyang Pilipino Program' (the 4Ps programme) <https://www.officialgazette.gov.ph/programs/conditional-cash-transfer/>

A2: Integration of MHPSS and NCDs in humanitarian settings: brief examples from around the world

The research for this scoping report identified a number of examples of the integration of MHPSS and NCDs in humanitarian settings, of which 16 are presented here. These clearly demonstrate that integration is not a new concept, and that action is already taking place globally – but also that there are also challenges and much still to learn.

The table sets out a brief description of each initiative, including where and when it took / is taking place, listing the key partners and target population, and indicating whether MHPSS and NCDs were integrated from the inception of the project. The examples include nine examples from within the Movement (the RCRC column) and cover multiple regions of the world – Africa, Asia, the Caribbean, Eastern Europe, the Middle East and South America.

RCRC	Where	When	Key partner:(s)	Target population	Description	Integrated from inception?
✓	Armenia	2019–22	Armenian Red Cross, Danish Red Cross, World Diabetes Foundation (funder)	2,000+ older people with diabetes, their families and community	'Prevention of diabetes and diabetes care among elderly [people] in Armenia' initiative is the second phase of a programme that focused on diabetes among vulnerable populations (2016–18) that found that there was a need for explicit PSS support. It aims to reduce the psychosocial and physical complications of diabetes, including through Social Support groups that meet regularly, facilitated by Armenian Red Cross volunteers. Participants are referred from health clinics and share their experiences and ask questions; a PSS component is articulated within the objectives. There are also community-based Healthy Aging peer groups that support a broader older population to live well. ⁴³ See also case study, Annex A1.1.	No
–	Caribbean (initial focus on St Vincent and the Grenadines)	2021	Primary Care International with PAHO (lead)	Nurses, doctors and pharmacists	WHO has developed Emergency NCD kits to assist Member States in ensuring continuity of medical care for persons with NCDs, during natural disasters and health emergencies. PCI is working with PAHO in the Caribbean region to support with the deployment and use of the kits there. In light of the eruption of La Soufrière, this work has been accelerated in St Vincent and the first series of live (virtual) training workshops took place in May. The training includes a focus on all major NCDs, including mental health (including consideration of depression and anxiety, grief and loss, acute trauma reactions, alcohol misuse, psychosis, psychoeducation and the use of medication). ⁴⁴	Yes

RCRC	Where	When	Key partner(s)	Target population	Description	Integrated from inception?
-	Democratic Republic of Congo	2015-17	MSF, local Ministry of Health, LSHTM	People with diabetes	The 'Integrated Diabetic Clinic within an Outpatient Department' model was established by MSF at a hospital in Mweso that it had supported for eight years, in response to increasing numbers of people with diabetes and growing stigmatisation. Physician involvement was limited to initial and six-monthly checks and specific referral criteria; the project was primarily nurse-led. Following an initial review of the care provided, MHPSS was formally integrated into the model, bringing the existing psychosocial support officer into the diabetes care package. Support was also provided by a nutritionist and counselling staff using locally appropriate materials. Patient files were formalised, and patients given their own health 'passports'. ⁴⁵	No
✓	Georgia	2014-16	Georgia Red Cross, Danish Red Cross, World Diabetes Foundation (funder)	Included IDPs and Azeri population from Azerbaijan	The Diabetes Prevention Project in Rural Georgia aimed to improve diabetes prevention, diagnosis and care. 45 self-support groups were established for people with or at risk of diabetes and their families, which helped to embed lifestyle changes, and it was hoped that these would be self-sustaining after the project end. Among the recommendations of the project were that self-support groups should take a more comprehensive approach, structured and supported by volunteers and explicitly note the importance of psychosocial support. ⁴⁶	No
	Iran	2013-present	ICRC, Iranian Red Crescent, Society for Recover Support	Vulnerable, undocumented Afghan community	This initiative in Mashhad is run in partnership with a local NGO, providing a range of NCD services through a clinic, including GP consultations, screening, drug provision and health education (including on nutrition). MHPSS support is provided by four psychologists. Self-help groups initially established for women are set to expand into groups for people with diabetes, to enable better psychological support. Around 650 people receive support through the initiative, of whom 250 have diabetes. ⁴⁷	Yes
-	Jordan	2015-present	MSF, LSHTM	Syrian refugee population and host population (30%), as required by the government	This project set up two primary-care clinics in Irbid, with a maximum of 4,000 patients. It focused at first on NCDs, but in 2016 an MHPSS strand was added, with MHPSS counsellors delivering individual and group psycho-education sessions. These primarily focused on medication adherence, extending over time to address undiagnosed and untreated mental-health problems. NCD and MHPSS care were delivered in the same building and MHPSS sessions were framed around 'living well', reducing the chance of stigma. However, the project was not sustainable in full once MSF funding was no longer available. ⁴⁸ See also case study, Annex A1.2.	No

RCRC	Where	When	Key partner(s)	Target population	Description	Integrated from inception?
-	Libya	2019	Primary Care International with WHO (lead) and DfID (funder)	Primary care doctors	PCI provided five-day 'train the trainer' sessions on mental health (based on mhGAP), as part of NCD training in Libya, building capacity across the '5-by-5' (i.e., including mental health under the NCD umbrella). As well as learning about diagnosis and management, participants practise communication skills through role play, and small-group discussions take place on the need to consider family, social, spiritual and cultural issues in MHPSS. Remote mentoring is then provided to participants, to help support and cascade learning. ⁴⁹	Yes (but as standalone training)
✓	Kenya	2013–present	Kenya Red Cross Society (KRCS)	Refugees in the Dadaab refugee complex	Since 2013, the Kenya Red Cross Society (KRCS) has been providing support and medication for PLWNCDs in the Dadaab refugee complex in Kenya. A Novartis Access initiative partnership (2016–19) enabled 40 CHWs to provide NCD drugs and services to over 450 people, and patients were encouraged to join a support groups, each led by a community health worker, which provided health information, nutrition counselling and psychosocial support. Many more people were reached through community-based sessions, that include raising awareness of NCD risk factors and improving understanding of the community health system. See also case study, Annex A1.3.	
✓	Kenya	2020	KRCS and Danish Red Cross	People living with NCDs, people affected by Covid-19, health workers	In 2020, the Covid-19 Response Humanitarian Project addressed the impact of Covid-19. It strengthened PSS support for some of the country's most vulnerable populations (including PLWNCDs) by provision of psychological first aid (PFA) training to MHPSS workers, who could then provide counselling to people affected by Covid-19 (including support for affected health workers). A survey of KRCS staff, volunteers and PLWNCDs in Nairobi (urban) and Meru (rural) counties found significant disruption to NCD care and support services, with misinformation about Covid-19 fuelling stigma. Care for PLWNCDs during Covid-19 includes provision of food and hand sanitiser, use of PPE by visiting community health workers, and extended clinic hours to enable social distancing. ⁵⁰	Yes
✓	Kenya	2020–present	KRCS and the Danish Red Cross	People living in Kilifi and Tana River counties	KRCS is developing a comprehensive set of tools that will ensure that NCD care and management is mainstreamed during emergencies. It focuses on the Kilifi and Tana River counties, which are areas that are particularly prone to natural disaster (flooding). Information-gathering tools now include more questions on NCDs (including medicines), and an NCD emergency kit is being adapted from the existing WHO NCD kit model, covering diabetes, hypertension, mental-health disorders, injuries and asthma. 79 first responders, volunteers and health workers have been trained in the need to address NCDs in an emergency and the tools and Kit will be tested in a real-time evaluation over 5–10 days, depending on the extent of flooding.	Yes

RCRC	Where	When	Key partner:(s)	Target population	Description	Integrated from inception?
✓	Philippines	-2019 present	Philippines Red Cross	People with chronic kidney disease and their families	The national society runs a centre providing free dialysis for chronic kidney disease patients, which also employs a clinical social worker explicitly to focus on MHPSS and psychological first aid. He contacts patients to check on their wellbeing and that of their families. This includes addressing concerns about medication and frustration about the health system (for example due to Covid), and also provides support to the family if the patient dies. Telephone support has been provided during .Covid .See also case study, Annex A1.4	
✓	Russia		IFRC, Russian Red Cross, DG ECHO ((funder	Ukrainian refugee population	Partnering with Russian insurance companies to provide insurance for people of all ages displaced from Swiss francs 200 Ukraine, at a cost of per year per person. The entry point to the health system was through the local Red Cross branch (rather than having to travel), where a needs assessment is done, with referral then covered under the insurance scheme, including up to GP visits per year, medication, one 10 hospitalisation, and MHPSS support and care provided either by the Russian Red Cross or through further referral to ⁵¹ .mental-health services if required	Yes
-	Thailand	23-2020	International Rescue Committee, IRC Thailand, ELRHA (funder), Johns Hopkins University, Khon Kaen University	Myanmar refugees in Mae La camp	This initiative is in its early stages and aims to integrate a mental-health intervention (the common elements treatment approach – CETA) into existing NCD care being delivered in the camp. Lay health workers (refugees themselves) will receive CETA training and will roll out the session intervention to a subset-12 of people living with hypertension, diabetes and/or epilepsy. The RCT will enable a comparison between intervention and control group of health outcomes, factors influencing treatment ⁵² .compliance and costs	Yes
✓	Ukraine	-2021 present	ICRC	Victims of violence, including people living with diabetes	Two primary health centres have been identified in eastern Ukraine for this pilot project, which, for the first time, integrates MHPSS into an NCD/primary health care programme (with a focus on diabetes, which is a significant burden in Ukraine). This is currently at assessment phase and will be evaluated after six .months and a year	Yes
✓	Uruguay	20-2019	IFRC, Uruguayan Red Cross	People not adhering to NCD treatment and care, including migrants	A survey of those not adhering to treatment found that among the migrant population it was the psychosocial repercussions of migration (the loss of home and socioeconomic conditions in the host community) and lack of knowledge about the right to health care were barriers to treatment, exacerbated .19-by uncertainty around Covid Customised follow-up by volunteers trained in MHPSS, building a bond between volunteers and beneficiaries, has led to improvement in self-care, has delayed further 19-but Covid ⁵³ .monitoring	Yes

RCRC	Where	When	Key partner:(s)	Target population	Description	Integrated from inception?
-	Various: Gaza, West Bank, Jordan, Lebanon, Syria	2012 MHPSS) from (2016	UNRWA	Palestinians and Palestinian refugee population	The Family Health Team Approach provides comprehensive primary health care for the whole family, including for NCDs, and it has explicitly included .2016 MHPSS services since around .These services are delivered by staff trained in mhGAP to provide detection, counselling and referral. It enables the identification and support for people with MHPSS needs without stigmatising .through specialist care	No

A3: Key informant interviews – a summary

A. Overview

This Annex presents a brief summary of each of eight key informant interviews, which were held during the period November 2020 to February 2021 to gather data and perspectives from stakeholders within or closely aligned to this area of work.

Four of the interviews were with Movement staff and the remainder were drawn from external organisations: the London School of Hygiene and Tropical Medicine, the International Rescue Committee, the NCD Alliance and the WHO.

Each organisation represented in the interviews approaches the integration of MHPSS and NCDs in a different way. However, without exception, all those interviewed agreed that **integration of MHPSS and NCDs would be a positive step**, both to improve care for individual patients and to improve efficiency of service delivery. There is a growing realisation that integration is needed, as it becomes increasingly clear both that NCDs are a priority in humanitarian settings and that there are strong practical feedback loops: better NCD care means better mental health, and better MHPSS means better NCD outcomes.

Challenges to integration mentioned by several of those interviewed include: the ongoing failure to prioritise NCDs and MHPSS, particularly in the initial acute stage of a humanitarian emergency; a lack of materials, training, mentoring and support for health workers in integrating MHPSS and NCDs (although this can be partially alleviated through task-sharing and task-shifting); and the absence of a single way to integrate MHPSS and NCDs, because success depends on adapting to the health system and national/cultural context.

Covid-19 is a specific challenge that many mentioned as having had a deleterious effect both on delivery of NCD services and on mental health more broadly. The indirect impacts of the pandemic (such as the lockdowns) have led not only to limited access to services but have increased pressure on out-of-pocket spending on health and have increased stress and anxiety among patients and families who were already in vulnerable situations.

B. The Movement

Dr Bhanu Pratap – Senior Officer, Care in Communities, IFRC

In his role as senior officer for Care in Communities at IFRC, Bhanu has responsibility for Care in Communities, Healthy Ageing, First Aid, NCDs and MHPSS. NCDs and MHPSS are two areas that share many important commonalities and cause and effect relationship, as they are chronic, non-communicable and require long-term support, there are clear co-morbidities, they share risk factors, and there is a general dearth of funding (only 1.6% of development assistance for health goes to NCDs and even less to mental health).

Too often, there are separate tools to tackle NCDs and MHPSS and they are dealt with in different departments. His early experience in IFRC was that NCDs and MHPSS components were always treated in vertical streams, but one of the good examples was the Philippines Typhoon Haiyan operation (2014), in which IFRC worked with the national society to build capacity in an integrated way on both MHPSS and NCDs. The Movement is increasingly looking at both NCDs and MHPSS (for example, Healthy Ageing, Care in Communities and other community health initiatives) but this is still not necessarily approached in an integrated way: 'It's not obvious – but we have to make it obvious' and 'We need a mindset change.'

The IFRC is in the process of developing its global NCD vision, framework, expanding beyond prevention into care, referral, and management, with MHPSS integrated within this and for all contexts, i.e., long-term development, emergency and fragile/complex settings.

Culturally and socially appropriate interventions are required, including promotion of task-shifting and task-sharing, with the clear role for volunteers working as community-based health workers being acknowledged and recognised.

Integration and health systems strengthening are ongoing global discussions, particularly in the context of universal health coverage, which is best delivered through capacity-building at primary health care level –

and large multilateral institutions such as the Global Fund and the World Bank are looking at community and health-systems-strengthening approaches.

A key message from the interview was the need to move away from a disease-specific approach to a life course, person-centred approach: 'We have to take care of the person not just the disease ... For real integration, the person must be at the centre, not the disease.'

Dr Carla Kamitsuji and Dr Senop Tschakarjan – both MHPSS HQ specialists – psychiatrists, Health Unit, ICRC

Carla and Senop both have backgrounds as psychiatrists and are now working for the ICRC in Geneva. Both stated that integration is essential: 'Everything needs to be integrated, not just mental health!' The humanitarian world has been slow to appreciate the need to tackle mental health and other chronic conditions – and, indeed, that co-morbidities are more, not less, of a problem in humanitarian settings, where continuity of care is mostly likely to be threatened.

