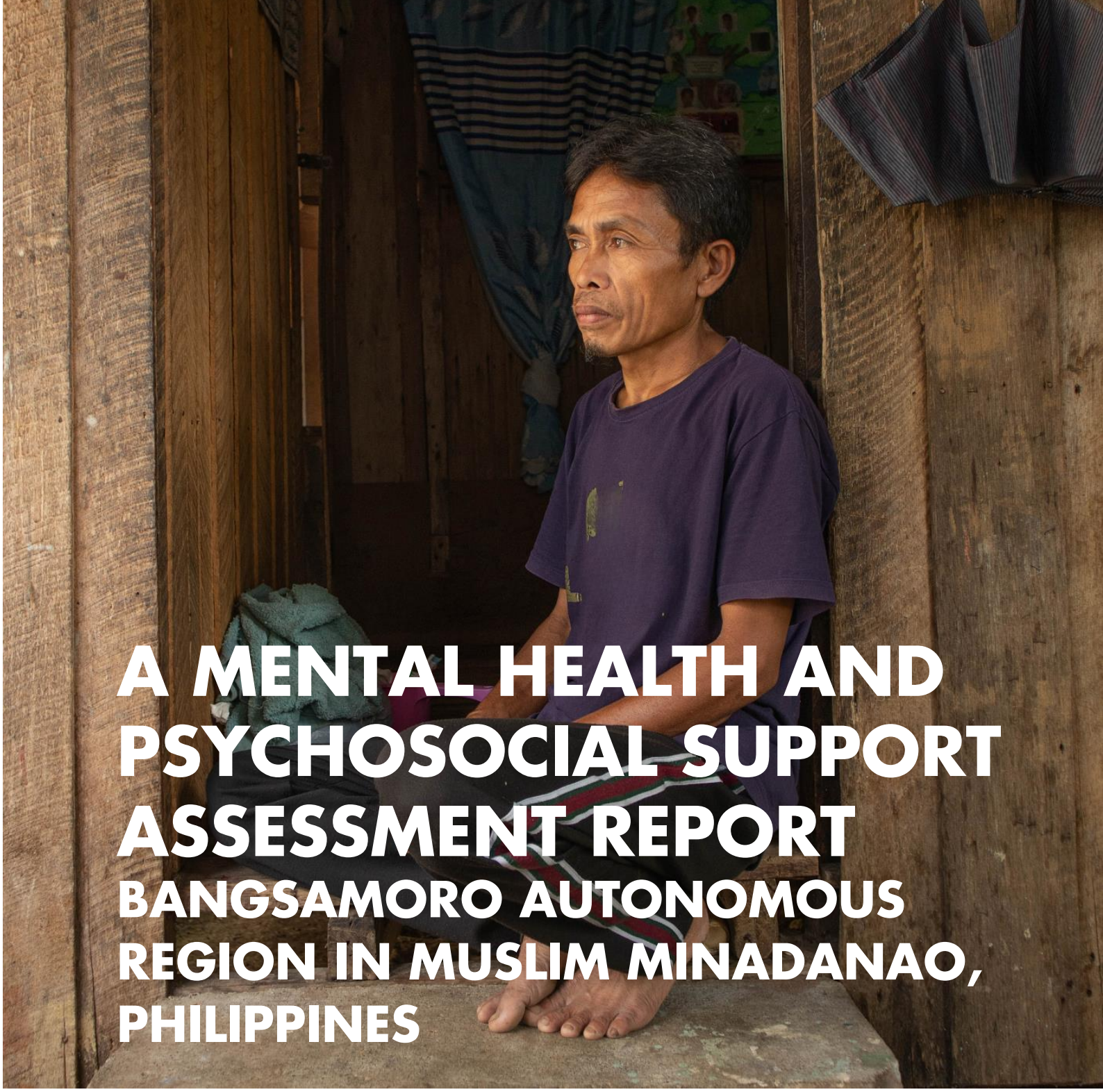


A MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT ASSESSMENT REPORT

BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINADANAO, PHILIPPINES

PHILIPPINES MISSION

AUGUST 2023

ACTION AGAINST HUNGER

CONTENTS

LIST OF ACRONYMS

BANGSAMORO READI	Bangsamoro - Rapid Emergency Action on Disaster Incidence
BARMM	Bangsamoro Autonomus Region in Muslim Mindanao
BHS	Barangay Health Station
BHW	Barangay Health Workers
BOL	Bangsamoro Organic Law
CFSI	Community and Family Services International
CSO	Civil Society Organization
ECCD	Early Childhood Care and Developent
FGD	Focus Group Discussion
HEADSSS	Home, Education/Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety and abuse
IPHO	Integrated Provincial Health Office
KII	Key Informant Interview
MBHTE	Ministry of Basic, Higher and Technical Education
MH	Mental Health
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MISP	minimal initial service package for reproductive health
MILG	Ministry of Interior and Local Government
MoH	Ministry of Health in BARMM
MOSEP	Mindanao Organization for Social and Economic Progress
MSSD	Ministry of Social Services and Development
MSWO	Municipal Social Welfare Officer
NGO	Non-governmental organization
PCMH	Philippine Council for Mental Health
PFA	Psychological First Aid
RHU	Rural Health Unit
UNHCR	United Nations High Committee for Refugees
WHO	World Health Organization

I. ASSESSMENT AIMS, OBJECTIVES AND APPROACH

CONTEXT AND RATIONALE

Action Against Hunger in the Philippines

Action Against Hunger has a long track record of emergency, early recovery and development work in the Philippines, one of the organization's biggest areas of intervention.

Since 2000, the organization has provided humanitarian assistance to conflict-affected families in Central Mindanao and to the disaster-affected population across the country, including Metro Manila in the wake of Typhoon Ketsana (Ondoy), Super Typhoon Haiyan (Yolanda) in the islands of Samar, Leyte and Panay, Marawi conflict, and more recently, on Super Typhoon Rai (Odette), Abra earthquake, and resilience programs in various provinces in Mindanao.

The organization's projects directly support the displaced and affected population and the host communities, while advancing gender integration, gender equity and women's empowerment so that all people - women, men, boys, and girls - have equal abilities and opportunities to lead more fulfilling lives.

Action Against Hunger supports the implementation of the country-level strategy related to improving nutritional outcomes and building relationships with key stakeholders including within the national and local government institutions, the donor community, NGOs and the private sectors, in partnership with local and international NGOs, further enriching its experience in managing projects jointly.

Action Against Hunger in the Bangsamoro Autonomous Region in Muslim Mindanao

The Bangsamoro Autonomous Region of Muslim Mindanao (BARMM) experiences a high level of exposure to armed conflicts, which are ongoing due to political, clan, or religious factors. These conflicts have continued even during the COVID-19 lockdown in Mindanao, with armed groups plotting kidnappings, bombings, and other attacks. This region, particularly southern and western Mindanao, as well as the islands of Basilan and Sulu, is affected by terrorist violence, primarily carried out by Muslim extremist individuals and groups.

Action Against Hunger has been actively working in BARMM, particularly in the Marawi conflict-affected areas. In 2018, we focused on strengthening the capacity of local health structures to identify, counsel, and treat malnourished children under 5 years old and pregnant and lactating women. We also provided direct support to nutritionally at-risk households.

Currently, Action Against Hunger is involved in inclusive disaster risk reduction and climate change adaptation programs, alongside humanitarian response in Mindanao. These projects integrate shock-responsive social protection, food security, and livelihood initiatives to anticipate, prepare for, and mitigate the impacts of climate change hazards and risks among vulnerable communities. Our approach involves building resilience by incorporating climate risk information into programs and capacitating communities and local government units. We have formed partnerships with local government units, science and academic institutions, and local civil society or people's organizations to sustain their efforts in the region.

BARMM Context

The latest World Risk Index (2022) positions the Philippines as the most disaster-prone country, with recurrent earthquakes, floods and volcanic eruptions. Additionally, in the island of Mindanao, communities are affected by recurrent displacement due to ongoing armed conflict, clan feuds, and

natural disasters. In 2022, conflict and violence triggered around 123,000 displacements, 91 per cent of which took place in the BARMM.[1]

BARMM region was reformed as a result of the ratification of the Bangsamoro Organic Law (BOL) in January 2019, which created an autonomous political entity for the Muslim population in the region, known as the Bangsamoro.

The region is home to a diverse population that includes six indigenous groups (Tausug; Maguindanao; Maranao; Iranun; Kalagan: Yakan) as well as a significant Muslim population. The goal of the creation of the BARMM was to provide self-governance and autonomy to the Muslim population in the region, which has historically sought greater control over its affairs.

While the creation of the BARMM represents a positive step toward peace and autonomy, the region still faces various challenges, including poverty, underdevelopment, and security concerns.

With the poverty incidence rate of 63 percent, BARMM is one of the poorest regions in the country. In 2021, BARMM recorded poverty incidence among families at 29.8 percent which translates to 0.23 million poor among BARMM families; 37.4 percent of people in BARMM were poor in 2021 which translates to 1.71 million considered poor families or below the poverty threshold. Basilan province recorded 53.5; Lanao del Sur at 10.9 percent; Maguindanao at 38.0 percent; Sulu at 62.5 percent; Tawi-Tawi recorded 36.5 percent while Cotabato City recorded 39.7 percent.[2]

BARMM records the lowest literacy rate in the country at 86.4 percent, according to the Philippine Statistics Authority's most recent census. Also, BARMM's economy is considerably smaller and less diverse than the national economy – accounting for just 1.4 per cent of national GDP in 2020 – and relies heavily on household consumption and foreign remittances.[3] The labor market in the region is characterized by pervasive deficits in decent work for the approximately 1.3 million women and men in the labor force, with the bulk of workers being employed in low-quality jobs, that are less productive and poorly paid.[4]

When it comes to health and nutrition, the 2022 Philippine National Demographic and Health Survey reveals some really worrying data: BARMM presents the highest fertility rate in the country (3.1), yet only 48% of pregnant women have received any antenatal care from a skilled provider and just 28% completed 4 or more antenatal care visits. Also, about 49% of people in BARMM suffer from chronic malnutrition, while 45 per cent of children under five are affected by stunting – the highest prevalence of stunting in the country.[5]

But the effects of natural disasters are far-reaching, going beyond physical health to impact on the mental health and psychosocial wellbeing of individuals.

According to the World Health Organization (WHO), in crisis or emergencies 35–50% of the population manifests light to moderate distress that may be remedied through psychosocial intervention and may be resolved in the first weeks, 15–20% of the population present lasting light to moderate distress (psychosomatic issues, posttraumatic stress disorder, etc.). Specific mental health support intervention is necessary in this case, and only 3–4% of the population suffer from a major psychiatric disorder (psychosis, severe depression, major anxiety disorder) and need psychiatric treatment.

[1] Data from the Internal Displacement Monitoring Center. Country Report 2022.
[2] 2021 Family Income and Expenditure Survey (FIES)
[3] 2021. Philippine Statistics Authority, "2000-2020 Gross Regional Domestic Product"
[4] 2022. International Labour Organization Country Office for the Philippines. Decent work: the road to lasting peace Labour administration and inspection needs assessment in the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM).
[5] 2023 World Food Programme: A self-reliant and resilient Bangsamoro: The Road to Improved Food Security and Nutrition in BARMM

While for the people living in areas affected by conflict, the percentage estimated to have a mental health condition is one in five (22.1%).[6] But despite BARMM region being an area hit both by natural disasters and armed conflict, there's very little information regarding the mental health and psychosocial wellbeing of its population.

At national level, mental illness is the third most common disability in the Philippines. Around 6 million Filipinos are estimated to live with depression and/or anxiety, making the Philippines the country with the third highest rate of mental health problems in the Western Pacific Region.[7] In 2017, there were about 3.3 million cases of depressive disorders (3.3% of population), and 3 million cases of anxiety disorders.[8] Particularly worrisome are modelled estimates from the 2019 Global Burden of Disease Study indicating that mental disorders and self-harm accounted that year for around 13 per cent of the total burden of disease among Filipinos aged 10 to 19.[9]

In 2020, aggravated by the COVID-19 pandemic, suicides increased by 57%, with the Philippine Statistics Authority reporting 4,420 self-harm cases and going up in the list of leading causes of death in the country in a 25th position.

Still, the resources and infrastructures to respond to these needs are scarce. The WHO Special Initiative for Mental Health Situational Assessment for the Philippines concluded that the country has very few mental health specialists and most work in Manila; many provinces do not have a psychiatrist. It also revealed a gap in the availability of mental health specialists in provinces to offer mental health at secondary care hospitals supervise and support the integration of mental health in primary care and to oversee the provision of psychosocial support at the local level.