A tailored approach is needed to prevention in humanitarian settings because of the restrictions on what is possible: 'A simple "behaviour change" message is not useful' and instead there should be a focus on building resilience. Daily stressors can have a higher impact on individuals than earlier trauma from being in a conflict setting. Given this, focusing on the PSS elements of security and protection first then creates the space to focus on more severe conditions such as PTSD, if required.

Stigma is a major issue concerning mental-health conditions and other NCDs such as epilepsy (the ICRC addresses these conditions).

An on-the-ground challenge is that many staff feel that they do not have the capability and/or capacity to integrate MHPSS into the care they offer, even if they wish to, and there is also resistance in shifting to a chronic care approach.

An example of the interplay between physical and mental health is the very high level of type 2 diabetes among adolescents in Armenia, who have been subjected to significant stress over a long period of time. Additionally, the failure to follow up on the impact of psychological trauma on physical complications of surgery means that the links between the two are not appropriately appreciated.

Laura Archer – Senior Officer, Medical Services in Emergencies, IFRC Health and Care Department, IFRC

Laura previously worked with MSF in various projects that included treatment of NCDs. She was involved in the development of an interagency guide on implementing NCDs in humanitarian settings, and now works with the IFRC's Medical Services in Emergencies. Her role includes advocating for NCDs (including MHPSS) to be integrated in clinical response to acute crises. She has worked with clinical emergency response units (ERUs) to adapt emergency kits to include NCD medicines – including psychotropic medication such as antidepressants – noting that many NCD patients require care during the 3–4-month mandate of an ERU.

She strongly supports integration of NCDs and MHPSS into emergency humanitarian response and recognises the need to improve work in these areas: 'Looking at the aging population, rising obesity and so on, to me integration is a no-brainer – and from a health-systems perspective, we save time and money by addressing these issues early.'

An emergency often means that the response is reactive rather than proactive, but Laura hopes to incorporate an NCD working group into future work on standardising and classification of emergency teams: 'We need to continue working to professionalise our response.'

Clinicians hired in ERUs come to the emergency already trained in their area of clinical scope. In order to better prepare clinicians to adapt their practice to ERU contexts, IFRC is currently working with partners to develop training in palliative care in humanitarian settings, as emergency situations may render some conditions (including NCDs) unmanageable given the resource constraints, and hence require palliative care.

The 'real value of RCRC' is beyond the clinicians: 'our two big advantages are access to communities [through community-level volunteers] and access to government and high-level discussions [through national societies]'.
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Dr Carmen Valle-Trabadelo – co-chair, Inter-Agency Standing Committee (IASC) Reference Group on MHPSS in Emergency Settings

Carmen's current role is MHPSS technical advisor at the IFRC Reference Centre for Psychosocial Support, and primarily as co-chair of the IASC Reference Group on MHPSS in Emergency Settings. She used to work on mental health-system strengthening, awareness-raising and advocacy at country level with WHO and CBM.

The entry point for MHPSS is often through the NCD department in Ministries of Health, so a strong understanding of how to use this entry point (while also advocating to move MHPSS outside of NCD departments alone) is essential, as it might be difficult to raise MHPSS otherwise. MHPSS should not be seen as just a small subsection of NCDs – indeed, many of the best examples of integration of MHPSS are from chronic but infectious diseases, such as HIV. It is essential that the continuum of mental health and wellbeing, the need for psychological and sociological considerations, and the multisectoral nature of MHPSS is recognised, and this is not possible if MHPSS is seen as 'sitting under' NCD departments. In humanitarian settings, 'we tend to leave existing illnesses behind and look at what has been generated by the crisis', missing an opportunity to link conditions.

Covid-19 has made evident the need for integration of MHPSS. The links between physical and mental health and between social welfare and mental health are stark: this learning should be part of advocacy in the post-Covid-19 era.

When mhGAP is used in humanitarian settings, the focus tends to be only on a small number of modules – which suggests that those implementing are already working at full capacity.

The introduction of WHO's Quality Rights early in the reconstruction process in humanitarian settings could help to foster a less medicalised, more person-centred and more rights-based approach.

Looking into available information on how MHPSS affects NCDs and vice versa or identifying gaps in information that need to be researched, is an important step forward. In doing so, taking a broad perspective – and, for example, looking at how peer support can help, what is the role of PSS in NCD preventions, and what role advocacy can have – would be very valuable.

C. External interviews

Dr Éimhín Ansbro – research fellow, NCDs in humanitarian settings, London School of Hygiene and Tropical Medicine

Éimhín is currently a research fellow at the London School of Hygiene and Tropical Medicine and has on-the-ground experience in humanitarian settings, including time spent as a doctor with MSF in Irbid, Jordan. She welcomed the IFRC initiative because 'putting funding into what you are doing now and documenting what is known is really important'.

The Irbid initiative was initially established to provide NCD care for the refugee population, but quickly evolved to include MHPSS services. This was absolutely essential because 'patients were not able to focus on NCDs because they had more pressing priorities – finance, accommodation, food' and needed resilience to be built up before they could prioritise their own disease management.

Cultural sensitivities should also be considered prior to an initiative being established: for example, because of stigma around mental health, calling support systems 'living well groups' has proved more culturally acceptable in Jordan. (This is described in more detail in the case studies.)

MSF's guidelines on NCDs (2020) of which Éimhín is a co-author, are specifically adapted to humanitarian settings and cover both clinical and operational aspects. The guidelines are used to support MSF projects on the ground and Éimhín noted that it has become a reference tool beyond MSF itself. Task-sharing, group therapy and framing around a holistic approach all seem important, but there is not yet the research data to back this up.

The economic repercussions of Covid-19 have impacted on integration efforts, making it even harder for

patients to navigate what was already a fragmented system: patients are poorer and there are fewer meds available.

Covid-19 has also highlighted the importance of digital delivery, which will be important in the future. WhatsApp is already being used for peer support and tailored messaging, and apps such as Headspace (an engaging and effective mindfulness app, currently available in English, French, German, Spanish and Portuguese) can be made available.

Grace Dubois – policy and research manager, NCD Alliance

Grace recently joined the NCD Alliance from MSF, where she worked across the organisation writing Clinical Guidelines. The NCD Alliance focuses on global policy; particularly relevant is its current work on NCD integration into universal health coverage, with a focus on the most vulnerable, including people in humanitarian settings.

NCD/MHPSS integration is essential because ‘irrespective of the mandate ... we are looking at people, not at specific diseases or conditions’ – although integration will look different in each different context. Grace also noted that there are few discrete projects on NCDs in humanitarian settings, so integration into other issues (including infectious disease and mental health) becomes even more essential. There is also interest from funders in global mental health, so integration can help with funding for NCDs, including NCDs included in the Lancet NCDI Poverty Commission, which goes beyond the WHO’s 5x5.

Grace emphasised that staff on the ground must themselves be supported in their work or their health, including their mental health could suffer: ‘As humanitarian actors we often work through local people, who are excellent at serving their population but who often undergo great stress – we must support our staff, including on NCDs.’

People living with NCDs have found themselves at increased risk of severe disease and death from Covid-19 throughout the pandemic and, although country-level NCD services have been disrupted, local civil-society organisations have often shown themselves to be well positioned to support people living with NCDs and have often been more adaptable than international organisations.

Improving coordination between international organisations, local civil society, and the Ministry of Health to enable better data collection is time-consuming but essential. There is a wealth of potential information to collect/that is already being collected in humanitarian settings that may not be collected through existing official channels but that could usefully be used to direct services.

Dr Fahmy Hanna – technical officer, Department of Mental Health and Substance Use, WHO

Fahmy co-chairs the IASC MHPSS Reference Group and leads WHO’s interagency work on mental health in emergencies including, over the past year, supporting WHO work on NCDs and mental health. He made a clear distinction between MHPSS, which is not itself a disease, and mental-health disorders.

He takes a broad approach to integration of MHPSS, going beyond NCDs: ‘I would say the same about TB care, or about Covid, or about HIV: MHPSS needs to be a crosscutting topic across and within sectors, and in the health sector it needs to be integrated everywhere.’

Increasing the capacity of the health workforce, coupled with systems strengthening, is essential for delivery of the tools, experience and knowledge that already exist. Fahmy identified the gap not as a lack of tools, but the capacity to implement these tools, with solutions including training the workforce in mhGAP and task-sharing/task-shifting to enable wider delivery. In South Sudan, for example, there are just three mental-health professionals for 12 million people so, without task-shifting, most people will receive no support.

Many humanitarian organisations such as IMC, MDM, MedAir, IRC and many others have shown that mhGAP can also be pragmatically and selectively delivered, beginning with a smaller number of conditions, chosen for the local context. A misconception about mhGAP is that it is about prescribing medication, but each module incorporates PSS interventions, so it is important to ensure that those being trained include these aspects in delivery. He commented that fieldworkers do not need more toolkits; instead, these existing tools need to be rolled out with appropriate training, supported by task-shifting as appropriate.

Fahmy noted that, were the ICRC’s specialist mental health professionals to provide more supervision and training, this could ‘leave a footprint and help to strengthen the system’. At community level, Movement

volunteers can be trained to include the PSS aspects of mhGAP within their work.

Dr Lilian Kiapi – director, Health Unit, IRC

Lilian was IRC NCD focal point in 2015, when IRC was developing a theory of change that would have integrated MHPSS and NCDs. At the time, academic and operational partners advised that a single pathway would mean that aspects of MHPSS could be neglected – so the integrated approach was dropped. It has since become clear that patients have needs across both areas, and that services are often provided in the same setting: ‘I really believe that the two services should be integrated, though we may need to consider different pathways for service planning and delivery’.

An important gap in integrating MHPSS and NCDs is a shortfall in knowledge, ability, and skills. Clinical staff and community health workers are being trained on mhGAP and on NCDs, but are not supported to integrate these services, and it would be helpful if PSS training could include specific advice on NCD follow-up. If integration is rolled out thoughtfully, with appropriate tools and training, it can be achieved without overloading staff.

‘To move the needle, we need to be able to monitor how we are doing’, but currently there are not even indicators to show how many NCD patients receive adequate MHPSS support. For example, health staff provide some level of counselling (for example on treatment adherence) but this is not strategically linked with PSS provision and its effectiveness is unknown.

Anecdotally, Covid-19 has increased MHPSS needs, with intense anxiety about vulnerability of NCD patients and accompanying stigmatisation. Lilian also noted that stigmatisation is a particular issue for epilepsy – but treatment tends to focus on drug provision only, rather than support for patient and family.

IRC, Johns Hopkins, and a Thai university have recently begun a research project in camps in Thailand to ascertain whether integrating aspects of MHPSS into care for people with diabetes and hypertension has an impact on treatment outcomes.

A4: Grey literature review

As part of building understanding of the current context, a review of the grey literature on integration of MHPSS and NCD prevention and care in humanitarian settings through community-based programmes and health-care services was undertaken by the IFRC Psychosocial Centre. The review addressed three guiding questions:

1. How is the prevention and care of MHPSS and NCDs integrated into community-based programmes in humanitarian settings focused on but not limited to the Movement?
2. Is the prevention and care of MHPSS and NCDs integrated into primary, secondary, and tertiary health-care services in humanitarian settings?
3. What are the opportunities, challenges, and dilemmas of integrating MHPSS and NCDs interventions in humanitarian settings at the level of health-care services and community-based programmes, across the continuum of care from promotion, prevention and treatment?

The review was carried out in November 2020 and identified 26 documents for inclusion:

- **Settings:** 35% (9 documents) focused on community-based strategies, 52% (12) focused almost exclusively on health-care systems/services, 23% (6) discussed using both health-care systems/services and community-based approaches and the remaining document was unspecified.
- **NCD(s) addressed:** 92% (24) of the documents were on NCDs broadly, with 8% (2) focused on diabetes specifically.
- **Mental health and/or PSS:** 35% (9) documents focused on MHPSS holistically, while 35% (9) explicitly focused on psychosocial support and 27% (7) focused on mental-health conditions and neurological disorders.
- Three of the documents also included links to **Covid-19**.

The results of the grey literature review (and many of the documents identified) have been incorporated within the Findings of this report, but the high-level findings of the review include the following:

Integration of MHPSS into other clusters/sectors is not new. There are efforts to increase MHPSS in all sectors of humanitarian settings including, but not limited to, education, gender-based violence and protection programmes.⁵⁴

Health systems strengthening is also evident through the integration of MHPSS into the primary healthcare system in humanitarian settings,⁵⁵ as well as (separately) integrating NCDs into the primary healthcare system in humanitarian settings.⁵⁶

There are initiatives to provide practical support to humanitarian health workers through guidelines and kits from the WHO: the NCD Emergency Kit, the Package of Essential Noncommunicable Disease Interventions (WHO PEN), and the mhGAP Intervention Guide.

Advocacy efforts for MHPSS and NCD integration in humanitarian settings are becoming more evident in comms articles. In 2018, the NCD Alliance published a blog advocating for MHPSS to be at the centre of NCD programmes in humanitarian settings,⁵⁷ which followed up from an NCD Alliance blog in 2017 that looked at taking a gendered perspective on this topic, describing the need for prevention and care of NCDs that can be exacerbated by psychosocial distress in humanitarian settings.⁵⁸ The Novo Nordisk Foundation wrote about a grant for the Danish Red Cross intending to improve the conditions of PLWNCDs in Kenya, Iraq and Lebanon that describes the aim of bringing together humanitarian actors, researchers, and local partners to find the links between NCDs and mental-health conditions.⁵⁹

Efforts to integrate MHPSS and NCDs in humanitarian settings are materialising, as evidenced by several programmes and guidelines. Those gathered by the scientific commentary include initiatives that have been or are being implemented by the Red Crescent National Societies and MSF, with guidelines on integration from MSF, HelpAge International, ICRC and IFRC.⁶⁰

Introduction

Focusing on the bi-directional integration of Non-Communicable Diseases (NCDs) and Mental Health and Psychosocial Support (MHPSS) prevention and care into humanitarian settings, the project centers at the operational level by first conducting a scoping review on the topic concentrating on but not limited to the Movement. The project identifies and explores the challenges, opportunities, and gaps for bi-directional integration of NCD and MHPSS prevention and care into humanitarian settings at the operational level with the Movement. For this project, the definition of humanitarian settings is from the Sphere Standards, which describes humanitarian action occurring context of crisis which are “a range of situations including natural disasters, conflict, slow- and rapid-onset events, rural and urban environments, and complex political emergencies in all countries” *.

Aligned with the Pathways of Integration Framework from the World Health Organization (See Appendix Table 1) the project focuses on strategies for integrated MHPSS/NCD services delivered through a community platform carried out in schools, workplaces, and communities. Still, we will investigate the health care platform for MHPSS/NCD strategies within self-care, primary care, and hospital care as health-care services often provide more person-centered, coordinated care to people with (often comorbid) mental and physical health conditions. The project outputs will be aligned with the five-by-five approach (five main risk factors (tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol and environmental risk factors) for the five major groups of NCDs (cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, and mental health conditions). COVID-19 and psychosocial support will be added to the 5x5 model as environmental risk factors.

Aim

To review the grey literature on integration of MHPSS and NCD prevention and care in humanitarian settings through community-based programmes and health care services.

Guiding question

1. How is the prevention and care of MHPSS and NCDs integrated into community-based programmes in humanitarian settings focused on but not limited to the Movement?
2. How is the prevention and care of MHPSS and NCDs integrated into primary, secondary, and tertiary health care services in humanitarian settings?
3. What are the opportunities, challenges and dilemmas of integrating MHPSS and NCDs interventions in humanitarian settings at the level of health care services and community-based programmes, across the continuum of care from promotion, prevention and treatment?

Methods

Databases

MSF Field Research, Relief Web, IFRC, Humanitarian Practice Network, UNHRC, Elrha, ICRC Resource centre, Think Tank Search, HumanitarianResponse.org, ODI, IRC, Prevention Web, Forced Migration Review, WHO- iris ALNAP, UNDP, Intervention, COVID-19 Humanitarian, NCD Alliance, MHPSS Innovation, Terre des Hommes

* [2019, Sphere Glossary](#)

	Inclusion	Exclusion
Population	<ul style="list-style-type: none"> • People living in protracted crises • “ “ in disaster prone setting • “ “ low- and middle-income countries 	<ul style="list-style-type: none"> • People not living in humanitarian settings or fragile settings
Intervention	<ul style="list-style-type: none"> • Community- workplace interventions or programme/activity • “ “- school interventions or programme/activity • “ “- community interventions or programme/activity • Health care- self- care interventions or programme/activity • “ “- primary care interventions or programme/activity • “ “- hospital care interventions or programme/activity 	<ul style="list-style-type: none"> • Population-wide interventions including legislation/regulations, information/ awareness, and intersectoral collaboration
Outcomes	<ul style="list-style-type: none"> • Guidelines for humanitarian organization • Guidelines for governments • Best practices from interventions • programme reports • Case studies of interventions 	<ul style="list-style-type: none"> • Peer-reviewed scientific research • Documents that focus exclusively on mental health or NCDs

Table 1. PICO- Inclusion and Exclusion Criteria

Search terms:

Integrating	Prevention	Care	Mental Health	Noncommunicable diseases	Community based settings	Health care services	Humanitarian settings
Referrals	Primary prevention		Mental health and psychosocial support	Non-communicable diseases	Civil society	Primary care	Protracted crises
Continuity of Care	Secondary prevention		Psychosocial support	NCDs	Workplace	Self-care	Humanitarian emergencies
Task shifting	Tertiary prevention		Mental wellbeing	Diabetes	School	Hospital care	Crisis settings
Diagnosis	Health systems strengthening		Psychological wellbeing	Hypertension	Community		Fragile settings
			Isolation	Heart disease	Families		
			Loneliness	Cancer	Education		
			Social inclusion				

See Appendix for list of the included search results.

Results and Discussion

All searches were carried out between November 4th 2020 and November 18th 2020. 26 documents were included in the review. With these twenty-six documents, there were two different analysis levels including at the community-based level and the health systems/service level. 23% (n= 6) discussed using both HCS and community-based levels. 35% (n= 9) focused on community-based strategies, 52% (n= 12) focused almost exclusively on health care systems/services, and one document was unspecified. The documents were also analysed if they focused on a specific NCD or not. 92% (n= 24) were on NCDs broadly and 8% (n= 2) focused on diabetes specifically. The documents were also analysed to see if they described PSS, MHPSS, or specific mental health conditions or neurological disorders. 35% (n= 9) focused on MHPSS holistically, while 35% (n= 9) documents focused on psychosocial support explicitly, and 27% (n= 7) focused on mental health conditions and neurological disorders. Included in this review are 3 documents which include links to COVID-19.

High-level overview

Most efforts to increase MHPSS and NCD prevention and care in humanitarian settings **exist in silos** as indicated by guidelines, project evaluations and outcomes, and country reports^{***}. Since **the integration of MHPSS and NCD prevention and care in humanitarian settings is extremely limited**, this section first gives an overview of the integration of MHPSS and NCDs into other sectors independent of each other to see how the integration of each area is taking place before reviewing the data on the integration of MHPSS and NCD prevention and care in humanitarian settings.

There is a strong effort to increase **MHPSS in all sectors** of humanitarian settings including but not limited to education, gender-based violence, or protection programmes^{*** ****}. MHPSS in all sectors was also seen last year with the adoption of the International Red Cross and Red Crescent Movement policy on addressing mental health and psychosocial needs including the call to integrate MHPSS into all services and ongoing programmes like programmes for physical health^{*****}. Additionally, there is evidence of integrating MHPSS into the primary health care system in humanitarian settings^{*****} as well as integrating NCDs into the primary healthcare system in humanitarian settings^{*****}.

Furthermore, WHO is making strides in creating standardized evidence based NCD care toolkits including the basic **NCD kit** (NCDK) that focuses on essential medicines for People Living With NCDs (PLWNCDs) and some mental health conditions and neurological disorders^{*****}. The NCDK aims to cover a range of critical aspects for outpatient care in a variety of settings. The included medicines fall within the WHO Package of Essential Noncommunicable Disease Interventions (**WHO PEN**) for primary care in low-resource settings and the WHO mhGAP humanitarian intervention guide for mental health management, including treatment of psychosis, depression, and epilepsy^{***** *****}. **WHO's mhGAP Intervention Guide**, is an evidence-based manual for these conditions for non-specialist health-care providers in humanitarian emergencies where access to specialists and treatment options is limited^{*****}. The integration of MHPSS and NCDs

* 2015, ODI- Mental health and psychosocial service provision for adolescent settings.

** 2020, Global Fund Must Integrate Mental Health Into Its TB, HIV Strategies, Opinion Piece Says.

*** 2020, Global Humanitarian Response Plan: COVID-19 (April – December 2020) GHRP July Update

**** 2018, JRP for Rohingya- Humanitarian Crisis

***** 2015 Evaluation of UNHCR's Emergency Response to the influx of Syrian Refugees into Turkey.

***** 2018, JRP for Rohingya- Humanitarian Crisis

***** 2019, Syrian Arab Republic: tackling noncommunicable diseases (NCDs) in emergencies through primary health care

***** 2017, WHO NCD Kit

***** 2019, Syrian Arab Republic: tackling noncommunicable diseases (NCDs) in emergencies through primary health care

***** 2020, WHO package of essential noncommunicable (PEN) disease interventions for primary health care

***** 2010, WHO mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings

into various sectors like education as well as primary health coverage is clearer than that of integration of MHPSS and NCD prevention and care in humanitarian settings. Still, efforts to integrate the two are evidenced in high-level advocacy and communications.

Advocacy and communications

High-level advocacy and communications were underscored in the grey literature. Several large **international organizations highlighted the need to advocate for NCD and MHPSS integration in humanitarian settings**. IRC has committed to "providing care for crisis-affected clients living with NCDs, integrating NCD programming into recovery and development efforts across different contexts, undertaking research projects and developing innovative approaches to improve the quality of care for the people we serve" *. They also note "Crisis-affected populations are at risk of exposure to a combination of trauma and daily stressors including mental health conditions which can exacerbate NCDs". **UN Interagency Task Force on NCD** describes the challenges of NCDs including MH conditions for refugees and asylum seekers "Refugees and asylum seekers are particularly vulnerable to NCDs including mental health conditions and may face barriers to adequate health care" **.

Novo Nordisk Foundation published a piece on the grant for the Danish Red Cross *** intending to improve the conditions of PLWNCDs in Kenya, Iraq, and Lebanon. They highlight the project bringing together humanitarian actors, researchers, and local partners to find the links between NCDs and MH conditions. The work by Médecins Sans Frontiers (MSF) was advocated for by **NCD Alliance** in a blog post, stressing that MHPSS must be at the core of humanitarian NCD programming ****. They highlight the discussion of MHPSS and NCD integration, underscoring its current **relevance for the high-level global health agenda**. NCD Alliance also underscores a **gendered perspective** displaying the need for prevention and care of NCDs that can be exacerbated by psychosocial distress in humanitarian settings *****. They also described how women are affected at a younger age by NCDs, have less social protection, and are often the main healthcare providers as daughters and sisters. Using a gendered perspective, they illuminated another reason in which NCD including mental health care must be moved up on the global agenda. This advocacy and communications are part of the global dialogues, an important aspect for the trajectory of this field.

Only 2 documents touched upon the integration of MHPSS and NCD prevention and care in humanitarian settings **within the context** of COVID-19. One news article from the WHO discussed NCDs in the context of COVID-19 in Lebanon, including mentioning **the provision of medications for the management of chronic diseases including mental health conditions** *****. The Global Humanitarian Response Plan- COVID-19 in July 2020 notes **the interruption of services** including chronic conditions, as well as risk factors for dying from COVID-19, and the MHPSS requirements for vulnerable groups. Here, **they recommend the integration of MHPSS in all sectors** *****.

Operational level

In addition to the initiatives that contribute to undertaking in the areas on a high-level, there is evidence of efforts to integrate MHPSS and NCD prevention and care in humanitarian settings as seen **through operational level including guidance materials, project outcomes/models of care, and project recommendations**.

Guidance materials from an organization

Operational guidance was mostly clearly evidence through the **healthy lifestyle promotion initiative** which included a **guide for volunteers, toolkit, and manual** *****. The initiative was carried out in

* 2019, IRC NNCDs in Humanitarian Settings

** Responding to the Challenges of Non-communicable Diseases- UN Interagency Task Force on NCDs

*** 2020, Novo Nordisk Foundation supports Danish Red Cross initiative on noncommunicable diseases

**** 2018, Mental health and psychosocial support must be at the core of humanitarian NCD programmes

***** 2017, Women and NCDs in humanitarian emergencies

***** 2020, Noncommunicable diseases in the context of COVID-19 in Lebanon,

***** 2020, Global Humanitarian Response Plan: COVID-19 (April – December 2020) GHRP July Update

***** N.D., Community-based, Getting started guide for healthy lifestyle promotion manual and toolkit for youth

N.D., Community-based, Community toolkit for the healthy lifestyle: noncommunicable diseases (NCDs) prevention and *****

control module

Volunteer manual for the healthy lifestyle: noncommunicable diseases (NCDs) prevention and control module ,٢٠١٤ *****

partnership with the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) and the Danish Red Cross (DRC). It includes 20 sessions to be used by Red Cross Red Crescent Youth volunteers and staff to **teach about healthy lifestyles to youth in the school and community**. The activities included allowing volunteers and youth to learn about the major NCDs, the health consequences of the NCDs, the fundamentals of behaviour change, assessing their risk, and establishing a supportive environment to create change. the four principal NCDs, the dangers of NCDs, the behaviours.

The initiative included dimensions of MHPSS through addressing resilience in an exercise, a **section on home-based psychosocial support for NCD diagnosis**, and **linking to social support networks** including family, friends, and clinics. Moreover, there is also a new Care in Communities: Guidelines for National Red Cross Red Crescent Societies- A community health systems approach 2020. In this guideline, they emphasize **providing PSS for PLWNCs** . For example, there are evidence-based essential community-based NCD interventions suitable for delivery by community-based healthcare workers which includes providing psychosocial support by listening to the concerns of patients and their family *.

There are also the MSF Non-communicable Diseases- Programmatic and Clinical Guidelines which includes integration with mental health services through training NCD staff in basic mental health care, having specialist mental health service, including referral systems. The guidelines also describing psychoeducation for people who experience psychosis including a healthy lifestyle **.

In 2012, Help-Age International published their health interventions for older people in emergencies guidelines. In this, one their five key action points is to provide integrated essential health services including NCDs and MH conditions including access to essential therapies where MHPSS interventions can be implemented ***.

Project outcomes

MSF opened an NCD service at two primary care centres in Jordan for non-camp based Syrian refugees and vulnerable Jordanians utilising a **multi-disciplinary primary care model**. The programme focused on the NCDs causing most deaths in pre-war Syria: **cardiovascular disease (CVD), including hypertension, diabetes (DM), and chronic respiratory disease**. The program developed to include adaptations such the introduction and "**expansion of MHPSS** in response to significant mental health needs among Syrian patients; the establishment of essential **referral pathways**; the refinement of **health education** and introduction of **group sessions**; the introduction and expansion of a **home visit** service and the creation of a **humanitarian liaison officer** role to address social and protection needs." They also found some **stigma around MHPSS services** among patients where finances were put towards transport for medical consultation over MHPSS services, health sessions, or laboratory visits ****.

Since 2011 UNRWA has used a **Family Health Team Approach, a person-centred model** aiming for comprehensive care for the whole family using long-term provider-patient/family relations. They have also been using an e-health system to improve quality, efficiency, and the ability to collect data where it is operational in Gaza, Jordan, Lebanon, and West Bank as well as Syria but with more challenges with the ongoing conflict. They found an integrated FHT approach to **improve staff and patient satisfaction** including through **longer patient consultation times and decreased medical consultations per doctor**. Part of the FHT approach was a **friendship committee** at each health centre to foster **community participation**. Lastly, the department of health adopted a portion of the mhGAP for patients who need additional mental health care for depression, unexplained medical complaints (including anxiety), grief, and epilepsy *****.