OBJECTIVE OF THE ASSESSMENT

Considering the above context, Action Against Hunger conducted an assessment in the BARMM region with the following objectives:

- ✓ To understand and document the current MHPSS service delivery systems, capacity, gaps and challenges.
- ✓ To develop strategies to contribute to health system strengthening in BARMM and increase Mental Health and Psychosocial Support (MHPSS) implementation capacity in our projects and programs.

The assessment aimed to analyze the coverage of mental health and psychosocial support services in the region not only by the health system, but also by other agencies and non-governmental organizations. By doing so, we hope to be able to influence the importance of investing in psychosocial support for people exposed to critical events in the region and to improve existing mechanisms to respond to the most complex cases.

[6] 2019. Charlson F. et al. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis.
[7] 2017. Mental health atlas 2017. World Health Organization
[8] 2021. Prevention and management of mental health conditions in the Philippines. The case for investment. Manila: World Health Organization Regional Office for the Western Pacific.
[9] 2019. Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2019.

METHODOLOGY AND SCOPE OF THE ASSESSMENT

The methodology of the assessment followed a cascade approach, starting with desk research to analyze national and regional policies, bills and guidelines for MHPSS delivery.

At regional level the assessment has involved Key Informant Interviews and Focus Group Discussions with representatives of the Ministries of Health (MoH), Ministry of Basic, Higher and Technical Education (MBHTE), Ministry of Social Services and Development (MSSD) and the Disaster Risk Reduction Management Operation Center (Bangsamoro READI) under the Ministry of Interior and Local Government (MILG). The World Health Organization (WHO), United Nations Children's Fund (UNICEF) and national body bodies Community and Family Services International (CFSI) and the local NGO Mindanao Organization for Social and Economic Progress (MOSEP) present in the BARMM region also participated.

At provincial level, the assessment has covered three provinces: Maguindanao del Norte, Maguindanao del Sur and Lanao del Sur. These were prioritized and selected as representative of the region due to the high number of mental health reported cases, the recent change in the division of the provinces which might affect the health service management, the local community acceptance due to Action Against Hunger ongoing and previous intervention, the accessibility in terms of roads and weather condition within the assessment timeframe, and the security situation. Here, representatives of the Integrated Provincial Health Offices (IPHOs) have participated in key informant interviews (KII).

Focus Group Discussions (FGD) were held at the municipal level with staff of a total of seven (7) rural health units (RHUs) and six (6) barangay health stations (BHS).

Meetings were also held with community members in each of the barangays visited, including community leaders.

A total of 115 people participated in the assessment, as represented in table 1.

Table 1. Distribution of Assessment Participants

BARMM REGION			HEALTH REPRESENTATIVES		STAKEHOLDERS		COMMUNITY MEMBERS		BHWS & BNSS	
			MEN	WOMEN	MEN	WOMEN	MEN	WOMEN	MEN	WOMEN
REGIONAL LEVEL		MoH	1	3						
		MSSD				5				
		MBHTE				1				
		Bangsamoro Readi			2	2				
		CSOs			5	7				
Maguindanao	Province Level	IPHO		2						
	Del Sur Municipalities	South Upi	1	3	1		1	9		
		Upi	3	3			2	7		4
	Del Norte Municipalities	Parang		7			1	6		2
		Pagalungan		3			1	5		4
Lanao Del Sur	Province level	IPHO		1						
	Municipalities	Marantao		1						
		Saguiaran	1	5			2	2		2
		Ditsaan-Ramain			1			7		2
Total			Men				Women			
			22				93			
			115							

The FGD and KII were conducted with the support of tools from the Toolkit "Assessing mental health and psychosocial needs and resources" developed by the WHO and United Nations High Commissioner for Refugees (UNHCR) and the "International Federation of Red Cross and Red Crescent (IFRC) Monitoring and evaluation framework for psychosocial support interventions" adapted to the context and needs. This adaptation has included the integration of the "Guidelines on the Adoption of Baseline Primary Health Care Guarantees for All Filipinos" related for mental health to assess their coverage, as well as the "Guidelines in the Provision of the Essential Health Service Packages in Emergencies and Disasters" and the Quality of Mental health Services as described in the "Mental Health Act".

The information for this assessment has been gathered between the 2nd and the 14th of August 2023 by Action Against Hunger's Health and Nutrition Coordinator for the Philippine's mission, MHPSS Expert from the headquarters and a local MHPSS consultant.

II. NATIONAL AND BARMM LEVEL MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT POLICIES

The Mental Health Act of the Philippines was passed in 2018 affirming the basic right of all Filipinos to mental health as well as the fundamental rights of people who require mental health services. In this Act, the state commits itself to promoting the well-being of people by ensuring that:

a) Mental health is valued, promoted and protected;
b) mental health conditions are treated and prevented;
c) timely, affordable, high quality, and culturally-appropriate mental health case is made available to the public;
d) mental health services are free from coercion and accountable to the service users;
e) and persons affected by mental health conditions are able to exercise the full range of human rights, and participate fully in society and at work free from stigmatization and discrimination.

According to the Act, within six months after the effectivity of the implementing rules and regulations the Philippine Council for Mental Health shall develop a strategic plan for implementation which is the Mental Health Strategic plan 2019-2023. Under the vision of Mental Health and wellbeing for all Filipinos, this 2019-2023 strategy plan aims at three main goals:

- Mental Health and Wellbeing is valued, protected, and promoted.
- Mental Health conditions are identified, treated and prevented.
- Persons affected by mental health conditions are able to exercise the full range of human rights.

The Philippine Council for Mental Health is responsible for implementing the provisions of the Mental Health Act, coordinating the activities and strengthening the working relations among national government agencies, and drafting the country's strategic plan on mental health. The BARMM being an autonomous government, decided to establish its own Bangsamoro Mental Health and Psychosocial Support Technical Working Group. This working group will be responsible for recommending programs, projects and policies for the mental health and wellbeing of Bangsamoro people as it is established in the Parliament Bill n° 193 or the "BANGSAMORO MENTAL HEALTH ACT OF 2023". It recognizes the importance of Islamic education in mental health and stresses its inclusion in the region's mental health plan narrative.

To support this bill, and the creation of the Technical Working Group a Consultative Meeting on Mental Health in BARMM composed of the different agencies and relevant national and international non-governmental organizations has been conducted and the participants are currently working on supporting the National Mental Health Policy and BARMM Mental Health Care Act harmonization through:

- Cultural Adaptation: Develop culturally sensitive materials and training modules that acknowledge the unique cultural, religious, and social factors of the BARMM population. This could involve collaborating with local community leaders and religious authorities to ensure that MHPSS services are respectful of cultural norms.
- Language Accessibility: Translate mental health resources, awareness campaigns, and training materials into relevant local languages spoken within the BARMM region to enhance accessibility and understanding.
- Local Partnerships: Partner with local NGOs, community-based organizations, and mental health professionals within the BARMM to ensure that policy implementation aligns with local needs and preferences.
- Tailored Initiatives: Develop targeted MHPSS initiatives to address specific challenges faced by the BARMM population, such as trauma resulting from conflict or displacement, while integrating these initiatives into the broader national policy framework.

For this, the following strategies are being proposed to bring national and regional mental health policies closer together, ensuring that both levels work together to provide effective and culturally sensitive mental health and psychosocial support services to the population, especially in the BARMM region.

- Policy Mapping: Conduct a thorough review of existing BARMM regulations related to mental health and psychosocial support to identify gaps and areas for alignment with the principles of the National Mental Health Policy.
- Policy Integration: Amend or adapt BARMM regulations to incorporate key components of the National Mental Health Policy, such as stigma reduction, service integration, and community engagement.
- Reporting Mechanisms: Establish reporting mechanisms that allow the BARMM to provide updates on the implementation of MHPSS initiatives and progress toward policy goals to the national government.
- Cross-Jurisdiction Collaboration: Facilitate regular communication and collaboration between the BARMM health department and the national health authorities to ensure ongoing alignment and coordination of MHPSS efforts.

Also at regional level, exists the BARMM Ministry of Health Mental Health Unit, a recently established component within the healthcare system of the Ministry of Health-Bangsamoro Autonomous Region in Muslim Mindanao (MOH-BARMM). Formerly integrated under the Non-Communicable Diseases program, this unit is now recognized as a distinct entity due to its significant role in addressing mental health issues in the region.

The Bangsamoro Mental Health Program was initiated in 2019, amid the height of the pandemic, with the challenging goal of addressing mental health concerns in Bangsamoro communities. The program adopted a hybrid approach, offering psychological first aid and MHPSS training to health workers at a regional office. This approach proved to be highly effective. Since then, the program has continued to expand its training services, reaching health workers across the entire BARMM region.

Also supporting the efforts of effectively implementing the Mental Health Strategic plan, earlier this 2023, the Committees on Basic Education sponsored a measure seeking to promote mental health and well-being in basic education by institutionalizing a school-based mental health program. If passed into law, the Senate Bill 2200 will establish a mental health program that will define the role of every stakeholder in the school community to appropriately respond to mental health concerns through prevention, intervention, postvention and recovery. It will be developed in consultation with learners, their parents, and parent-substitutes, and implemented by the Department of Education.

III. FINDINGS ON THE LEVEL OF IMPLEMENTATION OF MHPSS LAWS AND GUIDELINES IN BARMM

3.1 Services Provided by the Ministry of Health

PRIORITIES AND PLANS FOR THE INTEGRATION OF MENTAL HEALTH AND PSYCHOLOGICAL SUPPORT IN THE HEALTH SYSTEM

Following the Philippines Health agenda 2016-2022 a *Guidelines on the Adoption of Baseline Primary Health Care Guarantees for All Filipinos* was announced in August 2017 by the national Department of Health as Administrative Order No. 2017-0012. In this order, health services were defined per each life stage as population-based and individual-based where all primary health care services are integrated including mental health services. However, since they are trying to implement this holistic approach for all health services, it became harder at regional level to define their goals and priorities. The health agenda 2023-2028 also emphasizes the importance of other determinants of health other than the

health services, focusing on ensuring the well-being of the population with four main strategic interventions: Enable to be healthy, Protect from health risks, Care for health and wellness, and Strengthening health institutions and workforce.

Based on the BARMM mental health management team interview, their focus in the region is the individual-based services for diagnosing and treating severe mental health cases, with limited guidance and knowledge on how to implement the population-based services, especially when it is integrated into other services, and how to engage other sectors to achieve the strategic health interventions' goals.

As for the MHPSS specific plan and priorities for 2023, the resources in the region are allocated to strengthen the diagnosis and referral by training all the general practitioners on mhGAP and launching of Inter-Agency MHPSS referral pathway.

FORMAL MENTAL HEALTH SERVICES PROVIDED AT REGIONAL, PROVINCIAL AND MUNICIPAL LEVEL. COVERAGE AND IMPLEMENTATION METHOD.

Leadership and Human resources:

While at the national level, the mental health program is under the Non-communicable Disease cluster, during the restructuring of the Ministry of Health in BARMM region the mental health program lobbied to be a separate unit where they can advocate to have specific budget and defined strategic planning.

At regional level the Mental Health department is managed by:

- Head of the Department: Psychiatrist
- Program Coordinators: mhGAP Coordinator, MHPSS Coordinator, Tele-counselling Coordinator.

Roles and responsibilities:

The psychiatrist is responsible for providing diagnostic services to MH referred cases from community, health facilities and other agencies, department planning and budgeting, overseeing the department service implementation, and any other tasks that might be assigned by the minister of health which might not be related to the mental health.

For the coordinators, there is no standard number or division of the projects. They have been defined based on the department implementation plan and staff availability. Their main responsibilities are to facilitate the implementation of mental health annual plan, provide technical support to the mental health focal persons at province level, and follow-up on the departmental indicators.

Limitation:

No clear guidance for the department head on how to implement the holistic approach of the primary health services, limited capacity to follow-up on the service implementation since they are only trained on mhGAP and Basic MHPSS with no psychologist on the team, and the team is not only dedicated to mental health due to staff and budget limitation that lead to more focus on the sever cases that needs individual-based services.

At the provincial level, the Integrated Provincial Health Office led by the chief of technical provides technical support and implementation oversight for the health services provided at the municipal level. The Mental Health Unit is represented by one mental health coordinator. At this level, the mental health coordinators don't have specific roles and responsibilities; they follow the instructions from the Ministry of Health (MOH) and facilitate the implementation of the regional plan. There is no standard qualification to become the coordinator, but whoever assigned will receive mhGAP and basic MHPSS training.