The **Diabetes Prevention Project in Rural Georgia** intervention increased knowledge about diabetes prevention, diagnosis, and treatment. They also **screened for diabetes, trained people in diabetes self-management, and created self-help groups**. They found the Georgian Red Cross increased its NCD and diabetes management and programming capacity, engaged with local diabetes actors, raised

* 2020, *Care in Communities: Guidelines for National Red Cross Red Crescent Societies- A community health systems approach 2020*

** 2020, *MSF- Non-communicable diseases - programmatic and clinical guidelines*

*** 2012, *Help-Age International- Health interventions for older people in emergencies*

**** 2018, *Mixed methods evaluation of MSF primary care based NCD service in Irbid, Jordan: February 2017- February 2018*

***** 2018, *UNRWA Health Department Annual Report 2018*

***** 2015, *UNRWA Health Department Annual Report 2015*

awareness, and advocated for NCD actions at the Ministerial level *.

The project from **Diabetes Prevention and Self-Care Education for Vulnerable in Armenia**. It aimed to **improve diabetes prevention and care with a focus on the establishment of Self Support groups** for people with diabetes and primary prevention activities targeting the general population and youth. The project targets 16 communities. They found that Self Support Groups (SSG) for diabetes patients addressed a gap in the health care system through creating and developing self-care skills at both the community and health facility level. They also found the project supported the ARCS capacity overall **.

In August 2020, **The Danish Red Cross and Kenyan Red Cross** carried out a Case Study Report on Non-Communicable Diseases and Covid-19 in Meru and Nairobi Counties, Republic of Kenya. Operationally, they had a COVID-19 response for MHPSS through the provision of **“tele-counselling for COVID-19 patients, their families, and healthcare workers** as well as frontline responders including KRCS staff and volunteers and health care workers, among others” ***.

The Overseas Development Institute and ReBUILD consortium: Mental health and psychosocial service provision for adolescent girls in post-conflict settings: The Case of Gaza Strip, report emphasizes how the Ministry of Health and WHO have **integrated mental health into the NCD departments** including all primary health care centres. They used a **stepped care model** which is facility-based rather than community-based for 38 centres north of Gaza, where general practitioners and nurses can identify and manage common problems like depression or anxiety, and make a referral for a more specialized service when necessary. Since the report focused on adolescent girls, they noted that as MHPSS was within the NCD department, few of them reached the services as they were **primarily utilised by older persons**. The report also highlighted a marked **lack of continuum of care for MHPSS**. Moreover, it seems that training and education for doctors and nurses are increasing but seem to **be donor-driven and without much follow-up** ****.

Project Report Recommendations

The end of project report for **Diabetes Prevention Project in Rural Georgia** highlighted that going **forward self-support groups** for PLWNCDs and their families to be strengthened **with psychosocial support activities** and access to health services for a wider approach. The report also highlights that diabetes was less of an individual issue but rather a **family issue** where modifying risk factor behaviours is a topic for the household *****. The mid-term report from **Diabetes Prevention and Self-Care Education for Vulnerable in Armenia** underscore that going forward a strengthening of emotional support for diabetes patients, relative, and volunteers. They suggest **a PSS specialist** from the tuberculosis program as a resource program going forward. In the Self Support Group, they encourage creating **space for speaking openly** about their negative emotions, as well as a **supervision system for the volunteers** to have a debrief for when they encounter challenging situations *****.

In the evaluation of **MSF primary care based NCD service** in Irbid, Jordan has several specific recommendations. Recommendations include "provide a **tiered and integrated approach to mental health and psychosocial support** so that patients are triaged to receive the appropriate level of care." They also recommend "**providing transport costs** may encourage patients to attend MHPSS/ HE group sessions." Lastly, they recommend "**Increase awareness of and access to MHPSS services** via continued engagement with the broader clinical team and communication with patients e.g. through psychoeducation sessions, posters, and videos in the waiting room, text messages." *****.

* 2016, End of Project Review Report of The Diabetes Prevention Project in Rural Georgia

** 2018, Implementation Review of Diabetes Prevention and Self-Care Education for Vulnerable in Armenia

*** 2020, A Case Study Report on Non-Communicable Diseases and Covid-19 in Meru and Nairobi Counties, Republic of Kenya

**** 2015, Mental health and psychosocial service provision for adolescent settings.

***** 2016, End of Project Review Report of The Diabetes Prevention Project in Rural Georgia

***** 2018, Implementation Review of Diabetes Prevention and Self-Care Education for Vulnerable in Armenia

***** 2018, Mixed methods evaluation of MSF primary care based NCD service in Irbid, Jordan: February 2017- February 2018

Discussion and recommendations

Summary

Several documents highlighted the approach of integration of MHPSS within various sectors like education, GBV, and protection. There is an effort to integrate MHPSS into primary health care as well as NCDs into primary health care. To a lesser extent, there are efforts for the integration of MHPSS and NCD prevention and care in humanitarian settings. Some of these efforts include high-level advocacy and communications on the integration of MHPSS and NCDs in humanitarian settings. Moreover, **the data was not particularly comprehensive** with only a few documents actually highlighting what integration of MHPSS and NCD prevention and care in humanitarian settings looks like on an operational level. The few documents that highlight this, focused on the integration of MHPSS and NCDs at the operational level including **guidance materials, project outcomes, and project report recommendations**.

Guidance materials were on health promotion for youth. There were sessions to be provided by RCRC staff and volunteers **teaching about healthy lifestyles to youth in the school and community**. The Care in Communities: Guidelines for National Red Cross Red Crescent Societies- A community health systems approach 2020 clearly illustrates efforts to increase MHPSS within care for **PLWNCDs** (4).

Opportunities

The opportunity to integrate MHPSS currently lays within shifting or developing models of care for NCDs and MHPSS to promote their integration within promotion and care. Project outcomes from the DRC, MSF, UNRWA, and ODI discuss **models of care** including the FHT approach, a multi-disciplinary primary care model, and a stepped care model. This could be interpreted as the best way to enable the integration of MHPSS and NCDs within the current contexts of humanitarian settings. Another opportunity for integration is through a **family approach** rather than an individual approach in modifying risk factor behaviours for NCDs as well as creating space for **open dialogues on the negative feeling** associated with NCD or MH wellbeing, this, in turn, may address the **stigma** that was raised as a limiting factor in the uptake of MHPSS in NCD care settings. Continuing **to raise awareness** may also contribute to the reduction of stigma through **psychoeducation**.

Challenges

One clear dilemma that is the link between community-based programmes, such as the initiative for healthy lifestyles for youth from the IFRC is not yet well integrated to primary health care or health facilities as documentation from MSF, DRC, ODI and UNRWA focus on a clinical approach, which may deter people from seeking MHPSS if there is a stigma around primary health care facilities and/or mental ill-health. Stronger links between community-based practices and primary health care practices may be beneficial for the integration of MHPSS and NCDs. Crucially, the **comprehensiveness of this literature on the integration of MHPSS and NCDs was satisfactory**. Thus, this review can serve as a guide, but with **limited documentation** to support the conclusions and the applicability of these findings.

Recommendations

University of Copenhagen Scientific Review

1. Since the current grey literature is broad, we recommend focusing on the umbrella terms including "MHPSS" and "NCDs" and "humanitarian settings" as we did with the addition of "models of care". A focus on models of care could be more useful over specific levels of care and intervention types as the evidence points to development from this level.
2. Consider stigma in the search as it was mentioned in several reports. This could be integrated into the analysis or framing of the research questions.
3. Analysis levels can again utilise the WHO framework but use the community-schools and community-community level and the healthcare- self-care and healthcare-primary care rather than other levels of community- work and health care- hospitals as they were highlighted less.
4. There was some focus on the staff and volunteers' uptake of MHPSS programmes or integrated aspects of, for example, task shifting. It may be useful to frame the scientific literature review from their perspective to also limit the scope of the review if need be.

5. Consider factors of age which emerged in the literature, when integration occurs through NCD departments, they may be missing youth.

Appendix

Table 1: Pathways to integration across delivery platforms

Platform	Function	Delivery channels	Pathways to integration (examples)
Population-wide	Universal prevention and health promotion	Legislation/regulation	Policy measures addressing NCD risk factors (such as alcohol and tobacco demand reduction)
		Information/Awareness	Health literacy/awareness campaigns (such as physical activity for reducing depression)
		Intersectoral collaboration	Mapping/attribution of shared risk factors (such as deprivation, exclusion, education)
Community	Selective prevention and health promotion	Workplace	Wellness at work programmes (such as well-being, stress, NCD risk factors)
		School	Health promotion and early identification (such as physical activity, life skills, substance use)
		Community	Self-help and support groups (such as alcohol use, self harm, overweight)
Health care	Targeted prevention, care and treatment	Self-care	Self-management of NCD risk factors (for reduced depression and dementia risk, for instance)
		Primary care	Linking training in use of treatment guidelines (in areas such as WHO mhGAP and PEN packages)
		Hospital care	Management of physical health conditions (such as adults with severe mental disorders)

IFRC:

1. [N.D., Community-based, Getting started guide for healthy lifestyle promotion manual and toolkit for youth](#): primarily NCDs with some integrated aspects of MHPSS- health behaviors/ techniques to positively influence peers- **Community-based; Technical guide; PSS, Risk factors for NCDs- supported by DRC and Philippines Red Cross**
2. N.D., Community-based, [Community toolkit for the healthy lifestyle: noncommunicable diseases \(NCDs\) prevention and control module](#): includes Home-based psychosocial support for NCD diagnosis; **Community based; technical guidance; 4x4 NCDs, PSS**
3. 2014, [Volunteer manual for the healthy lifestyle: noncommunicable diseases \(NCDs\) prevention and control module](#): Section with Home-based psychosocial support for NCD diagnosis. **IFRC Community-based, guidance document, 4x4, PSS**
4. 2020, Care in Communities: Guidelines for National Red Cross Red Crescent Societies- A community health systems approach 2020; includes reference to providing psychosocial support to those living with an NCDs; **community-based, guidelines, NCDs and PSS**

Reliefweb:

5. 2018, UNRWA Health Department Annual Report 2018, discussion of NCDs and MPHSS. Integration of MHPSS into the Primary Health Care (PHC) and the FHT Model, hospitalization, and health purchase strategies -8 - **hcs**
6. 2015, [UNRWA Health Department Annual Report 2015- UNRWA Annual report](#); Refugees' health is protected through a people-centred primary health care system using Family Health Team (FHT) model- Here they are encompassing a number of health outcomes like NCDs, CDs, maternal health, school health, community mental health, ect. Trying to integrate MHPSS to its primary health care system through this model; **task shifting from medical officers to nurses to reduce workload, community-based mental health and psychosocial wellbeing; counseling and education for health promotion, at schools or health centres; people-centered primary healthcare systems and community-based interventions**
7. 2020, [Noncommunicable diseases in the context of COVID-19 in Lebanon, WHO News](#). Supporting the provision of medicines for the management of chronic diseases including mental health conditions. Patients registered in the chronic medications program, which is operated for the **Ministry of Public Health by the YMCA- Health service; funding/program update; NCD and mental health provision- the 5 NCDs (not risk factors) mh medications- was 10**
8. 2019, [Syrian Arab Republic: tackling noncommunicable diseases \(NCDs\) in emergencies through primary health care- WHO News article. WHO and its partner Primary Care International \(PCI\)](#) provided remote mentoring and support to the health facilities and implementing partners through the duration of the programme (PEN- Package of Essential Noncommunicable disease) to ensure adherence to protocols for diagnosis and treatment of major NCDs for several months- **Health service/system; advocacy/ broad project outcome; when WOH NCD emergency kit for medications for NCDs and certain psychological and neurological conditions MH NCD diseases- was 11**
9. 2020, [Global Humanitarian Response Plan: COVID-19 \(April – December 2020\) GHRP July Update. UN Office for the Coordination of Humanitarian Affairs \(UNOCHA\)](#). Indirectly linking pre-existing NCDs with COVID-19 risk of death, MHPSS in all sectors, GBV and socio-economic situations/poverty- **Health systems ; Report; NCDs and MHPSS- was 14**
10. 2012, [Help-Age International- Health interventions for older people in emergencies.](#)

MSF Field Research

11. 2018, Mixed methods evaluation of MSF primary care based NCD service in Irbid, Jordan: February 2017- February 2018;; **Health service and community based; project outcome, MHPSS and the 5 diseases- was 20**

12. 2018, [JRP for Rohingya- Humanitarian Crisis](#); highlight the need to integrate MH into PHC as well as NCDs. Primary Health Centres and Health Posts: Consolidating preventive and curative services based on the government endorsed an essential package of health services; Mental health: Mainstreaming mental health services in primary healthcare facilities and facilitate referral to a higher level. access to mental health services and psychosocial support at Primary Health Care (PHC) level as well as community-based prevention, screening and early referral will be considered a priority to improve the mental well-being of the population; **Community and health system; report/needs analysis and strategy; MHPSS and GBV**
UNHCR: **Health service; advocacy through news piece; 5 diseases- high level advocacy piece- worldwide-MH**
13. [Novo Nordisk Foundation supports Danish Red Cross initiative on noncommunicable diseases](#) "That is why we need to incorporate a focus on mental health into combating noncommunicable diseases among Syrian refugees in Lebanon and Iraq- good advocacy piece-**MH- unspecified**
14. [2020, MSF Non-communicable Diseases Programmatic and Clinical Guidelines](#)

Think -Tank Search

15. 2020, [Global Fund Must Integrate Mental Health Into Its TB, HIV Strategies, Opinion Piece Says](#). Stating that MH must be incorporated in HIV and TB response, especially under UHC perspective. Could be relevant but distally. - was 29- **MH, HCS**
16. 2015, [Mental health and psychosocial service provision for adolescent settings](#). ODI, Integration of MHPSS into PHC, child health, protection programmes and nutrition programmes (UNICEF, Save the Children, and WHO). **Health services and community based, literature review, PSS and MH**

IRC

17. 2020, [Non-communicable diseases \(NCDs\) at the International Rescue Committee](#). Highlighting need for NCD programming into recovery and development across different contexts, into community health programmes, and areas of health, safety, and economic well being. - acknowledgement of MHPSS and NCD link. Crisis-affected populations are at risk of exposure to a combination of trauma and daily stressors including mental health conditions which can exacerbate NCDs. **Health systems, news article/advocacy, MH and NCDs broadly**

Intervention Journal:

18. 2019, [Sports and physical activity in psychosocial interventions with adolescent groups of the Rohingya community in Bangladesh: potential, limitations and critical factors for success](#). Sports and physical activities as psychosocial intervention are mainly used to create a healthy environment which helps the participants and their surroundings to cope with their daily stresses in positive ways and can improve their mental health and psychosocial wellbeing.
19. 2019, [Physical activity as a psychosocial intervention among Rohingya refugees in Bangladesh: a rapid ecological community assessment](#).