At the municipal level, one focal person should be assigned in each municipality, and he/she could receive either basic MHPSS or mhGAP training or both. Their function, although not clearly defined at the provincial level, is to be able to comply with the *Baseline Primary Health Care Guarantees for All Filipinos* related to mental health and psychosocial support. This includes case identification and referral, medication, psychosocial interventions, and self-harm case management with different specificities according to life stage with a trained mhGAP doctor if applicable.

While at Barangay level, it doesn't matter if the assigned nurse or midwife has received any training or orientation on mental health cases, she/he along with the Barangay Health Workers (BHW) tasked to make sure that the medicated mental health cases are taking their medication, update the patient family record and report to the Rural Health Unite any noticed cases based on their observations.

Table 2: BARMM Primary health care technical supervision structure

	BARMM PRIMARY HEALTH CARE TECHNICAL SUPERVISION STRUCTURE		TOTAL NUMBER		MENTAL HEALTH PROGRAM	REPORTING LINE
National Health Facility Registry v3.0	Regional	Ministry of Health Office (MOH-BARMM)	1	>	Mental Health Unit	Report to the Minister of Health
	Provincial	Integrated Provincial Health Offices (IPHOs)	5	>	Mental Health Coordinator	Report to the chief of technical- IPHO and the Project Coordinator-MOH
	Municipal	Rural Health Units	131	>	Mental Health Focal Person Trained mhGAP doctor	Report to the Municipal Health officer-RHU Mental Health Coordinator-IPHO
	Barangay	Barangay Health Station	720	>	Barangay nurse or midwife Barangay health worker	Report to the Public Health Nurse - RHU

Finance:

For 2023, the MOH-BARMM has allocated about 263K USD for mental health and 877K USD for the non-communicable disease cluster, 0.25% and 0.85% respectively from the total Ministry budget. The Mental Health Unit's management team reported that despite the success in the allocated budget, it is still insufficient to enforce the establishment of the program and meet the mental health act requirements, since the psychotropic medicines are very expensive.

At regional level, the budget is defined per project and per province by the management team who informs the Mental Health focal person at the provinces accordingly. Even if health service delivery is decentralized in the Philippines and the priority for each service/ program should be defined at municipal level in BARMM due to the health system restructuring, the services are still defined and managed by BARMM Ministry of Health with different progress in decentralizing. Among the services difficult to decentralize, mental health is struggling the most. Thus, there is no control over the budget at provincial, municipal and barangay level.

Information System:

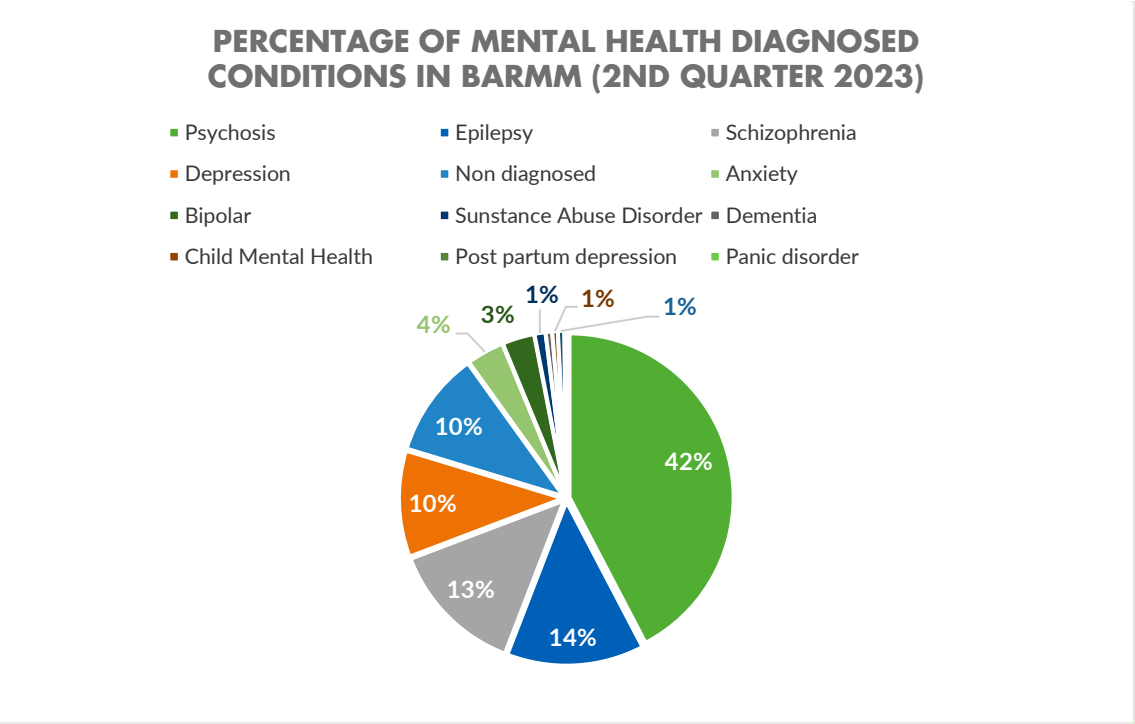
The program indicators collected and analyzed at regional level, include the number of human resources, number of trained personnel, and number of medicated cases. Mental Health reports are issued to the

regional level quarterly from the provinces they don't follow standardized tools and protocols for screening and reporting. Each project coordinator sends the list of needed information to the province focal person, and they report accordingly.

Per the national Department of Health Annual Report for 2022, there is no mention of any indicator related to mental health services, which reflects the absence of any documentation mechanism all over the country. For BARMM, reporting is focused on the medicated cases that were either diagnosed by the public or private sector and referred to the Ministry to receive medication and follow-up, while mild cases and psychosocial consultation, even if the service was provided, will not be reported.

The following table displays the latest data reported by the Ministry of Health of diagnosed cases in BARMM during the second quarter of this year, 2023:

Figure 1: Percentage of Mental Health Diagnosed Conditions in BARMM (2nd Quarter 2023)



This data, with **psychosis, epilepsy and schizophrenia** leading the number of identified cases in the region, contrasts with the national data. At country level, relevant mental health statistics from 2017[10] showed that depression and anxiety were the most common conditions, present in 3.3% and 3% of the population respectively. An increasing suicide rate of 3.2% was also significant and especially worrying among adolescents (11.6% of students aged 13–17 years had seriously considered attempting suicide during the 12 months before the survey, conducted in 2015).

The lack of standardized tools and protocols for screening and referring cases may explain this result, as during the assessment, many health staff recognized that cases were identified based on observation of clear symptoms. As the report accounts only for those under medication, the final picture does not include other milder cases.

Resources for primary health service delivery

Section 27.b of the *Universal Health Care (UHC) Act or Republic Act (RA) No. 11223* states that, *"The DOH shall institute a licensing and regulatory system for stand-alone health facilities, including those providing*

[10] Prevention and management of mental health conditions in the Philippines. The case for investment. Manila: World Health Organization Regional Office for the Western Pacific; 2021.

ambulatory and primary care services, and other modes of health service provision." to fulfill the UHC goals in ensuring that only safe and quality primary care services are being delivered to every Filipino. Administrative order No. 2020 – 0047 was set to provide guidance on licensing the public health care facilities includes the personnel, physical facility, medical equipment and instrument, service delivery, information management, quality improvement, and environmental management.

In the Philippine health structure, there are two levels of health facilities to provide the primary care backage, the Rural Health Unit at municipality or city level and Barangay Health Station (BHS) at barangay level, per this order the certification is only applied for the RHUs while the BHS considered as health structure outside the RHU to provide specific services *"Barangay Health Stations (BHS) shall be under the supervision of their respective rural health units/urban health centers and shall not secure their own DOH-LTO."*

During our assessment, we did not directly assess RHUs' accreditations, but we noticed that some are making some changes in the infrastructure to meet the license requirements, meaning that the RHUs in BARMM are still working to be certified. While all government parent-child friendly facilities (PCFs) shall provide both individual-based and population based primary care services. There is no clear guidance on the distribution of the service between the RHU and the BHS and it depends on the workload, availability of human resources, and the type of health services. The following table represents the availability of the primary health facilities at municipality and barangay level in the targeted locations:
Findings:

- Not all barangays have a BHS but they have at least one assigned nurse or midwife who visits the barangay at least once a week, and at least one resident BHW who is practically the one responsible for primary health services delivery.
- The national ratio for establishing BHS is 1 BHS for 5000 population, while in the assessed targeted areas, 4 out of 7 municipality 57.1% have less than 1 BHS for 5000 population and this increases the burden of providing all the planned services by one health worker per barangay.

Table 3: Primary Health Care Facilities and Human Resources in the Targeted Areas.

TARGETED PROVINCE	**LANAO DEL SUR**			**MAGUINDANAO DEL SUR**		**MAGUINDANAO DEL NORTE**	
	IPHO			One IPHO for both			
# Municipality supervised by the IPHO	40			24		12	
TARGETED MUNICIPALITY	**MARANTAO**	**SAGUIARAN**	**DITSAAN-RAMAIN**	**UPI**	**SOUTH UPI**	**PARANG**	**PAGALUNGAN**
	RHU	RHU	RHU	RHU	RHU	RHU	RHU
# of Barangays supervised by the RHU	34	30	35	23	11	25	12
# of Nurses and midwifes	27	24	20	48	24	41	21
# of GP	2	1	1	1	1	1	1
# of BHS	5	6	3	17	8	21	3
Municipality Population	37,747	26,672	24,309	59,004	43,197	102,914	46,277
1 BHS:5,000 population ratio	1/7,550	1/4,445	1/8,103	1/3471	1/5,400	1/4901	1/15,426

HEALTH WORKERS MHPSS CAPACITIES

During this assessment, the capacities to provide psychosocial services by non-specialized professionals (psychiatrists or psychologists), both within and outside the health structures of other government agencies, have been assessed.

Within the health system, the objective in each RHUs is to have two people to implement and manage the Mental Health Program, one is the designated Mental Health Focal person which are usually nurses trained to support these actions, the other one is a trained General Practitioner to identify cases requiring a psychiatric diagnosis. The General Practitioners who have completed the level 2 mhGAP training can diagnose. If they are unable to do so, they have to refer them to the psychiatrist. They also prescribe the recommended medication in each case, but we found some RHUs where doctors are recent graduates and could not even do the prescription, having to refer to the psychiatrist anyway.

Although having a focal person is the norm, in Saguiaran municipality in Lanao del Sur, the RHU did not have one for mental health after the previous staff left recently.

Most of the mental health assigned staff were trained very recently on MHPSS and mhGAP. The most active actor contributing to the capacity building of MHPSS among health workers is the World Health Organization, which has delivered:

- MHPSS training on July 2022. Participants include nine (9) people from regional level (nurses) and 36 from the provinces.
- As a follow up, they did an actual demonstration: each province had supervision and mentoring and they cascaded it to the municipalities. The Philippine Mental Health Association did the mentoring and follow up of the trained staff.
- For sustainability of these trainings, they also trained the Public Health Nurses (PHN) who are permanent staff in the structure. When the RHU does not have a trained doctor, the PHN consults the head of MH unit at regional level.
- Care for carers was recently conducted. The Community and Family Services International CFSI has created new IEC materials for this to be used at Barangay level.

Table 4. Number of Health Personnel Trained in BARMM Region.

HEALTH PERSONNEL TRAINED			
MHGAP TRAINING			MHPSS TRAINING
PROVINCE	LEVEL 1	LEVEL 2	
Maguindanao	118	33	89
Lanao del Sur	104	54	105
Marawi City	14	6	31
Basilan	21	18	24
Lamitan City	15	12	15
Sulu	57	33	44
Tawi- Tawi	57	21	29
LGU	0	0	16
Total	563		353

Data was shared by the mental health unit on the number of trained health staff from BARMM region, 54.9% of the target staff were from Maguindanao (Del Sur & Norte) and Lanao del Sur provinces. Only 16 from the Local Government Units (LGU) were targeted which indicates some acknowledgment of the importance of engaging the LGUs.

Both Integrated Provincial Health Offices interviewed acknowledged insufficient training at Municipality and Barangay level as one of the key barriers towards implementation. Regarding RHUs, all except one agreed on this point.

Specific training needs identified are detailed in the table below:

Table 5: Training needs per RHU feedback.

PERCEENTAGE RHU IDENTIFYING TRAINING AS A BARRIER TOWARDS IMPLEMENTATION	PRIORITY STAFF FOR TRAINING	SPECIFIC TRAINING NEEDS
85,71%	- Barangay Health workers - Midwives - Health staff in GIDA Barangays	- Screening, early case identification. - Effective referral. - Basic counselling. - Psychoeducation. - Suicide prevention

The knowledge about mental health and psychosocial support is very limited for the health workers at community level with the stigma or perception of the individual being crazy or having something wrong with the brain that causes these strange behaviors. They couldn't relate the psychosocial support to anything, and they reported that this term is new for them, specially the Barangay Health Workers.

During the last two years, they barely received any technical training specifically on psychosocial support. 15% reported receiving some training on communication skills and offering basic support to people who are bereaved. When they were asked *what training or skill they think they need the most*, they reported learning how to deal with mental health cases among the high priority since they need to follow up with those cases and it is difficult and scary to communicate with MH cases, along with communication, problem-solving, and basic support.

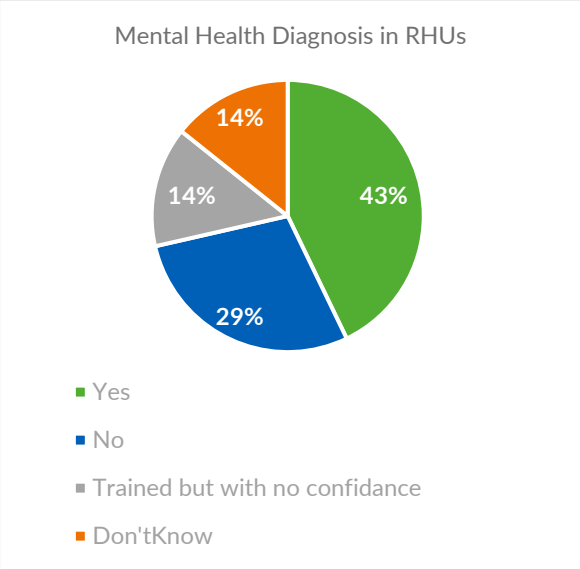
TRAINING PLANS:

✓ The World Health Organization is planning a community-based MH training for municipal social workers, BHW, Muslim religious leaders and nurses in September, targeting 90 people in total from different municipalities in Maguindanao: 4 participants per municipality. They are targeting 18 municipalities this year out of 36, planning to replicate this in the others during next year.

✓ Also, a training on Problem Management Plus[11] will be conducted in Manila before the end of the year, targeting one representative of IPHO and MoH of the six regions.

As a result of the previously implemented training, the Ministry of Health aimed to increase the diagnosis capacity at municipality level and reduce the number of cases that need to be referred to the psychiatrist. During the assessment, we checked the availability of diagnostic services for the main mental disorders since the biggest number of trained personnel were from the 3 provinces covered by the assessment. The result showed that even 50% of the Rural Health Units have trained staff on mhGAP and only 43% were confident to say that they can provide diagnoses of the main MH disorders, but they mentioned that cases like depression and anxiety could be

Figure 2. Mental Health Diagnosis in RHUs



[11] World Health Organization. Problem Management Plus (PM+): Individua
communities exposed to adversity. (Generic field-trial version 1.1). Geneva

under-diagnosed since they depend on the referral from community and they mostly receive referral only for sever neurological conditions like psychosis or schizophrenia.

At the Barangay Health Station level, they are not mandated to provide any diagnostic services. Their responsibility is limited to identifying cases and referral, in addition to follow-up with the cases under medication. During the assessment, 14 Barangay Health Workers and Nutrition Scholars were interviewed, in addition to 12 Barangay Nurses and Midwives. Out of these 26, only 4 reported having received training related to MHPSS.

67% reported to know where to refer mental health cases within the health system. All of these mentioned the Rural Health Unit as referral point, but they were not sure what kind of services are available there or if the cases could be diagnosed. Mainly, they refer to the RHU just for more information. For protection and social support services outside the health structure, they mentioned that MSSD usually provides financial support for the most vulnerable families to seek help, but not for the protection or social support service itself. On another hand, the health workers at RHUs seemed to be more knowledgeable about the availability of community-based services by other agencies, mainly the CSOs and MSSD. They knew there is a referral pathway, but were unsure of how it works and whether there are any other services other than the psychiatrist in the region.

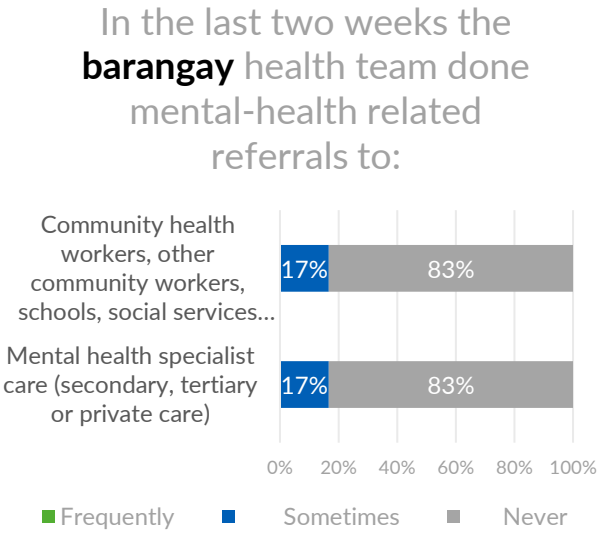
Table 6: Knowledge of available resources for MHPSS at municipal and barangay level.

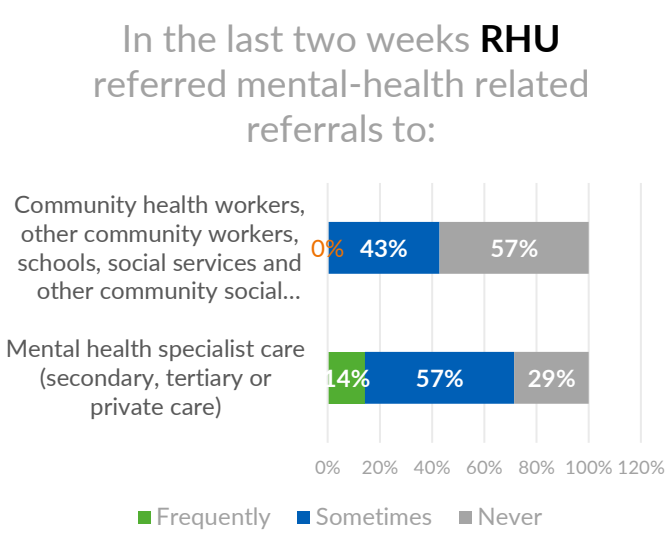
KNOWLEDGE OF AVAILABLE RESOURCES	BHS		RHU		
	Yes	No	Yes	No	Somewhat
Health staff knows the referral options to the mental health system. (For example, staff know the location, approximate costs and referral procedures for nearby mental health services.)	67%	33%	29%	14%	57%
Health staff knows available supports (for example, protection agencies/networks, community/social services, community support systems, legal services) offering protection and/or social support for social problems such as domestic violence and rape.	0%	100%	43%	29%	29%

Referral

For the referral pathway of mental health cases to specialized services or to community-based services, the data from the assessment showed agreement between the barangay and municipalitylevels on its weekness. . This is mainly because they don't know of its existence nor what kind of community services might be helpful for mental health cases. They mainly refer to the social services to facilitate the financial support for the cases since reaching out to any specialized services is expensive.

Figures 3 and 4. Mental Health Referrals by BHS and





COMPLIANCE WITH THE MHPSS PRIMARY HEALTH CARE GUARANTEES

The Philippines Health Agenda 2019-2022 commits to guarantee an explicit and comprehensive set of primary health care interventions - both at population and individual level - that will ensure healthy lives and promote well-being for all Filipinos at all ages. For that, the Department of Health worked on a Guidelines on the Adoption of Baseline Primary Health Care Guarantees for All Filipinos, which shall apply to all concerned and relevant stakeholders of primary health care such as, but not limited to: DOH Central Office Bureaus and units, regional offices, retained hospitals, national reference centers, laboratories, diagnostics clinics, drug outlets, and attached agencies of the Department of Health, other key government agencies, local government units (LGUs), public and private hospitals and health care facilities, health care providers, civil society organizations (CSOs), medical societies, development partners, academe, individuals, families and communities.

The objectives of this guidelines are:

a) To define the guaranteed population-based and individual-based primary health care interventions for each life stage;
b) To identify the health financing agent/mechanism for the identified primary health care interventions; and
c) To facilitate the citizens' knowledge and understanding of their health guarantees.
d) Scope and Coverage

The compliance with the specific guidelines for MHPSS was cross-checked during the FGD and KIIs held at the Rural Health Stations to verify the level of implementation. Guidelines regarding breastfeeding promotion and Early Child Development were also assessed. Below details the guidelines assessed for each life stage:

For Pregnant women: Screening, treatment/management and referral of behavioral or psychiatric conditions to higher level facilities, Provision of drugs as indicated, and Psychosocial intervention as well as Mental health and PSS, Minimal initial service package for reproductive health (MISP), and Women friendly spaces during emergencies.

For Post-partum: Post-partum depression assessment and counseling, Referral to Psychiatrist as needed.

For Neonates and infants up to 4: Infant and young child feeding, Clinical services for Early Childhood Care and Development (ECCD), including screening developmental milestones assessment of developmental delays, and mothers' education on: Early Child Development interventions through mother-infant interactions, Developmental milestones monitoring, mental health.

For School aged children 4-9: ECCD and disability screening, Mental health assessment and counseling, Referral to Child Psychiatrist, Psychosocial intervention and psychotropic drugs provision, Regarding self-harm: Clinical immediate assessment, first aid, and transport to the nearest tertiary facility, Regarding self harm: On follow up, referral to psychiatrist for assessment and School based interventions for self-harm.

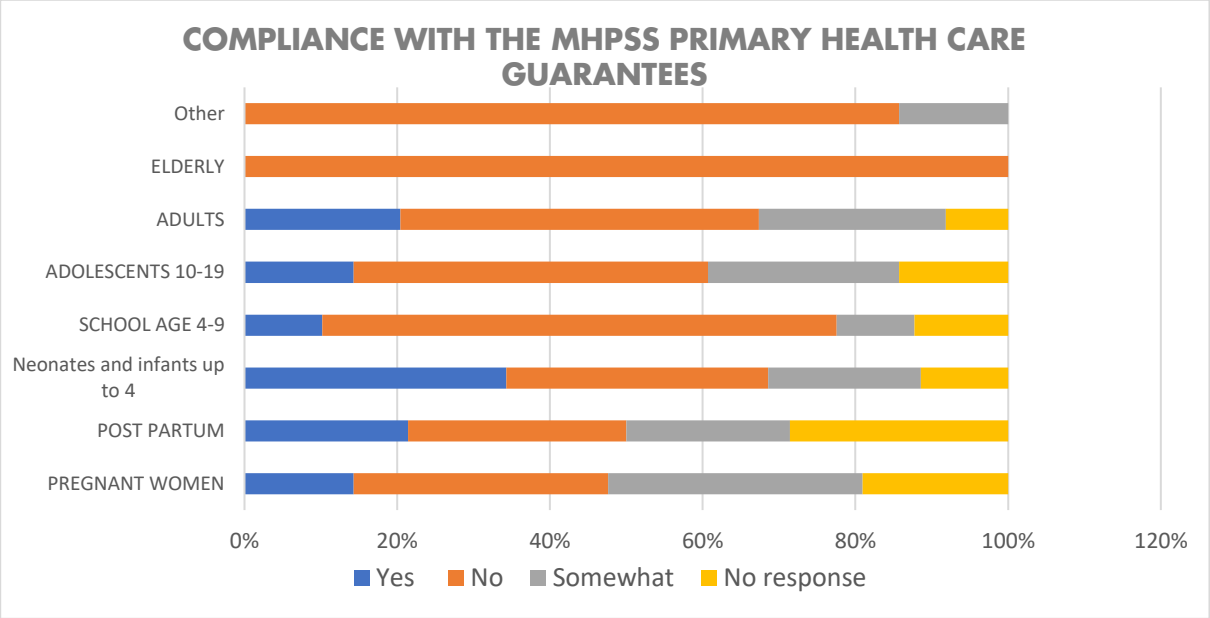
For Adolescents 10-19: Crisis helplines for self-harm, Psychosocial risk assessment, Special health services for special health problems and conditions such as disability, rape and abuse, medical, legal, and rehabilitation services as well as social, legal and support services, Women and child protection units at hospitals, Psychosocial intervention and psychotropic drugs, Regarding self-harm : Clinical immediate assessment, first aid, and transport to the nearest tertiary facility, Regarding self harm: On follow up, referral to psychiatrist for assessment, and Gender -based watch groups during emergency.