UNDP

20. 2010, EXTERNAL EVALUATION REPORT EMERGENCY PUBLIC HEALTH ASSISTANCE; STRENGTHENING NON-COMMUNICABLE DISEASES AND MENTAL HEALTH CONTROL AND PREVENTION PROGRAMME (D2-05). External evaluation for WHO. The main goal of the Strengthening Non-Communicable diseases (NCD) and Mental Health (MNH) Prevention and Control program is to improve the prevention and control activities of Non-Communicable Diseases and Mental Health services with special emphasis on community-based initiatives in Iraq. noted there were few countries to do this. MH, community based
21. [Mental health and psychosocial support must be at the core of humanitarian NCD programmes](#); advocacy blog piece highlighting MSF work in Jordan- **MHPSS, hcs**
22. [Women and NCDs in humanitarian emergencies](#); advocacy piece on women in humanitarian settings with NCDs and psychosocial distress- **MHPSS**

Danish Red Cross

23. 2018, Diabetes Prevention and Self-Care Education for Vulnerable in Armenia- Community based and health facility PSS, diabetes, prevention, self-care
24. 2016, Diabetes Prevention Project in Rural Georgia- community-based, diabetes with PSS recommended for next time with social support groups and community based
25. 2020, A Case Study Report on Non-Communicable Diseases and Covid-19 in Meru and Nairobi Counties, Republic of Kenya

ALNAP

yielded no relevant resources

Terres des Hommes

yielded no results

ELRHA

A few academic publications that may be relevant for the lit. review

Prevention Web

yielded no results

Forced Migration Review

yielded no results

MH Innovation

Not enough data but useful: [Total Health Screening for Integrated Care](#); project from GWU looking at integrated care screening in Uganda

A5: Scientific commentary

One of the contributions of the University of Copenhagen to this initiative was leading a rapid literature review on the integration of MHPSS and NCDs in humanitarian settings. This then informed a scientific commentary, 'Not an 'either/or': integrating mental health and psychosocial support within non-communicable disease prevention and care in humanitarian response', which has been accepted to be published by the Journal of Global Health. It is jointly authored by many in the project team*, with lead author Bishal Gyawali and second author Mary Harasym.

In summary, the commentary sets out the case for addressing mental ill-health and other NCDs in humanitarian response and the barriers to doing so, including the urgent need for more comprehensive resourcing. It ends with a call to humanitarian actors, researchers, and policymakers to recognise the benefits of bidirectional integration of NCDs and MHPSS and to take action to make it happen. It also includes a short appendix of selected guidance taking an integrative approach, identified during the initial rapid and grey literature reviews.

Not an 'either/or': integrating mental health and psychosocial support within non-communicable disease prevention and care in humanitarian response

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Noncommunicable diseases (NCDs) – including cardiovascular diseases, cancers, diabetes, mental ill-health, and chronic respiratory diseases – are highly prevalent in humanitarian settings. In 2017, NCDs accounted for 24 to 68 percent of the mortality in migrants from the most common countries of migrant origin, consisting of Syria, Afghanistan, South Sudan, Myanmar, and Somalia (1). About one-fifth of those living in humanitarian settings suffers from mental ill-health, such as depression, anxiety and post-traumatic stress disorder (2).

Mental ill-health and physical NCDs are often linked by the underlying individual, community, and societal factors, and frequently co-occur with interdependent causation (3). For instance, physical NCDs can lead to depression and anxiety, whereas mental ill-health can result in decreased help-seeking, poor treatment adherence and poorer prognoses for physical NCDs. Most of the disease burden in humanitarian settings is attributable to these multi-faceted and often co-morbid conditions, and short-term, disease-specific responses fail to adequately prioritize and address these conditions (4).

Although people in humanitarian response demonstrate significant resilience that draws on social and individual protective factors, experiences in humanitarian emergencies can contribute to significant mental health and psychosocial difficulties, leading to the need for effective interventions, such as mental health and psychosocial support (MHPSS) services. These services range from 1) the promotion of positive mental health and well-being through psychological first aid and recreational activities, to 2) prevention activities via peer support and group work groups, families, and individuals, to 3) basic psychological interventions, such as counselling and psychotherapy, which are usually provided in healthcare facilities with accompanying outreach work in community facilities, to specialized clinical care and treatment for individuals with chronic mental ill-health and for persons suffering such severe distress and over such a period that they have difficulties coping in their daily lives, such as activities in treatment centres for survivors of torture and alternative approaches to drug therapy (5).

The existing guidelines for international humanitarian aid have now emphasized the need to address NCDs through investing in MHPSS efforts that improve health outcomes and reduce morbidity (4, 6). However, it is only recently that NCD prevention and care have started to receive attention within humanitarian settings, and little is being done to take advantage of synergies by integrating MHPSS within NCD prevention and care. Furthermore, there is a lack of operational standardization due to the limited availability of evidence

base to inform the guidance and response, and the failure to include specifically community-based PSS considerations (7).

A particular challenge to integration is that the health systems operate in silos – with separate guidelines for care and for providers trained to deliver specific, rather than integrated, forms of care. Too often, healthcare facilities operate with vertical models, with NCD care and MHPSS managed separately in clinical practice and primary care (8). This separation also exists in upstreaming in the financing of service delivery. Most healthcare facilities in humanitarian response receive funding from a wide range of bilateral, multilateral, and private sources. Most donor funds, however, finance vertical and segmented programmes based on requirements, target populations, priorities, and outcomes, and tend to be short-term and targeted (8). As a result, services become fragmented, redundant, inefficient, and time-consuming, hampering integration by limiting time and continuity of care (9). More recently, the COVID-19 pandemic has exposed how deeply entwined mental ill-health and other NCDs can be and the perils of continuing to treat these conditions in silos, especially in countries that are experiencing humanitarian crises with limited resources to tackle both fighting pandemics and treating existing illnesses (10). The indirect impacts of the pandemic (such as the lockdowns) have negatively impacted the management of NCDs and mental ill-health, including a lack of support and access to facilities for improving lifestyle management, monitoring patients, and providing essential medicines on a regular basis (11, 12).

Given the scarcity of resources and competition from vertical and segmented project funding among donors in humanitarian response, there is a need to redesign systems that leverage scarce resources to better meet populations' needs holistically. Where possible, MHPSS should be included as an integral part of the community- and primary-level NCD services in humanitarian settings, taking a tiered approach that is responsive to individual needs (from basic MHPSS support for all to PSS or peer-support groups for vulnerable populations, and individual counselling and treatment where appropriate). Such integration can be bidirectional, with multi-level and multi-sectoral MHPSS approaches being incorporated into NCD prevention and care, or vice versa with NCD prevention and care approaches being integrated into MHPSS services.

Despite mental health being prioritized in humanitarian settings in recent years (5), limited human resources make it difficult to operationalize frameworks that facilitate effective integration of MHPSS into NCD services and vice-versa. A shortage of practitioners and the emphasis on specialists (psychologists, psychiatrists) over generalists (lay health workers) are some of the barriers in humanitarian settings (13). Specialists are essential for mental health care, but the training of general practitioners, lay health workers' roles, as well as strengthening family and community supports, and encouraging self-help, are equally important. Redistributing care tasks from more specialized clinically highly qualified healthcare workers to those with less formal, less specialized and less clinical training and qualifications but with more supervision, ideally from both specialists and peers and sharing tasks with an equally qualified and/or the multidisciplinary cadre of healthcare workers (such as physicians, psychologists, nurses and social workers) can allow for greater reach of MHPSS services and more efficient use of human resources.

Finally, socio-cultural barriers, such as discrimination and stigma, pose a significant barrier to MHPSS and NCD care integration (14). Significant stigma and discrimination against people living with NCDs, particularly mental ill-health, may be rooted in cultural norms, and in many places, mental health support has been provided through sources of help such as family and religious leaders rather than through the formal healthcare system in humanitarian response. Consequently, it is found to affect both the acceptance of mental ill-health and the willingness of the patient or affected person to seek care. A study conducted among Syrian refugees living with NCDs in Jordan reported that although patients recognised the psychological dimensions of their illness, they were reluctant to attend clinic-based MHPSS services due to the fear of discrimination (15). Moreover, the study reported that doctors tended to be reluctant to refer patients to the MHPSS, as they were concerned about stigmatization (15).

MHPSS-focused awareness and sensitization through social media, peer counselling and community and outreach involvement in providing psychoeducation and mobile MHPSS services can help reduce stigma and discrimination among patients, enable better adherence and access to treatment, and promote help-seeking behaviours at both the individual and community levels (16). Healthcare workers, especially those in primary care, and religious leaders and faith healers, as well as community leaders, should be considered the important target group for anti-stigma interventions, which are important in improving mental health literacy, attitude, and belief towards MHPSS.

Greater engagement with NCD patients and the provision of patient-centered care would foster the co-creation of culturally appropriate programmes that better meet the population's physical NCD needs and better anticipate their context-specific MPHSS needs. This cultural appropriateness should include consideration of the stigma attached to such support. This could also be reinforced by situating the programmes in non-clinical settings, such as community halls or schools, to increase both their acceptability and accessibility.

Thus, advancement in advocacy, research, policy, and practice is urgently needed to integrate MHPSS and NCD prevention and care in humanitarian response. We urge humanitarian actors and policymakers in collaboration with researchers to:

- recognise the benefits of integration of MHPSS and NCD prevention and care in humanitarian response;
- increase investment in operational research to develop, strengthen and evaluate innovative, effective implementation strategies to integrate MHPSS in NCD prevention and care;
- produce guidelines for implementation of effective integration that build upon practice-based evidence towards evidence-informed and evidence-based practice for effective integration;
- advocate with larger global, regional, and national stakeholders, raise awareness and increase outreach efforts with local and community stakeholders to reduce stigma about seeking care for NCDs, including mental ill-health; and
- devise sustainable humanitarian financing mechanisms for integration.

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Authorship contributions

BG prepared the first draft of the manuscript and was revised by MH, SH and KC. AB, MB, FK, ER and ST provided technical inputs and contextualization. All authors read and approved the final version of the manuscript.

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Competing interests

The authors have completed the ICMJE Declaration of Interest Form (available upon request from the corresponding author) and declare no conflicts of interest.

References

1. WHO. Noncommunicable diseases country profiles 2018. Geneva: World Health Organization; 2018.
2. Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *Lancet* 2019;394:240-248. Medline: 31200992 doi: 10.1016/S0140-6736(19)30934-1.
3. Stein DJ, Benjet C, Gureje O, Lund C, Scott KM, Poznyak V, et al. Integrating mental health with other non-communicable diseases. *BMJ (Clinical research ed)*. 2019;364:l295-l. Medline:30692081 doi:10.1136/bmj.l295.
4. Aebischer Perone S, Martinez E, du Mortier S, Rossi R, Pahud M, Urbaniak V, et al. Non-communicable diseases in humanitarian settings: ten essential questions. *Confl Health* 2017;11:17. Medline: 28932259 doi: 10.1186/s13031-017-0119-8.
5. IASC. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC; 2007.
6. The Sphere Project. Sphere handbook: Essential health services – non communicable diseases. Geneva. 2011.
7. Tol WA, Barbui C, Galappatti A, et al. Mental health and psychosocial support in humanitarian settings: linking practice and research. *Lancet*. 2011;378(9802):1581-1591. Medline: 22008428 doi: 10.1016/S0140-6736(11)61094-5.
8. Jaung MS, Willis R, Sharma P, et al. Models of care for patients with hypertension and diabetes in humanitarian crises: a systematic review. *Health Policy Plan*. 2021;36(4):509-532. Medline: 33693657 doi:10.1093/heapol/czab007.
9. Ansbro É, Homan T, Qasem J, et al. MSF experiences of providing multidisciplinary primary level NCD care for Syrian refugees and the host population in Jordan: an implementation study guided by the RE-AIM framework. *BMC Health Serv Res*. 2021;21(1):381. Medline:33896518 doi: <https://doi.org/10.1186/s12913-021-06333-3>.
10. WHO. COVID-19 significantly impacts health services for noncommunicable diseases. Geneva. 2020. Available from: <https://www.who.int/news/item/01-06-2020-covid-19-significantly-impacts-health-services-for-noncommunicable-diseases>. Accessed 18 June 2021.
11. WHO. Rapid assessment of service delivery for NCDs during the COVID-19 pandemic. 2020. Available at: <https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic>. Accessed 15 June 2021.
12. WHO. The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment. 2020. Available at: <https://www.who.int/publications/i/item/978924012455>. Accessed 03 June 2021.
13. WHO. Noncommunicable diseases and their risk factors. Third United Nations High-level Meeting on NCDs. Available at: <https://www.who.int/ncds/governance/third-un-meeting/en/>. Accessed 13 March 2021.
14. Troup J, Fuhr DC, Woodward A, Sondorp E, Roberts B. Barriers and facilitators for scaling up mental health and psychosocial support interventions in low- and middle-income countries for populations affected by humanitarian crises: a systematic review. *Int J Ment Health Syst*. 2021;15(1):5. Medline: 33413526 doi:10.1186/s13033-020-00431-1
15. Maconick L, Ansbro É, Ellithy S, Jobanputra K, Tarawneh M, Roberts B. “To die is better for me”, social suffering among Syrian refugees at a noncommunicable disease clinic in Jordan: a qualitative study. *Confl Health* 2020;14:63. Medline:32905304 doi:10.1186/s13031-020-00309-6.
16. Noubani A, Diaconu K, Loffreda G, Saleh S. Readiness to deliver person-focused care in a fragile situation: the case of Mental Health Services in Lebanon. *Int J Ment Health Syst*. 2021;15(1):21. Medline: 33653392 doi: 10.1186/s13033-021-00446-2.