For Adults: Crisis helplines for self-harm, Screening, treatment/management of psychiatric disorders and referral to higher level facilities, any of the mentioned are treated at community level, Provision of drugs, Psychosocial interventions, Communication on Reproductive health (sexuality and gender-based violence), Promotion of violence-free, drug free and healthy workplace.

For Elderly: For self-harm: Immediate Assessment, and First Aid and Transport to Nearest Facility.

The following chart displays the actual level of compliance according to the responses of the health workers participating in the assessment:

Figure 5: Compliance with the MHPSS primary health care guarantees



The average compliance rate for the targeted MHPSS services, including screening and psychological risk assessment across all life stages is 16%. However, this rate increases to 24% for less targeted services, such as early childhood development check-ups and post-partum depression assessments during post-natal care. Nevertheless, there remains inconsistency in the implementation of these integrated services.

Even if all the investment of the program is for diagnosis and treatment, the compliance to provide medicine to all age group is only at 18%. Data shows that 43% of RHU has MH drugs mainly for adults reflecting that the medicine for this group is the most available one.

Similar to provision of medicines, the PSS interventions for all age groups are implemented at 18% even with limited resources.. While psychoeducation was at 29%.

Protection and self-harm were at 12% even with the showed increased attention for suicide cases.

HIGHLIGHT ON EACH LIFE-STAGE FINDING:

Pregnant Women

48% of the municipalities reported that they are partially providing Screening, Treatment, and Psychosocial intervention to pregnant women. By "partially providing" they mean basic counseling on the changes that may happen during the pregnancy and the provision of medicines for already diagnosed cases if it is available. 14% reported that they provide counseling services at the women friendly spaces during emergencies.

Post Partum

29% Reported that they check women for postpartum depression during the after-delivery visit, but only based on the observation and without specific tools.

Neonates and Infants Up To 4

Consultation during the IYCF services is the most common practice, even though it is not structured. 86% reported that they are doing it with some PSS consideration. 43% Reported that they educate mothers about Early Child Development. While no one is monitoring and screening, since they believe it takes too much time and they don't have the capacity to do it.

School Age 4-9

This age group is the most neglected group regarding the health service in general including mental health screening, referral, and education. We believe, that the health services in BARMM are passive meaning they are only provided to the ones who visit the facilities and seek health services. Children at this age group, have mainly completed their vaccines through the support of the national program. They also have not reached the reproductive health age yet and usually don't visit the facility and the health workers don't have any outreach activities for them.

Adolescents 10-19

43% Reported the availability of psychosocial risk assessment mainly using the HEEADSSS assessment in coordination with the education system.

Adults

None of the municipalities reported to be providing community-based psychosocial intervention nor follow up for adults.

3.2 MHPSS Services Provided by Governmental Agencies Contributing to the MHPSS National Plans and Strategies

This section covers information collected through Key Informant Interviews and Focus Group Discussions with representatives of the Ministries of Health, Education and Social Services and the Disaster risk reduction management operation center (Bangsamoro READi) under the Ministry of Interior and Local Government (MILG).

As part of the Mental Health Strategic plan 2019-2023 of the Philippine Council for Mental Health (PCMH), these three agencies were actively involved in the development of the Mental Health Act and the Implementing Rules and Regulations and are part of the technical working team created for designing the required strategic plans. For this reason, meeting them was prioritized during the assessment.

Their participation in the assessment delved into the type of programs and actions provided by their agencies with which they contribute to psychosocial well-being. More specifically, we checked to what extent they contribute, from outside the health system, to the "Guidelines on the Adoption of Baseline Primary Health Care Guarantees for All Filipinos" as well as with the "Guidelines in the Provision of the Essential Health Service Packages in Emergencies and Disasters".

1. MINISTRY OF BASIC, HIGHER AND TECHNICAL EDUCATION (MBHTE)

One of the key outcomes expected out of the Mental Health strategic plan is that Mental Health is mainstreamed in workplaces, schools and communities using the life course perspective. When it comes down to the education sector, the specific activities to achieve this are:

a) the development of guidelines, standards and strategies that promote MH and wellbeing among educators and learners in public and private educational institutions, and

b) the integration of age-appropriate, content pertaining to MH in different educational stages both in private and public institutions.

To analyze the level of MHPSS implementation and contribution to the Mental Health Plan, a KII was conducted with the Head of Health and Nutrition Unit at the MBHTE.

Programs and Actions

Officially launched in 2018, through DepEd Order No. 28, *OK sa DepEd*, is the convergence of DepEd's school health and nutrition programs for their effective implementation at the school level. It highlights six flagship programs, namely:

1. The school-based feeding program complemented by other nutrition support programs;
2. Medical, Dental, and Nursing Services, including the School Dental Health Care Program
3. Water, Sanitation, and Hygiene in Schools Program;
4. Adolescent Reproductive Health;
5. National Drug Education Program supported by comprehensive tobacco control;
6. School Mental Health Program.

However, and despite it being a key program, the School Mental Health Program has no specific budget allocation. To solve this, partnerships with other governmental agencies and NGOs is thei common approach. Among the activities developed under these collaborations are:

- ✓ Development of specific materials during COVID-19, supported by Save the Children to address the mental health and psychosocial challenges of students during this time.
- ✓ "Adolescent Mental Health Workshop". In collaboration with the Rural Health Unit of the Municipality of North Upi. Described in Annex 1.
- ✓ "Peer to peer support training". Supported by the Local Government Unit and the Local Youth and Development Office. It trained students from different secondary schools on basic skills for providing psychosocial support to each other. Aware of how the youth often prefers not to elevate or share their concerns, this initiative aimed at bringing students closer and strengthening supportive relationships.

Priorities and Plans

Under the Mental Health flagship programs, they intend to integrate MHPSS content in the curriculum through:

- Orientation on MHPSS
- Psychological First Aid (PFA)
- Alternative learning modules
- Workshops for trainers
- Tele counselling

The education system has a special unit for curriculum development which is in charge of the generation of materials to be integrated into all-ages plans, but the lack of budget and clear plans is hindering the process.

Other priorities to implement MHPSS in the educational system are:

- Address the suicide attempt cases, especially for the islands.
- Technical assistance in capacity building to professionals, both counsellors, nurses and teachers.
- Increase the number of awareness sessions in collaboration with RHUs.
- Integrate age appropriate MHPSS content in the curriculum.

Trained Workforce

The mandate of these staff is to implement MHPSS, but as they are not all trained, they have difficulties to accomplish this duty. They try to organize trainings for the staff on a yearly basis, mostly through partnerships with other organizations.

When asked whether *"At least one teacher in each educational setting is competent in identifying: Bullying, family-based violence or neglect, depression, anxiety-stress, developmental and behavioural disorders in children and adolescents, problems with alcohol or drug use, post-traumatic stress, acute trauma-induced anxiety, self-harm/ suicide, medically unexplained somatic complaints?"* the Key Informant acknowledged it would depend on the specific school but most likely not.

2. DISASTER RISK REDUCTION MANAGEMENT OPERATION CENTER (BANGSAMORO READI)

In July 2019, BARMM-READI was established as a disaster risk reduction management operation center run by the Ministry of Interior and Local Government (MILG). The office is mandated to coordinate with all the Ministers of the Bangsamoro Government, local government units, and the national DRRMC on programs and activities pertaining to disasters. Their work is structured in three divisions: Operations, planning; administration and training and they have 8 Emergency Operating Centers in Region and Provinces:

- ✓ BARMM- Region
- ✓ Maguindanao del Sur
- ✓ Maguindanao del Norte
- ✓ Lanao del Sur
- ✓ Basilan
- ✓ Sulu
- ✓ Tawi- Tawi
- ✓ Special Geographic Areas (SGA)

A FGD with four members of the BANGSAMORO-READI operation center focused on understanding how the emergency response teams contribute to the "Guidelines in the Provision of the Essential Health Service Packages in Emergencies and Disasters", approved in 2017, which state that in emergencies, the following should be given:

- ✓ Provision of support to staff who experienced extreme events upon manifestation of significant behavioral changes.
- ✓ Referral of more severe, complex or high-risk cases to specialists and facilities within 12 hours.
- ✓ Utilization of existing communal, cultural, spiritual and religious healing practices as approaches to MHPSS, as appropriate within 12 hours.
- ✓ Community Mental Health Education through fliers, fora and other information, education and communication (IEC) materials within 24 hours.
- ✓ Coordinated assessment of mental health and psychosocial issues using Global assessment tools and guidelines.
- ✓ MHPSS interventions for survivors of sexual violence, if requested by the survivor, and supported with significant signs and symptoms based on the assessment tool.
- ✓ Protection and promotion of responder's well-being during preparation, deployment and follow-up phases.
- ✓ Provision for psychotropic medications and sedatives when necessary.[12]
- ✓ Provision of psychological first aid for the general population, and provision of access and referral to graded and specific MHPSS interventions. Access to such MHPSS supports and interventions should be ensured for vulnerable groups. The affected population should be provided with regular updates on information including disaster/emergency status, relief efforts, and legal rights.

Although the relief team of Bangsamoro READi is the first to respond to the affected areas during emergencies, being responsible to account for 20% of the population in need, their members are not able to provide any MHPSS due to lack of training or orientation. Instead, they coordinate with the MSSD, which is able to provide Psychological First Aid in emergencies and develop the Situational reports which

[12] Action Against Hunger will not directly contribute to this guideline, either through training on it or supporting its distribution.

are then shared with the other agencies and NGOs responding to the emergency as a way to ensure the needs they identify can be covered.

Priorities and Plans

- ✓ Training for better preparedness to respond to the psychosocial needs of affected populations. They were trained on Basic life support and Emergency medical services six years ago. A more specific MHPSS training has been demanded at regional level to then be cascaded down to the staff of the Emergency Operating centers but is not being prioritized.

- ✓ Care for their staff. Being exposed to the fist impacts of emergencies also has great considerations on their well-being. They are able to provide some time off to the teams to recover after the response, but no specific support.

MHPSS Trained Workforce

First responders have no training in MHPSS. A basic orientation was done more than five years ago.

3. MINISTRY OF SOCIAL SERVICES AND DEVELOPMENT (MSSD)

The MSSD has the mandate to provide a balanced and responsive approach to social welfare whereby the rights, needs, and interests of all citizens within its jurisdiction are protected and addressed at all times, especially during the existence of a crisis, whether natural or human-induced, that affects their well-being and their participation in community affairs.

The FGD with them involved the 6 reference focal points of the different programs.

Programs and Actions

The MSSD has a set of regular programs implemented in the Bangsamoro region. Although there is not a specific MHPSS program, we can say the following contribute to protecting the mental health and psychosocial wellbeing of the communities, **both in emergency and recovery phase.**

MSSD PROGRAMS CONTRIBUTION TO GUIDELINES

PROGRAM	MHPSS GUIDELINES IN PRIMARY HEALTH CARE OR EMERGENCY IT CONTRIBUTES TO
Child And Youth Welfare Program (CYWP) The program targets the holistic growth and development of children, adolescents, and young people in the Bangsamoro Region. However, in this case the specific program for youth was not approved and they are only catering children.	Early Childhood Care and Developent and disability screening
Family And Community Welfare Program (FCWP) It seeks to improve the well-being of poor and vulnerable families and communities in the region. It specifically targets the poorest 5% through a holistic approach that covers subsidies, educational assistance, skills training, and financial management. It involves parental effectiveness sessions and Caregivers' education.	Caregivers' education on: ✓ Early Childhood Care and Development interventions through mother-infant interactions. ✓ Developmental milestones monitoring
Women's Welfare Program (WWP) Aims to promote the welfare of disadvantaged women giving special attention to the prevention, eradication of exploitation of women in any forms as well as promotion of skills for employment and self-actualization. The program includes group and individual counselling, psychoeducation and MHPSS messages and aftercare assessments for livelihoods and GBV. Training of Municipal Social Welfare Officers (MSWO) to provide MHPSS	✓ Screening, treatment/management and referral to higher level facilities. Based on observation. ✓ Psychosocial interventions. ✓ Communication on Reproductive health (sexuality and gender-based violence). Mostly based in GBV.
Older Persons and Persons with Disability Program (OPPWDP) This program focuses on addressing the specific needs of older individuals, providing them with the necessary assistance and care they require. Additionally, MSSD actively engages in mobilizing and strengthening regional structures for older people. There's no specific MHPSS but facilitates the referral services for professional health consultations and medical interventions.	None.
Recovery and reintegration program for trafficked persons This nationwide program is ensuring the provision of adequate recovery and reintegration services to trafficked persons. They do psychosocial interventions: Specialized MHPSS activities based in trauma recovery (sessions duration 3-5 days). Psychosocial support activities for the families of the victims.	Psychosocial interventions, with victims and families.
Disaster and emergency response Through the Emergency Relief Assistance program they provide immediate assistance and life-saving interventions to individuals and communities affected by natural or human-induced. They train the municipal social workers to respond to the emergency and provide PFA. Who are volunteers. They activate and coordinate the protection cluster during emergencies. They provide stress management to their teams after they work in an emergency.	Psychosocial interventions with adults Mental health and PSS in emergencies. Psychological First Aid. Provision of support to staff. Referral of more severe, complex or high-risk cases to specialists Coordinated assessment of MHPSS issues. Support to existing Women Friendly Spaces.

MSSD Priorities And Plans

- ✓ The MoH recently provided training on youth and child MHPSS at provincial level they aim to cascade down to the Municipal Social Welfare Officers to ensure effective implementation in their programs.
- ✓ To integrate an on-call psychologist to refer cases internally.
- ✓ To have an effective tool for identifying.

This agency works mainly with highly vulnerable groups, who suffer the most from the impact of emergencies and their consequences. Although Municipal Social Welfare Officers often have a background that favors the support to psychosocial vulnerabilities, they are not always trained to identify specific psychosocial risks. Standardizing this process can help plan and implement psychosocial interventions much more effectively.

MHPSS Trained Workforce

One of the key activities of the *Women Welfare Program* involves the training of the Municipality Welfare Social workers. In addition to having a background that is expected to favor basic support skills, they receive training on how to provide Psychological First Aid, which is one of the main interventions during an emergency. However, these social workers have difficulties in effectively identifying people who may need more focused support and are challenged in scaling up more specific training for some groups at the implementation level.

Inter-Agency Referral

There is good coordination among and between these agencies and the RHUs, reinforcing each other's efforts through a referral system. However, this referral system has been considered weak by the assessed key informants

During an emergency response, how often do you refer to?	MBHTE	BANGSAMORO READI	MSSD
Mental health specialist care (secondary, tertiary or private care)	Frequently Sometimes Never	Frequently Sometimes Never	Frequently Sometimes Never
Community health workers, other community workers, schools, social services and other community social supports, traditional /religious healers	Frequently Sometimes Never	Frequently Sometimes Never	Frequently Sometimes Never

An interagency advisory group is currently working on the definition of a unified referral pathway that will facilitate this process.

3.3 MHPSS CONTRIBUTION OF LOCAL AND INTERNATIONAL NGOs

National and international organizations present in the country play a fundamental role in guaranteeing and bringing mental health and psychosocial support services to the population during emergencies and times of adversity.

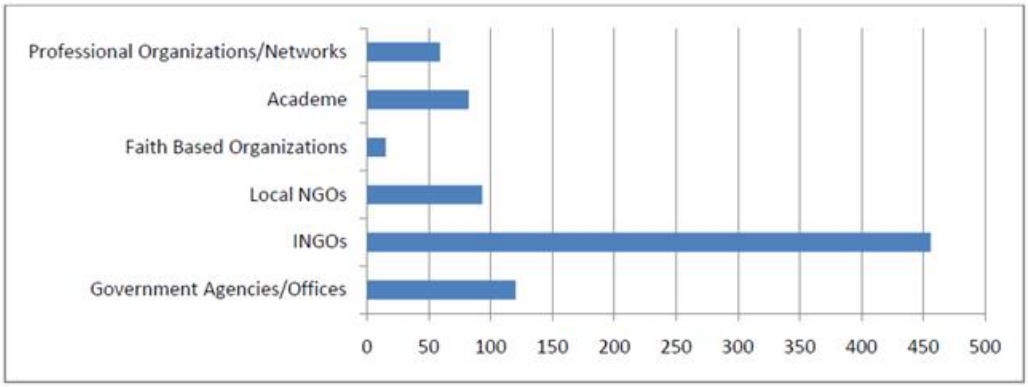
A mapping conducted in 2014 to have a clear idea of who is doing what, when and where (4Ws) in MHPSS as a response to the impact of Typhoon Haiyan (Yolanda), can give us a good picture of how these supports are activated and provided during emergencies even outside BARMM.[13]

A total of seventy-seven organizations, agencies and networks responded to the survey, including the following: government agencies, international non-government organization, local NGOs, faith-based organizations, universities and professional organizations and networks.

The tables below help us to understand what type of activities were most provided and by what type of actors.

Reported MHPSS Activities implemented by Sector.

Chart 6: Reported Mental Health and Psychosocial Support Activities Implemented by Sector.

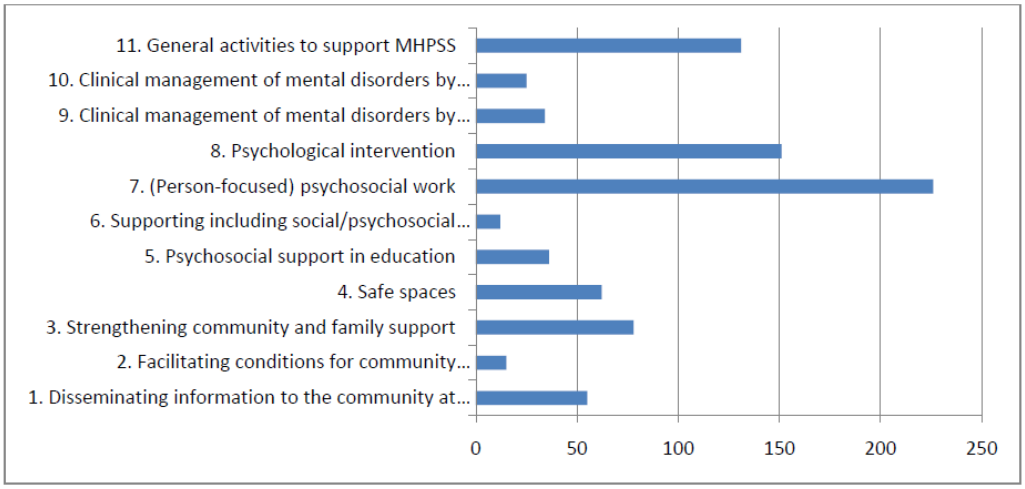


Although the report advises to look at this table with some caution, as the analysis did not consider the number of personnel involved or the amount of money invested in the operations, the fundamental role of national and international NGOs in responding to psychosocial needs in emergencies must be recognized.

Distribution of MHPSS Activities:

[13] 2014. Mental Health and Psychosocial Support in Philippines: Minimal Response Matrix and Mapping: Final Report. Psychosocial Support and Children's Rights Resource Center (PSTCRRC) and Mental Health and Psychosocial Support Network (MHPSSN).

Chart 7: Reported MHPSS activities type.



It is also interesting to look at the type of activities most provided:

1. Psychosocial work (person-focused),
2. Psychological interventions and
3. General activities to support MHPSS.

Our assessment involved four active organizations in the promotion and protection of mental health and psychosocial well-being in BARMM. It gathered an overview of their key programs and plans as well as their inputs in some of the most pressing issues and vulnerable groups. Two United Nations agencies (UNICEF and the WHO), a national organization (CFSI) and local NGO (MOSEP) were interviewed.

World Health Organization (WHO)

Active in BARMM since 2002, they are the most important stakeholder in the provision of MHPSS training to the Health Sector workers, working directly with the Ministry of Health and the IPHO health workers.

- Their actions have built the skills of 916 professionals: 563 have been trained on mhGap and 353 on MHPSS.
- They also provide training in more specific topics like *Care for Carers* and have planned two more before the end of the year on Problem Management + and Community-based MH.
- During emergencies, they coordinate the MHPSS subcluster and have a focal point for health in emergency, coordinating with MoH for implementation of PFA, play therapy and grief counselling.
- They have crafted a screening tool for depression, anxiety, self-harm and epilepsy to support the case identification.

Their current plans and priorities involve replicating their trainings to reach other provinces and municipalities, with a special focus on basic counselling and how to refer cases.

United Nation Children's Fund (UNICEF)

The organization established their Cotabato office in 2006, but they were supporting the region even before the its official establishment

- During emergencies, UNICEF establishes Child Friendly Spaces for which they mobilize youth networks and community volunteers. They train them on the provision of Psychosocial Support given health workers' capacities are usually overwhelmed during these times.
- They implement health and nutrition programs and establish temporary learning centers.

- They are also supporting adolescents' mental health in the region and are considering the opportunity of supporting the the adolescent health units. This year, they have launched, together with Plan International and the Bangsamoro Government the "Oky Philippines Period Tracker". This app provides the right information about girls' menstrual health in line with Islamic principles and cultural practices, creating a supportive environment for their health and well-being and encouraging their full participation in educational opportunities.

Also focused onchildren and youth, they have provided MHPSS training to different ministries including MoH and MSSD to ensure their support. They are active members of BARMM MHPSS consultative group and responsible for finalizing the referral pathways' draft (ANNEX 2) and for elaborating the Terms of Reference of the Technical Working Group that will support the Bangsamoro Mental Health Bill. Among their key priorities are to focus on teenage mothers and increasing the involvement of fathers in care duties as well as capacitating the population division, to minimize the impact of the personnel's rotation.

Community And Family Services International (CFSI)

CFSI is a humanitarian organization committed to peace and social development, with a particular interest in the psychosocial dimension. Their key areas of focus during emergency relief and early recovery are protection, education, livelihood, disaster risk reduction and strengthening the social dynamic infrastructure. Most of their projects have a joint approach of protection + psychosocial + Livelihoods.

- Child Friendly Spaces: During emergencies, they provide experiential learning, PFA, education in emergency and coping strategies.
- Training: They build capacities for different groups, among them teachers for an Education in emergencies.
- In non-emergency, they have provided training to the LGU's multidisciplinary teams to provide Psychological first aid, and also to Barangay Health Workers on Care for carers.
- They are leading a community of practice with the Ministry of Health to strengthen LGUs capacities to respond to psychosocial needs and are supporting them in their advocacy efforts. In collaboration with the Disaster Management Office, they work to ensure that the guidelines for MHPSS in risk management are complied.
- They are also actively supporting the BARMM MHPSS Bill through the consultative group.

One of CFSI's main current objectives is to strengthen their protection component and support Internally Displaced People still in camps and transitory settlements in Marawi after 2017 siege.

Mindanao Organization For Social And Economic Progress, Inc. (MOSEP)

MOSEP has been present in the region since 2012.

- They have responded to different emergencies like the Marawi siege (2017) or Typhoon Paeng (2022) providing primarily health response to people affected through their medical outreach teams.
  During these, they have done psychosocial support with children and Disaster Risk Management assessments.
- Now they are running five Women Friendly Spaces in collaboration with UNFPA where they provide:
  - ✓ GBV support: How to identify and refer cases
  - ✓ Orientation on Health
  - ✓ Cash for work and cash for training
  - ✓ Mentoring and coaching
- They implement Cash-based interventions to encourage pregnant women to complete the whole check-up and deliver the baby in a health facility.
- Also, through their mobile medical teams they conduct community sessions and education with families.

IV. ACCESSIBILITY AND QUALITY OF THE MHPSS SERVICES

The Section 15 of the Mental Health Act focuses on the quality of the mental health services provided, ensuring they:

- ✓ Are based on medical and scientific research findings.
- ✓ Respond to the clinical, cultural, gender, ethnic and other specific needs of individuals.
- ✓ Provided in the most appropriate and least restrictive setting.
- ✓ Provided in an age-appropriate manner
- ✓ Provided by health workers and professionals in a way that ensures accountability.

Our assessment found a very low level of implementation of psychosocial services at the RHUs, which did not allow us to adequately assess their quality according to these parameters.