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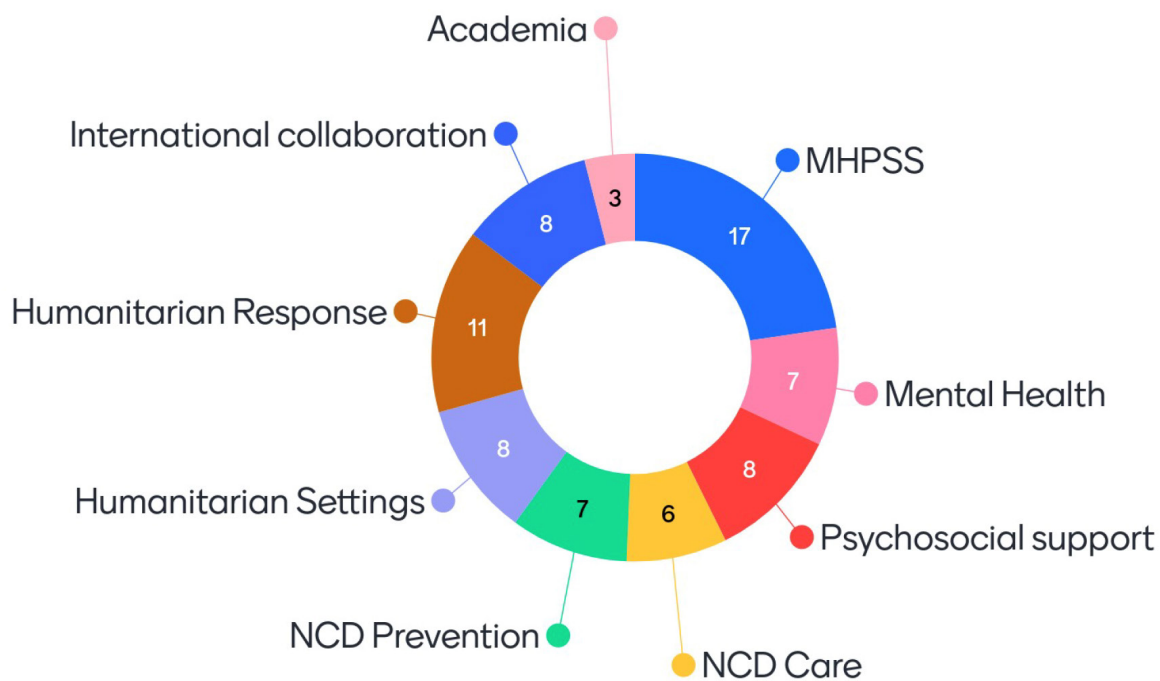
A6: The virtual roundtable event

The roundtable was held virtually on 9–10 June 2021. Thirty-seven people participated from agencies from across Europe, Latin America, Africa and Asia, drawn from 11 organisations – the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent National Societies, the International Rescue Committee, the Kenya Red Cross Society, the London School of Hygiene and Tropical Medicine, Médecins Sans Frontières, the NCD Alliance, Primary Care International, the Philippines Red Cross Society, the Sri Lanka Red Cross Society and the World Health Organization – in addition to the three partner organisations of the IFRC Psychosocial Centre, the Danish Red Cross Society and the University of Copenhagen. The agenda is provided at the end of this Annex.

Learning from throughout the two days – both the small-group discussions and the presentations – are woven throughout this scoping report.

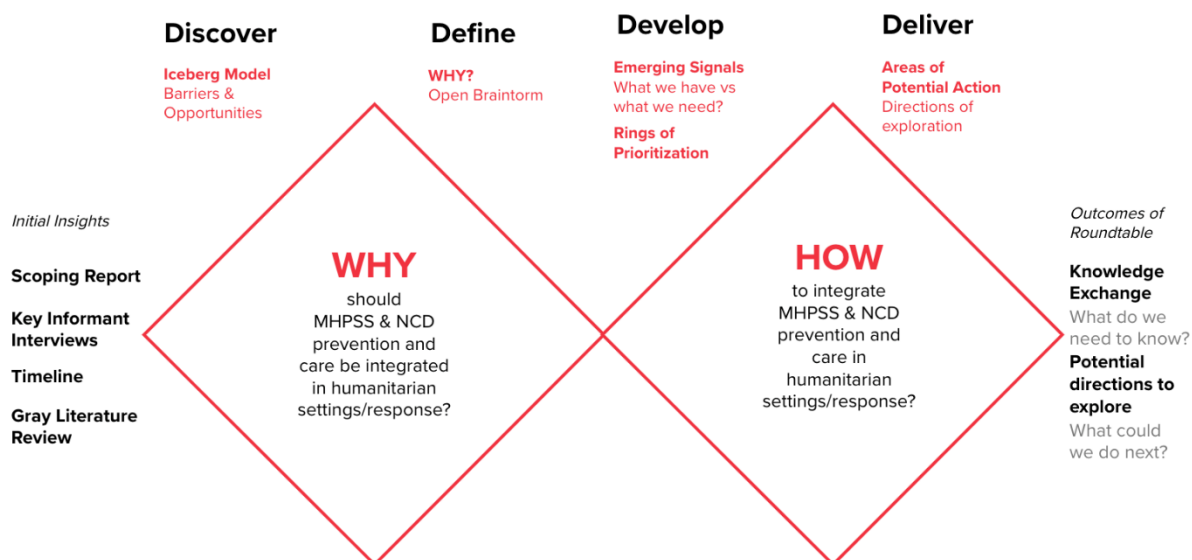
All participants were asked to select which area(s) they regard as being most professionally relevant to their day-to-day work, with MHPSS (17) and humanitarian response (11) being the most frequently selected (figure 5). The evident enthusiasm to attend, the quality of participants and the wide-ranging discussion are all indicative of the growing interest in how best to integrate MHPSS and NCD care and prevention.

Figure 5: Professional expertise represented at the roundtable



The roundtable took a systems approach, using human-centred design thinking to best capture the personal expertise of participants: the double-diamond approach (figure 6). The double diamond took participants through two sets of convergent and then divergent thinking, from a starting point of knowledge already gained from the scoping report and interviews. This participatory design approach maximised the sharing of information and experience by participants, gathering insights to use in the scoping report and identifying potential future directions for exploration.

Figure 6: The double-diamond approach to the two days of the roundtable



The first diamond – **why** MHPSS and NCD prevention and care should be integrated – was discussed on the day one, with small-group discussions to identify barriers and opportunities inherent in the integration of MHPSS and NCD prevention and care, posting suggestions on an online Mural board. These were collated and clustered into six areas for potential action (see figures 7–9).

1. Finance: funding, cost implications:
2. Knowledge: rules, policies, guidelines, research
3. Stakeholders: defining roles, task-sharing and task-shifting strategies
4. Environments: external factors that influence the integration
5. Execution: capacity building, adaptations, operations strategy
6. Partnerships: collaboration models.

Fewer opportunities were identified than barriers, so a key question becomes how best to seek out new and better opportunities and, on the second day – turning to the second diamond – discussion turned to **how** this can be taken forward. The clustered barriers and opportunities from the first day were adapted into ‘how might we...?’ action statements, such as ‘How might we best move towards the integration of MHPSS and NCD prevention and care in humanitarian settings from a Knowledge perspective?’ These were then subject to challenge mapping: brainstorming potential answers to the problem statements.

In addition to the group discussions, there were four sessions for presentations and facilitated panels.

The first facilitated panel addressed **the auxiliary role of the Red Cross and Red Crescent national societies to governments**, with the Philippines Red Cross (Prednison Morales) and the Sri Lanka Red Cross (Dr Mahesh Gunasekara and Pramudith Rupasinghe).

- This session provided an interesting juxtaposition of the two national societies. The Philippines Red Cross’s role focuses particularly on treatment, providing care auxiliary to that of the government, including through its Haemodialysis Center Samaritan Programme (see also case study A1.4). In contrast, the Sri Lanka Red Cross is focusing more on prevention, bringing in long-term programming and a triple nexus / development perspective, such as the Youth as Agents of Behaviour Change tool, addressing the social determinants of health rather than taking a treatment-based approach.

The next discussion, **'From practice-based evidence to evidence-informed practice'**, was with Médecins Sans Frontières (Rima Makki) on the integration of mental-health support in NCD services in Lebanon and on work by the International Rescue Committee (Laura Miller) to integrate an evidence-based mental-health intervention into primary health care to improve outcomes for refugees with hypertension, diabetes and epilepsy in refugee camps at the Thai border.

- This session highlighted two different approaches to the integration of MHPSS and NCDs. In Lebanon, integration has been introduced in stepwise fashion over a number of years, including the use of mhGAP and the implementation of group support for adolescents with diabetes. The initiative in Thailand is at an early stage and is being designed to use the Common Elements Treatment Approach (CETA – for which there is strong evidence of effectiveness), specifically looking at whether it improves outcomes for people living with NCDs and adding to the evidence on the cost-benefit of integrated interventions.

On the second day, the first panel was an opportunity for knowledge exchange, a reflection on how different parts of the **Red Cross and Red Crescent Movement** are working on MHPSS, NCDs and their integration in humanitarian response, now and for the future. Carla Kamitsuji and Sigiriya Aebischer Perone presented from the ICRC, followed by Theresa Baylon and Sofia Ribeiro from the IFRC.

- This panel was an opportunity for both the ICRC and IFRC to highlight ongoing integration efforts. The ICRC described how learning from Lebanon is now being applied to a new project in eastern Ukraine, where primary health care and MHPSS are being brought together for the first time, with MHPSS teams are being trained to understand more about NCDs. The IFRC is also working to improve integration as part of its revised NCD vision and the Care in Communities approach, with one person in the organisation holding the remit for both MHPSS and NCDs.

The final facilitated discussion looked at **operational research in humanitarian settings**, with presentations from IRC (Lilian Kiapi) and LSHTM/MSF (Éimhín Ansbro) on how research has informed practice and how practice has informed research.

- Both panellists highlighted the clear need for and challenge of a concise set of shared, robust indicators across both MHPSS and NCDs, which measure not only process outcomes but also impact and effectiveness. Systems and staff capacity need to be sufficient to enable data to be captured as part of routine monitoring, and there are many lessons to be learnt both from communicable diseases and from the practical experience of teams on the ground (who will be required to undertake the data collection, so systems must be fit for purpose). There was a strong call for more advocacy for research if the benefits of integration are to be understood and further realised.

The objective of the two days was achieved: sharing knowledge and informing potential avenues for future action through the definition of problem statements. The roundtable is an important part of the double diamond for the initiative as a whole. The first diamond has moved the partners in the project from a position of uncertainty and not-knowing, through a process of research, discovery, and definition (including the first draft of the scoping report), culminating in the roundtable. Once the problem statement is defined, the project partners will then be in a position to take this forward to develop ideas and, finally, to implementation. Figure 5 shows the two double-diamonds: the overarching diamond of the project as a whole, with the roundtable nested within it.

Figure 7: The double-diamond for the project as a whole

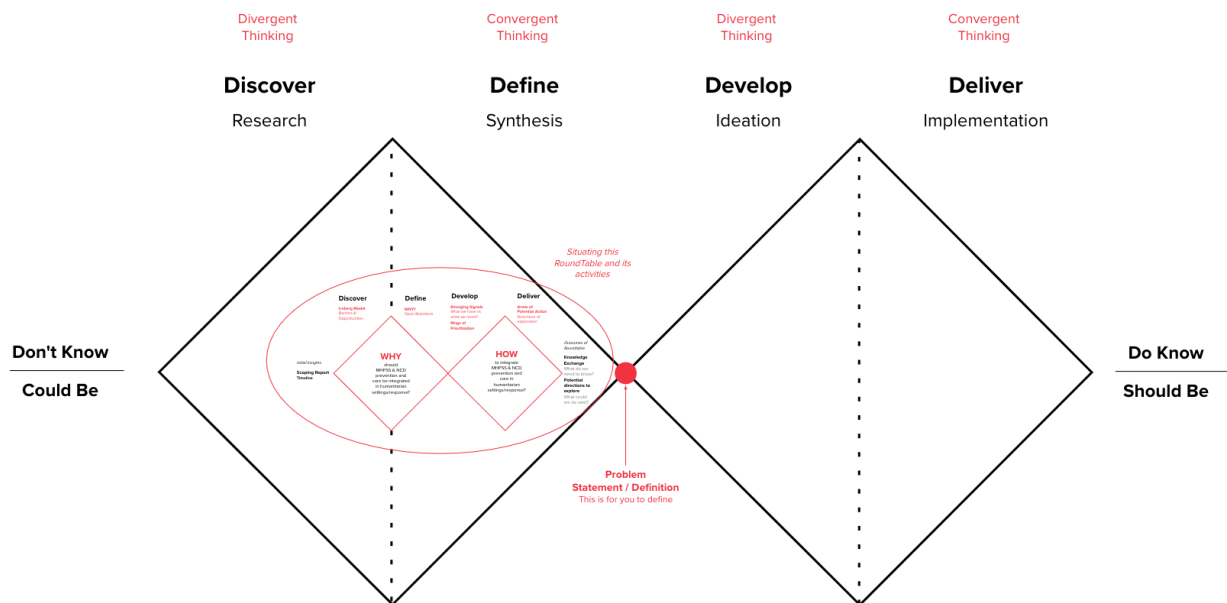


Figure 8: The clustering of opportunities afforded by the integration of MHPSS and NCD prevention and care in humanitarian settings (day 1)

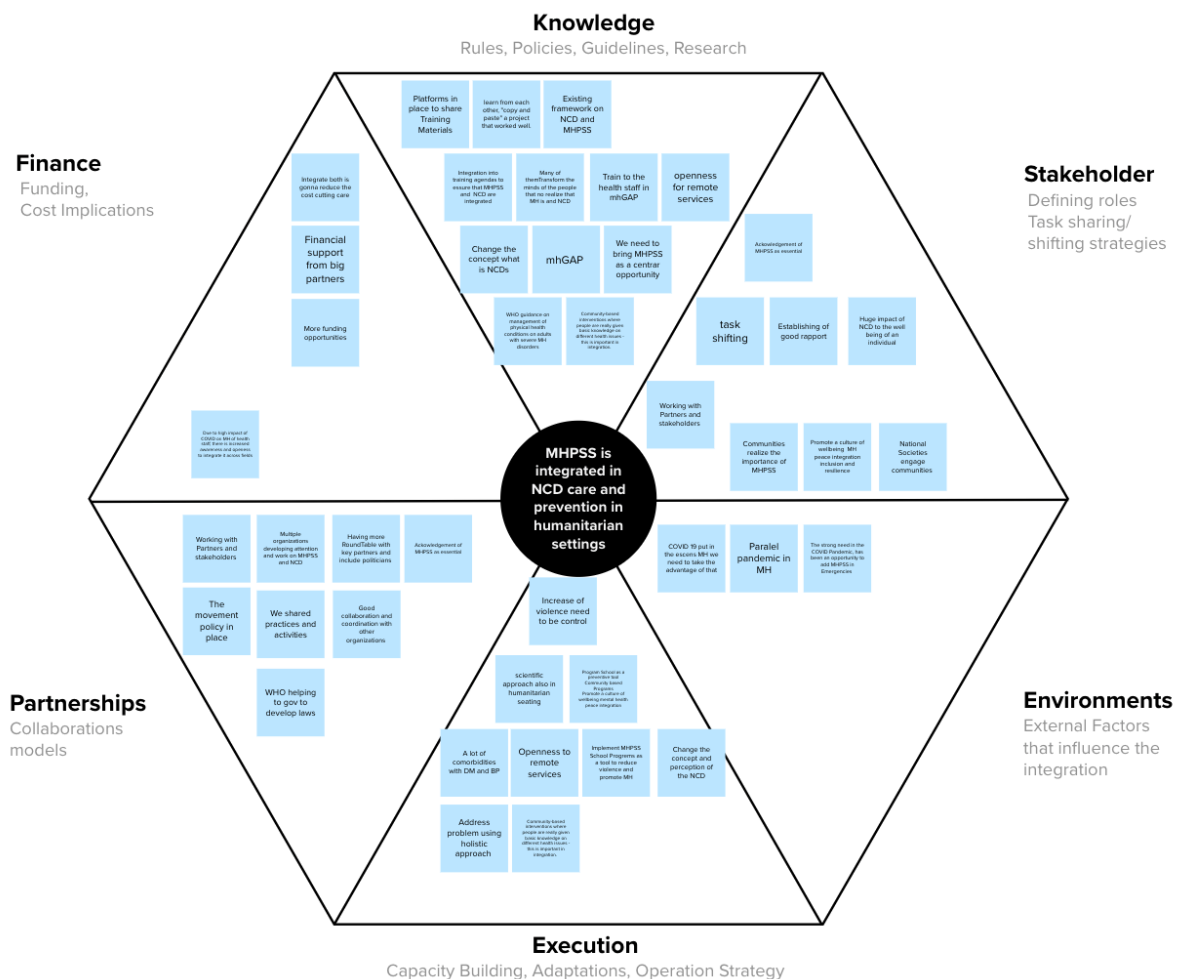


Figure 9: The clustering of barriers to the integration of MHPSS and NCD prevention and care in humanitarian settings (day 1)

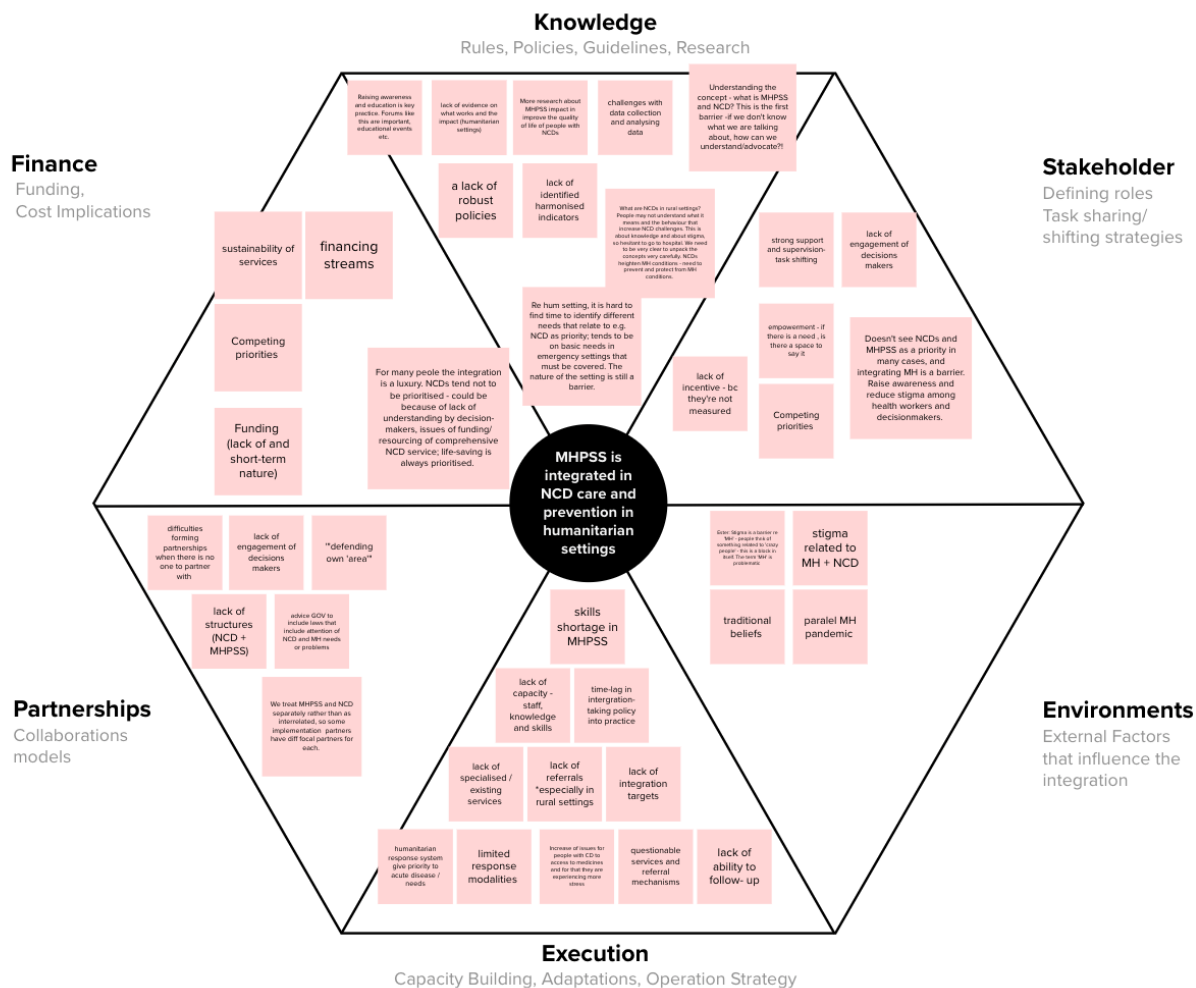
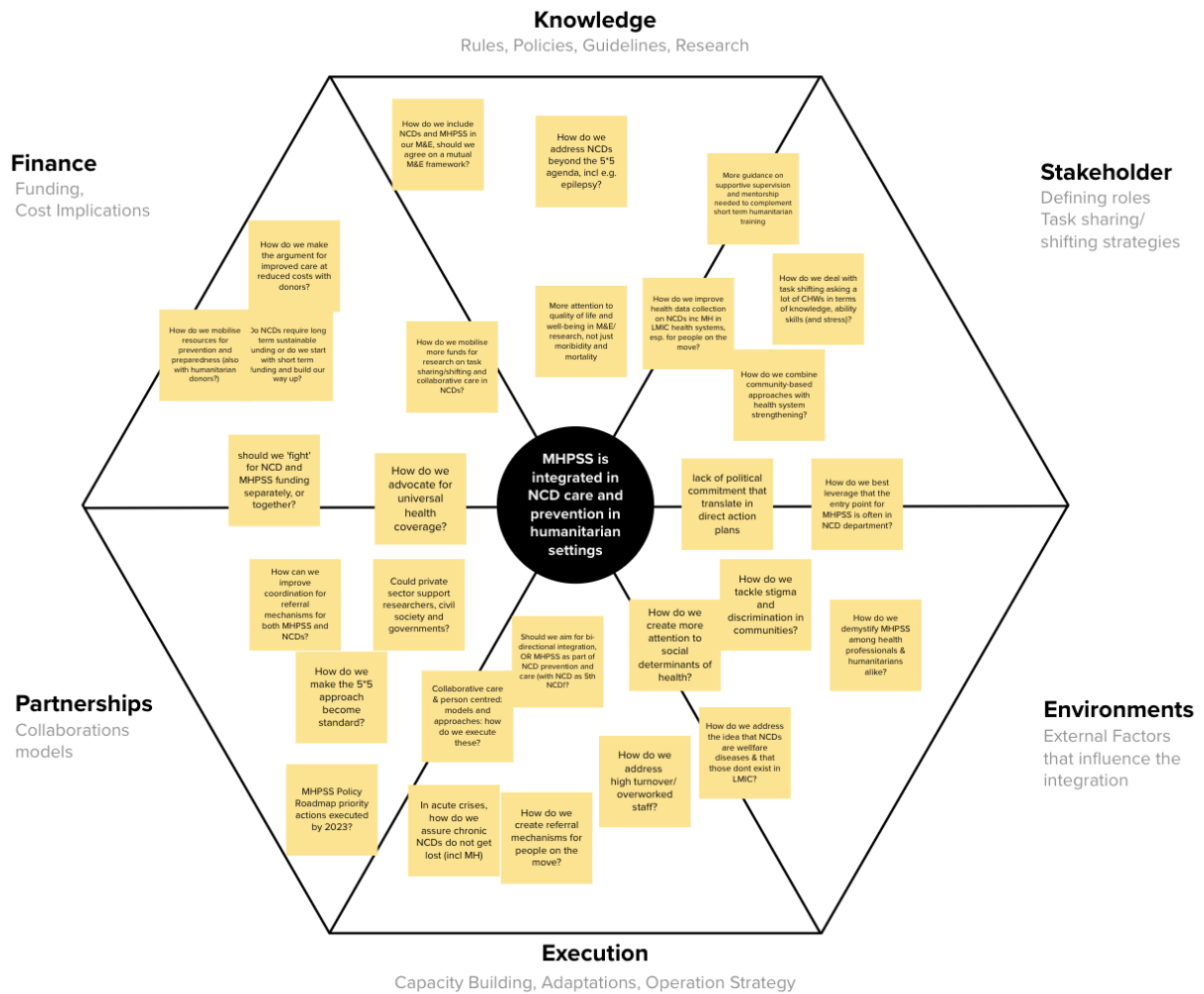


Figure 10: Summarising the key issues from across the six roundtable areas (day 2)



ROUNDTABLE AGENDA

DAY 1:

- Welcome and introduction to the project and the intention for the two days
- Global timeline overview: global efforts on MHPSS and NCD to date (see figure 3 of this scoping report)
- Facilitated discussion: The auxiliary role the Red Cross and Red Crescent National Societies have to governments to operationalise health-systems strengthening and localisation
 - Philippines Red Cross: Prednison S. Morales RSW, Social Welfare Officer, Psychosocial Support Programme
 - Sri Lanka Red Cross: Dr Mahesh Gunasekara, Director General and Pramudith D. Rupasinghe, Head of Operations
- Activity: Mapping barriers to integration of MHPSS and NCDs in humanitarian settings
- Presentations: Integration operations in Lebanon with Médecins Sans Frontières (integration of mental health support in NCD services) and operational research in Thailand with the International Rescue Committee (integration of mental health interventions into existing NCD care models in refugee camps at the Thai border)
 - Rima Makki, Mental Health Activity Manager, MSF OCG Lebanon
 - Laura Miller, Senior Technical Advisor, Health Programs, IRC
- Presentation: Introduction to the scientific commentary and Massive Open Online Course – Dr Bishal Gyawali – Department of Public Health, Section of Global Health, University of Copenhagen

Day 2:

- Plenary activity: Identify and organise major themes for integration of MHPSS and NCD prevention and care in humanitarian settings, drawing on project partners' work and participants' experience
- Knowledge exchange: Reflections on how parts of the Red Cross and Red Crescent Movement are working on MHPSS, NCDs and their integration of the two in humanitarian response, now and for the future
 - ICRC: Carla Kamitsuji, MHPSS HQ Specialist/Psychiatrist and Sigiriya Aebischer Perone, NCD Advisor, Health Unit, ICRC and Consultant, Division of Tropical and Humanitarian Medicine, Geneva University Hospitals
 - IFRC: Theresa Baylon, Consultant, Care in Communities and Sofia Ribeiro, MHPSS Officer, Health and Care Department, Geneva
- Group activity: Challenge mapping on future actions
- Panel: Operational research in humanitarian settings: Presentations from IRC and LSHTM/MSF on how research has informed practice and how practice has informed research
 - Lilian Kiapi, Director-Health, Country Support – Health Unit, IRC and Éimhín Ansbro, Research Fellow in Non-communicable Diseases in Humanitarian Settings, LSHTM
- Outline of the next steps of the project