However, we can say that there is some cultural gender and age adaptations of the services:

- ✓ The high awareness of the importance of the mental health of young people has led to the implementation of specific actions for this group, such as the Adolescent Friendly Spaces in which interventions based on the generalized HEADSSS assessment, also specific for this age group, are carried out.
- ✓ Support is prioritized in some spaces exclusively for women, such as the Women Welfare Program or during pre-birth checkups, attending to women's own psychosocial needs.
- ✓ The Bangsamoro mental health consultative group is also working on Drafting the Bangsamoro MHPSS manual with Islamic perspective. This has been piloted in a recent MHPSS training for LGU focal points delivered by the Ministry of Health, Bangsamoro Darul Iftah' BARMM.

Some of the methods used are based on medical and scientific research findings. People who have been trained in mhGap do use this manual as a reference to guide interventions. Also, one of the RHUs **reported** following the Adolescent Job Aid [14] method to conduct counseling with youth. Psychological First Aid used in emergencies. However, there is also confusion and a certain tendency to understand as psychosocial supports things that are not necessarily so. On several occasions professionals spoke of providing "play therapy", but they did not follow any methodology and had not been trained to do so, so it is quite possible that these are play interventions without a specific focus on MHPSS. Also, counselling was often used to monitor adherence to treatment and not as an orientation or accompaniment to the development of healthy coping skills.

The accessibility to MHPSS services has been assessed as the accessibility to the community and municipal health systems, as it is here where the Mental Health program should be implemented and where it is expected according to the basic guarantees of primary health care. To do so, we based on the social indicators of the "Checklist for Integrating Mental Health in Primary Health Care in Humanitarian Settings", by the World Health Organization & United Nations High Commissioner for Refugees.[15]

[14] 2010. World Health Organization. Adolescent job aid: a handy desk reference tool for primary level health workers.
[15] 2012. World Health Organization & United Nations High Commissioner for Refugees. Checklist for Integrating Mental Health in Primary Health Care in Humanitarian Settings. In: Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva: WHO, 2012.

Table 7: Accessibility Social Indicators.

SOCIAL INDICATORS	BHS	RHU
Health care facility is in safe walking distance of affected community	83,3%	Yes, except for GIDA Barangays
Furthest distance travelled by patients to access the health facility (in km)	60 minutes by foot average	60 minutes by foot average
The clinic has at least one female health care provider	83,3%	67%
Each of the local languages is spoken by at least one clinic staff member	100%	83,3%
Procedures are in place to ensure that patients give consent before major medical procedures	Doesn't apply	83,33%
Health care provision is organized in a way that respects privacy (for example, a curtain around consultancy area)	100%	58%
Information about the health status of people and potentially related life events (for example rape, torture) is treated confidentially	100%	100%
PHC care is affordable for all patients	100%	100%

The information collected shows that the primary healthcare facilities are generally accessible except for the "Geographically Isolated and Disadvantaged Areas" which make up a total of 954 out of 2590 barangay in the region. All visited health facilities are near the main road and other public facilities, which is acceptable for the local community, but in general the means of transportation are very limited and unavailable specially for the mountain barangays. Their popular transportation is a tricycle, modified motorcycle with a side car able to carry up to 5 people. Health workers admitted that it may takes 60 minutes in average to reach the health facility which is hard for pregnant women and sick people to handle.

BHWs reported that families prefer to reach them at where they live since they are closer than the facility itself, so the families can share their health concerns and get the advice where to go to seek health either at the BHS or somewhere else, by that they save time and money.

V. COMMUNITIES' BELIEFS AND NEEDS ON MENTAL HEALTH & PSYCHOSOCIAL SUPPORT. EXISTING AND DESIRED SUPPORT.

ATTITUDES AND BELIEVES

Mental illness remains stigmatized in the Philippines, discouraging people from seeking help. Several studies have addressed the psychological help-seeking behaviors of Filipinos, demonstrating general reluctance and unfavorable attitudes towards formal help-seeking despite high rates of psychological distress.[16] According to these, they prefer seeking help from close family and friends due to barriers

[16] 2020. Martinez, A.B., Co, M., Lau, J. *et al.* Filipino help-seeking for mental health problems and associated barriers and facilitators: a systematic review. *Soc Psychiatry Psychiatr Epidemiol* **55**,

including financial constraints and inaccessibility of services, self and social stigma attached to mental disorder, concern for loss of face, sense of shame, and adherence to Asian values of conformity to norms where mental illness is considered unacceptable.

A study in 2017[17] found that 65% of respondents believed that people with mental health conditions have little chance of recovery; 48% believed that they will be looked down on; 62% believed that it would be embarrassing to go out with a relative with such a condition; and 51% reported that they preferred not to tell others if they had a mental illness. Also, the perceived cause of mental illness may influence help-seeking, as it was often attributed to curses or evil spirits in rural areas, and respondents are reluctant to seek professional help, even when services were available.

Our assessment in BARMM region corroborates these results:

Stigma has been repeatedly mentioned as a key barrier towards the effective implementation of mental health and psychosocial support actions by health workers and non-governmental organizations.

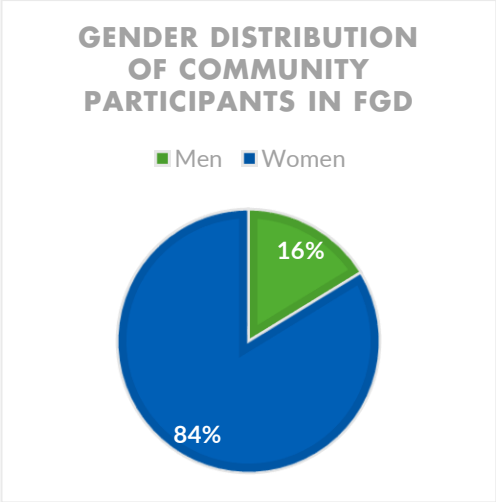
During the assessment 6 FGD with a total of 44 community members, including 2 Barangay chiefs, were conducted.

Age of participants was not recorded, but the participation of different groups was secured including a specific FGD with adolescents (15- and 16-year-olds) in Saguiaran.
When asked about their perceptions and beliefs around mental health, people "not in their right mind" was a common answer. Also "lack of understanding" and "weird behaviors" were mentioned.

Among youth, 3 out of 4 participants had never heard about mental health.

In all cases, gathering answers to this broad question was not easy as it is not a topic commonly treated or for which people have clear ideas and definitions.

Figure 8. Gender Distribution of Community Participants in Focus Group Discussion



Vulnerabilities and Coping Strategies

More specific answers came when asked about the most common psychosocial problems in their communities:

- Worry and overthinking: the most mentioned one, in different ways, but always related to economic problems. Together with having no jobs, poverty, hardship, and the increased cost of life, they reported big concerns related to the lack of resources, the incapacity to provide for the family members and the uncertainty it brings. It includes the difficulties for youth and children to go to school due to lack of money for their allowance. This situation is usually exacerbated during and after emergencies.
- Family problems: described as violence, hardship to adapt after returning from working in other countries and overall lack of resources.
- Alcohol abuse: reported mostly for men and youth, as a coping mechanisms and leading cause of violence in the household.

Other mentioned psychosocial problems were isolation, feelings of weakness and uselessness.

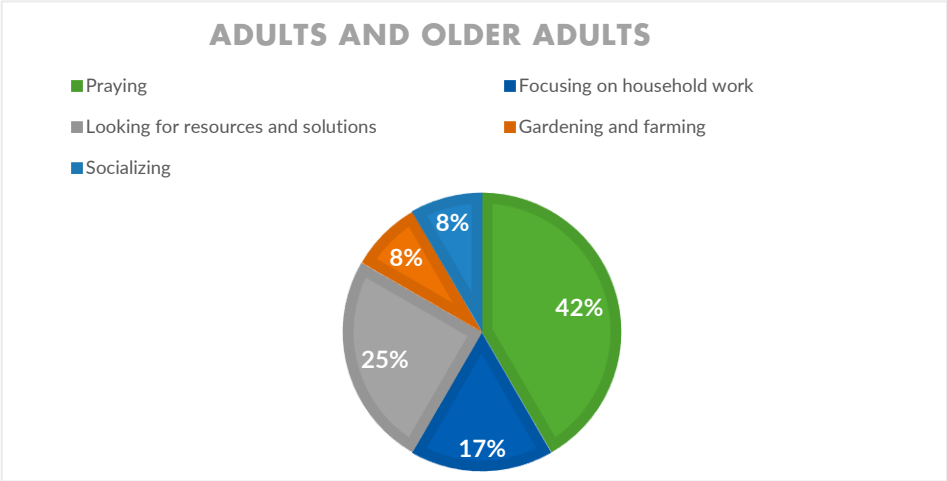
[17] 2017. Mental health literacy and health seeking behavior in the Western Pacific. Manila: WHO Regional Office for the Western Pacific; 2017. Bressington D, Ho GW, Lam C, Leung SF, Leung AY, Molasiotis A et al.

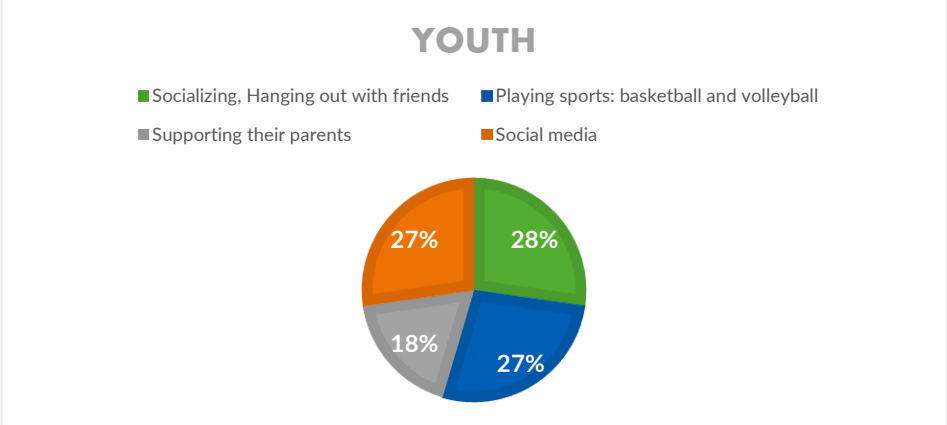
We delved into the most reported issues according to the different age groups, according to their **perceptions:**

ADULTS	*Lack of jobs and livelihoods.* *Lack of food and daily needs.* *As parents, worry for difficulties providing their children.*
OLDER ADULTS (+60)	*Worried and sad about not having food.* *Access to medicines.*
YOUTH	*School allowance.*
	Wanting to eat.
	Peer influence: alcohol and substance abuse.
	One of their challenges is going to school. *They don't have the allowance for food, so many don't go.*
	Youth worry about school and tend to isolation.
CHILDREN	*They just want to play.*
	Sad about not being able to go to school, comparing with other children.

Regarding coping strategies, adults and youth reported some differences.

Figures 9 & 10: Coping Strategies Among Youth and Adults





Gender differences were not reportedbut when asked explicitly men tended to more social-related activities: playing basketball and chess, playing with the children, etc while women were more prone to focus on housework and gardening activities.

MOST VULNERABLE GROUPS

This topic was addressed both with community members and local and international NGOs experienced in providing MHPSS during emergencies. Women and youth were identified as the most vulnerable, followed by senior citizens or the elderly, especially in the rural areas where resources accessibility is very limited. Details of the responses are displayed in the following table:

Table 8: Vulnerable Groups for Mental Health & Psychosocial Support.

GROUPS IDENTIFIED	COMMUNITY MEMBERS PERCEPTIONS	LOCAL AND INTERNATIONAL NON GOVERNMENT ORGANIZATIONS' PERCEPTIONS
Women	Housewives overstressed due to the household burden. Victims of Gender based Violence. They reported it to often be a cause of their husbands drinking problems.	Specially during emergencies, they hold all the household burdens which has a great impact in their psychosocial wellbeing.
Youth:	Distressed due to school activities and assignments. Prone to engage in drinking and aggressive behaviors. Pressure by social media. Tend to depressive symptoms. Increased suicidal attempts.	Increased suicidal attempts in the region by young people Peer pressure Social media addiction Poor coping mechanisms High rate of teenage pregnancies
Elderly	Older women were mentioned, specially those with no husbands and having less social support.	Great lack of awareness and association of psychosomatic symptoms with advancing age

Violence against women and girls is prevalent in the BARMM, although it is not unique to this region nor to the practices of people with religious faith[18]. Women in BARMM region are typically reluctant to seek help or tell anyone about experiencing violence, led by stigma and a culture of shame. [19]

In 2019, Action Against Hunger conducted a gender analysis in the country that revealed some specific considerations regarding women's situation in the region:

Roles in Mindanao have changed from traditionally assigned gender roles and responsibilities to women being more involved in non-reproductive activities. However, this has not seemed to have reduced their amount of time dedicated to reproductive work and has rather increased women's workload. In fact, according to the 2022 Philippine National Demographic and Health Survey, BARMM's trends in total

[18] 2018. Philippine Statistics Authority (PSA) and ICF. Philippines National Demographic and Health Survey 2017. Quezon City and Rockville, MD: PSA and ICF.
[19] 2022. Oxfam International. CREATING SPACES TO TAKE ACTION ON VIOLENCE AGAINST WOMEN AND GIRLS IN THE PHILIPPINES: INTEGRATED IMPACT EVALUATION REPORT

fertility rate (Average number of births per woman for the 3-year period before the survey) is 1.2 points higher than the national average.