REFERENCES

- 1 Mental ill-health includes mental disorders such as mood disorders, anxiety disorders, eating disorders, schizophrenia or other psychotic disorders, and neurological disorders: International Classification of Diseases, 'ICD-11 for Mortality and Morbidity Statistics: neurocognitive disorders' (Version : 05/2021) <https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2fid%2fentity%2f213458094>
- 2 G.A. Roth et al, 'Global, regional, and national age-sex-specific mortality for 282 causes of death in 195 countries and territories, 1980–2017: a systematic analysis for the Global Burden of Disease Study 2017' (2018) *The Lancet* 392(10159): 1736–88 [https://doi.org/10.1016/S0140-6736\(18\)32203-7](https://doi.org/10.1016/S0140-6736(18)32203-7)
- 3 H.A. Whiteford et al. 'The global burden of mental, neurological and substance use disorders: an analysis from the Global Burden of Disease Study 2010' (2015) *PLoS One* 10(2): e0116820 <https://doi.org/10.1371/journal.pone.0116820>
- 4 H. Wang et al., 'Global, regional, and national life expectancy, all-cause mortality, and cause-specific mortality for 249 causes of death, 1980–2015: a systematic analysis for the Global Burden of Disease Study 2015' (2016) *The Lancet* 388(10053): 1459–544 [https://doi.org/10.1016/S0140-6736\(16\)31012-1](https://doi.org/10.1016/S0140-6736(16)31012-1)
- 5 Harvard School of Public Health and World Economic Forum, *The Global Economic Burden of Non-communicable Diseases* (2011) http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf
- 6 UNHCR, 'Global trends forced displacement in 2017' <https://www.unhcr.org/statistics/unhcrstats/5b27be547/unhcr-global-trends-2017.html> and WHO, *Non-communicable Diseases Country Profiles* (2018) <https://www.who.int/nmh/publications/ncd-profiles-2018/en/>
- 7 UNHCR, 'Syrian refugee and affected host population health access survey in Lebanon' (2015) <https://data2.unhcr.org/en/documents/details/44869>
- 8 UNHCR, 'Syrian refugee health access survey in Jordan' (2014) <https://data2.unhcr.org/en/documents/details/45809>
- 9 S. Charlson et al., 'New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis' (2019) *The Lancet* 394(10194): 240–8 [https://doi.org/10.1016/S0140-6736\(19\)30934-1](https://doi.org/10.1016/S0140-6736(19)30934-1)
- 10 European Commission, European Civil Protection and Humanitarian Aid Operations, 'Forced displacement: refugees, asylum-seekers and internally displaced people (IDPs)' (2021) https://ec.europa.eu/echo/what-we-do/humanitarian-aid/refugees-and-internally-displaced-persons_en
- 11 WHO, *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group* (2010) <https://www.who.int/publications/i/item/9789241563949>
- 12 IFRC Psychosocial Centre, *Community-Based Psychosocial Support: Participant's Book* (2009) <https://pscentre.org/?resource=community-based-psychosocial-support-participants-book-english> and IFRC Psychosocial Centre, *Strengthening Resilience: A Global Selection of Psychosocial Interventions* (2014) <https://pscentre.org/?resource=strengthening-resilience-a-global-selection-of-psychosocial-interventions-english>
- 13 Danish Red Cross et al. *2018 Inspiration and Aspiration: Advocating for NCD Care in Humanitarian Settings – Outcomes of a Bootcamp, June 2018* <https://www.rodekors.dk/sites/rodekors.dk/files/2018-09/Inspiration%20and%20aspiration.%20Advocating%20for%20NCDs%20in%20humanitarian%20settings.pdf>
- 14 R. Nugent et al., 'Investing in non-communicable disease prevention and management to advance the Sustainable Development Goals' (2019) *The Lancet* 391(10134) 2029–35 [https://doi.org/10.1016/S0140-6736\(18\)30667-6](https://doi.org/10.1016/S0140-6736(18)30667-6)
- 15 D.J. Stein et al., 'Integrating mental health with other non-communicable diseases' (2019) *BMJ* 364 <https://doi.org/10.1136/bmj.l295>

- 16 WHO, 'Rapid assessment of service delivery for NCDs during the COVID-19 pandemic' (29 May 2020) <https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic> and for the impact on mental health services see WHO, 'The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment' (5 October 2020) <https://www.who.int/publications/i/item/978924012455>
- 17 S. Lock et al., 'Secondary stressors and extreme events and disasters: a systematic review of primary research from 2010–2011' (2012) PLoS Curr 4 <https://doi.org/10.1371/currents.dis.a9b76fed1b2dd5c5bfcfc13c87a2f24f>
- 18 UN, International Covenant on Economic, Social and Cultural Rights (1966), Article 12 <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>
- 19 See, for example, S. Reilly et al., 'Collaborative care approaches for people with severe mental illness' (2013) Cochrane Database Syst Rev. (11): CD009531 <https://doi.org/10.1002/14651858.CD009531.pub2>
- 20 J. Unützer et al. (Health Home Information Resource Center), 'The collaborative care model: an approach for integrating physical and mental health care in Medicaid health homes' (2013) https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model_052113_2.pdf
- 21 L. Maconick et al., "'To die is better for me", social suffering among Syrian refugees at a noncommunicable disease clinic in Jordan: a qualitative study' (2020) Conflict and Health 14: 63 <https://doi.org/10.1186/s13031-020-00309-6>
- 22 IFRC PS Centre 'A faith-sensitive approach in humanitarian settings: Guidance on mental health and psychosocial programming' (2018) <https://pscentre.org/faith-sensitive-approach-humanitarian-response-guidance-mental-health-psychosocial-programming/>
- 23 IHME, 'Financing global health: non-communicable diseases' (2019) http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2020/NCD_FGH_2019_Profile_2018.08.18.pdf
- 24 Government of the Netherlands, 'How do we fund MHPSS in crisis situations?' (undated) <https://www.government.nl/topics/mhpss/funding-and-support-for-mental-health-and-psychosocial-support-in-crisis-situations/how-do-we-fund-mhpss-in-crisis-situations>
- 25 WHO, 'The Impact of COVID-19 on Mental, Neurological and Substance Use Services: Results of a Rapid Assessment' (2020) <https://www.who.int/publications/i/item/978924012455> and OCHA, Global Humanitarian Overview 2021 https://reliefweb.int/sites/reliefweb.int/files/resources/GHO2021_EN.pdf
- 26 A. Ruby et al., 'The effectiveness of interventions for non-communicable diseases in humanitarian crises: a systematic review' (2015) PloS One 10(9): e0138303-e <https://doi.org/10.1371/journal.pone.0138303>
- 27 P.V. Marquez and S. Saxena 2016 'Making mental health a global priority' Cerebrum (2016): cer-10-6 and WHO 2017 Non-communicable Diseases Progress Monitor 2017 <https://www.who.int/publications/i/item/WHO-NMH-NVI-17.9>
- 28 U.N. Yadav et al. 'A syndemic perspective on the management of non-communicable diseases amid the COVID-19 pandemic in low- and middle-income countries' (2020) Front Public Health 8: 508 <https://doi.org/10.3389/fpubh.2020.00508>
- 29 Committee on the Science of Changing Behavioral Health Social Norms et al., 'Approaches to reducing stigma', ch. 4 of Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change (2016) <https://www.ncbi.nlm.nih.gov/books/NBK384914/>
- 30 M. Niescierenko et al. (Global Health Cluster), Strengthening Global Capacity for Emergency Health Action (2019) <https://www.who.int/health-cluster/partners/current-partners/emergency-response-capacity-report.pdf>
- 31 M. Abo-Hilal and M. Hoogstad, 'Syrian mental health professionals as refugees in Jordan: establishing mental health services for fellow refugees' (2013) Intervention 11: 89–93 https://www.interventionjournal.com/sites/default/files/Syrian_mental_health_professionals_as_refugees_in.8.pdf;

- K.M. Huster et al., 'Cesarean sections among Syrian refugees in Lebanon from December 2012/January 2013 to June 2013: probable causes and recommendations' (2014) *Yale J Biol Med.* 87(3): 269– 88 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144282/> and N. Savas et al., 'Syrian refugees in Hatay/ Turkey and their influence on health care at the university hospital' (2016) *Int J Clin Exp Med.* 9(9): 18281–90 <http://www.ijcem.com/files/ijcem0027188.pdf>
- 32 R. Joshi and D. Peiris, 'Task-sharing for the prevention and control of non-communicable diseases' (2019) *The Lancet Global Health* 7(6): e686–7 [https://doi.org/10.1016/S2214-109X\(19\)30161-5](https://doi.org/10.1016/S2214-109X(19)30161-5)
- 33 T.N. Anand et al. 'Task sharing with non-physician health-care workers for management of blood pressure in low-income and middle-income countries: a systematic review and meta-analysis' (2019) *Lancet Glob Health* 7(6): e761–71 [https://doi.org/10.1016/S2214-109X\(19\)30077-4](https://doi.org/10.1016/S2214-109X(19)30077-4)
- 34 R. Joshi et al., 'Task-shifting for cardiovascular risk factor management: lessons from the Global Alliance for Chronic Diseases' (2018) *BMJ Global Health* 3(Suppl 3): e001092 <http://dx.doi.org/10.1136/bmjgh-2018-001092>
- 35 Global Health Workforce Alliance et al., 'Scaling up the community-based health workforce for emergencies: joint statement' (2011) <https://www.who.int/workforcealliance/knowledge/resources/chwstatement/en/> and A. Rahman et al., 'Effect of a multicomponent behavioral intervention in adults impaired by psychological distress in a conflict-affected area of Pakistan: a randomized clinical trial' (2016) *JAMA* 316(24): 2609–17 <https://doi.org/10.1001/jama.2016.17165>
- 36 S. Aebischer Perone et al., 'Non-communicable diseases in humanitarian settings: ten essential questions' (2017) *Conflict and Health* 11(1): 17 <https://doi.org/10.1186/s13031-017-0119-8>
- 37 Reuters, 'COVID-19 drives 40% spike in number of people needing humanitarian aid, U.N. says' (1 December 2020) <https://www.reuters.com/article/us-un-aid/covid-19-drives-40-spike-in-number-of-people-needing-humanitarian-aid-u-n-says-idUSKBN28B3PJ>
- 38 WHO, 'Rapid assessment of service delivery for NCDs during the COVID-19 pandemic' (29 May 2020) <https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic> and for the impact on mental health services see WHO, 'The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment' (5 October 2020) <https://www.who.int/publications/i/item/978924012455>
- 39 KRCS, Case Study Report on Non-communicable Diseases and Covid-19 in Meru and Nairobi Counties, Republic of Kenya (August) (2020) – supplied to IFRC.
- 40 WHO, The mhGAP Community Toolkit: Field Test Version (2019) <https://www.who.int/publications/i/item/the-mhgap-community-toolkit-field-test-version>
- 41 S. Burchert et al., 'User-centered app adaptation of a low-intensity e-mental health intervention for Syrian refugees' (2019) *Frontiers in Psychology* <https://doi.org/10.3389/fpsy.2018.00663>
- 42 OCHA Services (undated), 'What is the Cluster approach?' <https://www.humanitarianresponse.info/en/coordination/clusters/what-cluster-approach>
- 43 World Diabetes Foundation (undated), 'Prevention of diabetes and diabetes care among elderly in Armenia, WDF18-1636' <https://www.worlddiabetesfoundation.org/projects/wdf18-1636>
- 44 Supplied to IFRC.
- 45 A. Murphy et al., 'Diabetes care in a complex humanitarian emergency setting: a qualitative evaluation' (2017) *BMC Health Serv Res* 17: 431 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5481869/>
- 46 Danish Red Cross and Georgia Red Cross, Diabetes Prevention Project in Rural Georgia: 01 February 2014 –01 July 2016 – Internal End-of-project Review Report <https://www.worlddiabetesfoundation.org/sites/default/files/End-of-project%20review%20report%2C%20diabetes%20Georgia%2C%20Sept.2016.pdf>
- 47 ICRC, 'ICRC healthcare activities for diabetes patients in Iran, Pakistan and Syria' (9 February 2021) <https://www.icrc.org/en/document/icrc-diabetes-patients-iran-pakistan-syria>

- 48 L. Maconick et al., "To die is better for me", social suffering among Syrian refugees at a noncommunicable disease clinic in Jordan: a qualitative study' (2020) *Conflict and Health* 14: 63 <https://doi.org/10.1186/s13031-020-00309-6> and É. Ansbro et al., 'Clinical outcomes in a primary-level noncommunicable disease programme for Syrian refugees and the host population in Jordan: a cohort analysis using routine data' (2021) *PLoS Med* 18(1): e1003279. <https://doi.org/10.1371/journal.pmed.1003279>
- 49 Primary Care International, 'Advancing the 5x5 approach to NCDs: including mental health in primary care' (2019) <https://pci-360.com/including-mental-health-in-primary-care/>
- 50 KRCS, Case Study Report on Non-communicable Diseases and Covid-19 in Meru and Nairobi Counties, Republic of Kenya (August) (2020) – supplied to IFRC.
- 51 Supplied to IFRC.
- 52 ELHRA, 'Integrating an evidence-based mental health intervention into non-communicable disease care' (undated) <https://www.elrha.org/project/integrating-an-evidence-based-mental-health-intervention-into-non-communicable-disease-care/>
- 53 Supplied to IFRC.
- 54 OCHA, 'Global Humanitarian Response Plan: COVID-19 (April–December 2020) GHRP July Update' (17 July 2020) <https://reliefweb.int/report/world/global-humanitarian-response-plan-covid-19-april-december-2020-ghrp-july-update-enar> and UNHCR 2018 Joint Response Plan for Rohingya Humanitarian Crisis – March–December 2018 <https://www.unhcr.org/partners/donors/5ab8e23a7/2018-joint-response-plan-rohingya-humanitarian-crisis-march-december-2018.html>
- 55 UNHCR, 2018 Joint Response Plan for Rohingya Humanitarian Crisis – March–December 2018 (2018) <https://www.unhcr.org/partners/donors/5ab8e23a7/2018-joint-response-plan-rohingya-humanitarian-crisis-march-december-2018.html>
- 56 WHO, 'Syrian Arab Republic: tackling noncommunicable diseases (NCDs) in emergencies through primary health care' (5 August 2019) <https://reliefweb.int/report/syrian-arab-republic/syrian-arab-republic-tackling-noncommunicable-diseases-ndcs-emergencies>
- 57 NCD Alliance, 'Mental health and psychosocial support must be at the core of humanitarian NCD programmes' (blog, 24 August 2018) <https://ncdalliance.org/news-events/blog/mental-health-and-psychosocial-support-must-be-at-the-core-of-humanitarian-ncd-programmes>
- 58 NCD Alliance, 'Woman and NCDs in humanitarian settings' (blog, 6 March 2017) <https://ncdalliance.org/news-events/blog/women-and-ncds-in-humanitarian-emergencies>
- 59 Novo Nordisk Foundation, 'Novo Nordisk Foundation supports Danish Red Cross initiative on noncommunicable diseases' (press release, 27 February 2020) <https://novonordiskfonden.dk/en/news/novo-nordisk-foundation-supports-danish-red-cross-initiative-on-noncommunicable-diseases/>
- 60 HelpAge International, Health Interventions for Older People in Emergencies (2012) <https://www.helpage.org/download/50cb2e743baf7>; ICRC, Managing Projects addressing Non-communicable Diseases: Operational Guidelines for Field Staff (2020) <https://www.icrc.org/en/publication/4456-managing-projects-addressing-non-communicable-diseases-operational-guidelines-field>; IFRC, Care in Communities: Guidelines for National Red Cross Red Crescent Societies (2020) <https://media.ifrc.org/ifrc/document/care-communities-guidelines-national-red-cross-red-crescent-societies/> and MSF, Non-communicable Diseases – Programmatic and Clinical Guidelines (2016) <https://fieldresearch.msf.org/handle/10144/618783>





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