Also, the latest data from the Philippine Statistics Authority, shows a 6.6% rate of teenage pregnancy of 15–19-year-olds in the Bangsamoro, which remains higher than the national average of 5.4% in 2022.

The situation of the youth's mental health is alarming, both at national level and specifically in the region of BARMM. Modelled estimates from the 2019 Global Burden of Disease Study indicate that- mental disorders and self-harm accounted that year for around 13 per cent of the total burden of disease among 10- to 19-year-olds[20].

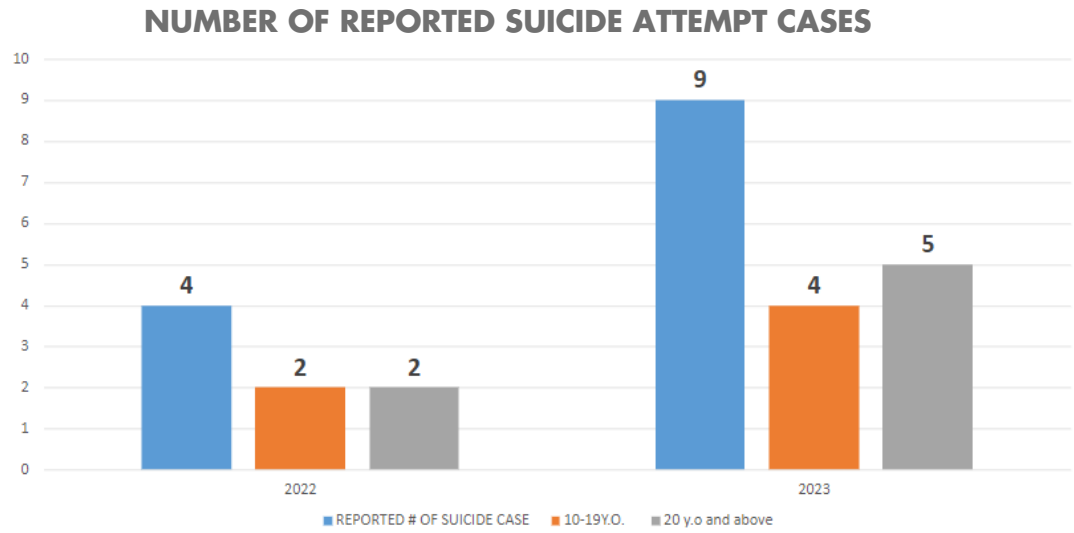
A study conducted by UNICEF on children and adolescents' mental health in the Philippines[21] showed how the specific causes of poor mental health vary substantially by age: for young children, developmental disorders predominate; for young adolescents there is a sharp increase in conduct disorders, depression and anxiety; for older adolescents and young adults, there is a predominance of depression and anxiety, with an emergence of psychosis and eating disorders.

During the assessment, the concern about an increase in the number of suicide attempts by young people has come up recurrently with the different participants.

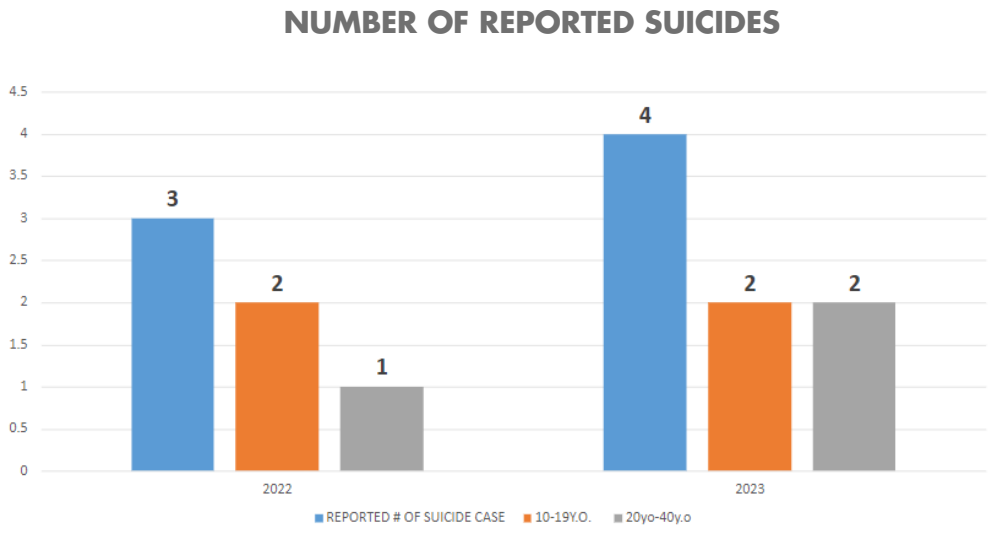
A CASE STUDY FROM UPI MUNICIPALITY

The RHU of North Upi municipality shared some recent data regarding the mental health of youth, coming from the number of suicides and suicidal attempts and out of the ADOLESCENTS MENTAL HEALTH WORKHOP (Annex 1).

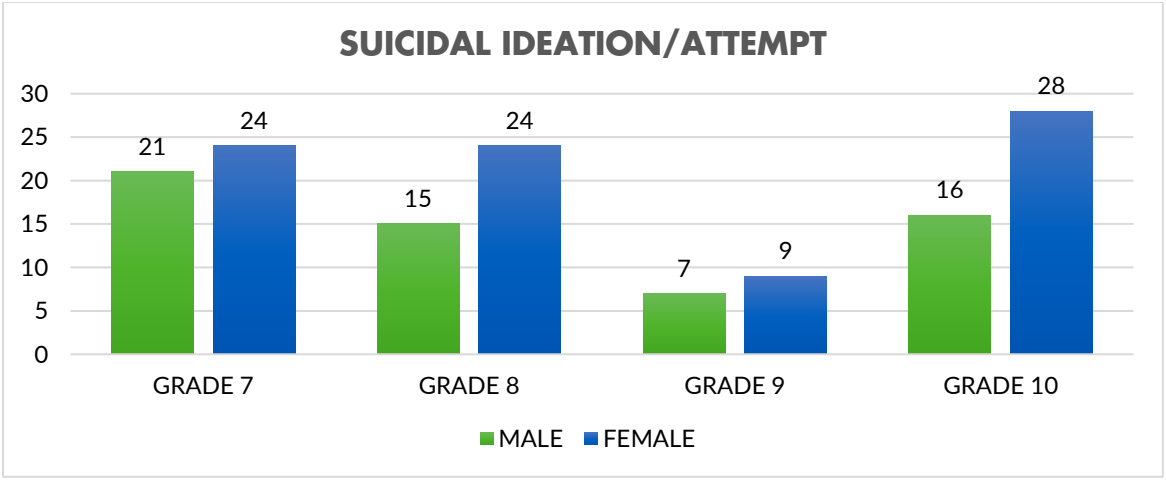
The result of this workshop gave the RHU pieces of evidence and more knowledge about the youth situation and facilitated the coordination with the LGU to obtain their support to prioritize the mental health services for youth, and a local referral pathway was defined and endorsed by the LGU and the RHU.



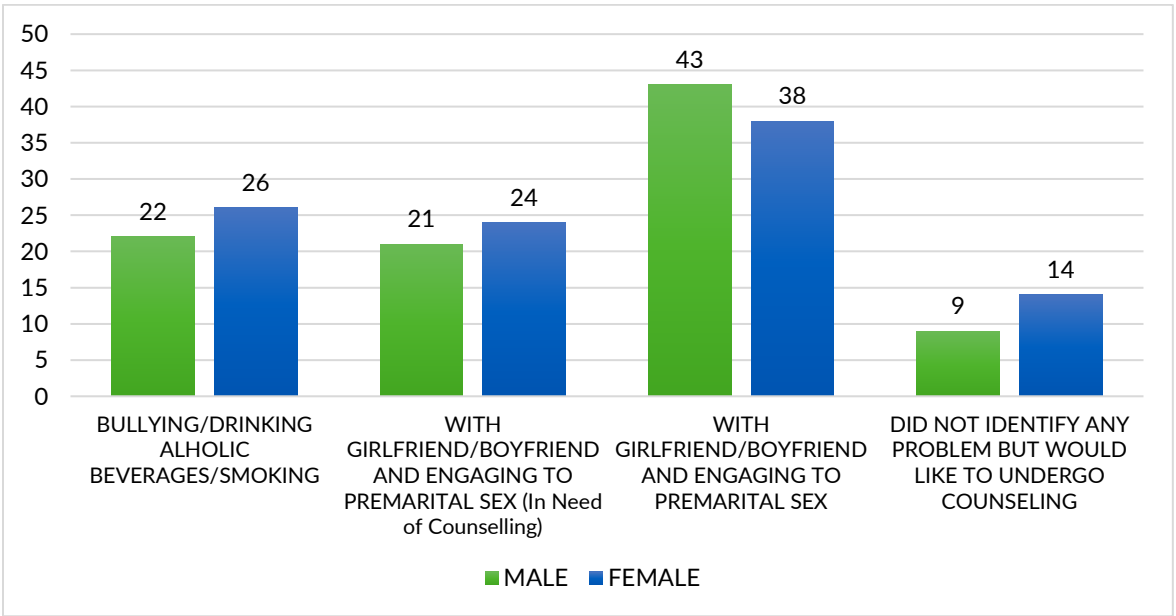
[20] 2019. Institute for Health Metrics and Evaluation, *Global Burden of Disease Study 2019*.
[21] 2022. UNICEF, Research Institute for Mindanao Culture, Burnet Institute: Strengthening mental health and psychosocial support systems and services for children and adolescents in East Asia and the Pacific: Thailand Country Report. UNICEF, Bangkok, 2022



The results obtained in the HEADSSS questionnaire conducted during the workshop, reinforced the cause for concern:



Some risk behaviors identified during the assessment are compiled in the following chart:



EXISTING AND DESIRED SUPPORTS

Community members were asked a "What is currently being done to help older adults, adults, youth, and children of different genders who are upset/ distressed?". Some of them reported nothing was being done to specifically address these issues, but the community groups or cliques such as youth groups, education, religious and community leaders provide many spaces that are protective and promote their wellbeing. Among the local initiatives and group spaces available, the following were mentioned:

- ✓ Feeding programs for children, run by community leaders and Barangays.
- ✓ Youth activities, organized by youth leaders and coordinated by the Bangsamoro Youth Commission. The level of activity varies from one barangay to another but usually includes sports, conducting the HEEADSSS questionnaire and promoting the importance of family, parenting, mind games, peer counselling.
- ✓ Religious groups: Every week, around 30-50 people join to discuss different topics under the Islamic perspective. Additionally, men attend other religious seminars only for male participants.
- ✓ In one Barangay, women participate in group exercise sessions organized by the Barangay Health Workers and in gardening activities.

Generally, people referred to their communities as supportive and participative, open to help each other and to engage in existing activities and supports.

To understand the kind of support that could increase communities' well-being we asked them: What more could be done to help older adults, adults, youth, and children of different genders who are upset/ distressed?

The most repeated answer was livelihoods. It was mentioned both as a way to stay busy and divert their attention and as the solution to their economic concerns. Youth also expressed or demanded the need to improve their access to education and School supplies.

Recreational activities followed. Communities would like to participate in activities where they can learn but also fight isolation and focus on something unrelated to their problems. Cooking and sports were the main contributions to the type of activities they would like to participate in.

But in addition, they also mentioned more specific psychosocial activities such as counseling and support groups. Sessions focused on stress reduction for husbands and community involvement to support each other were mentioned.

VI. KEY CONCLUSIONS AND RECOMMENDATION

This assessment provides some first-hand knowledge of the level of implementation of the Mental Health Act and some of its Implementing Rules and Regulations in the BARMM Region, both within and outside the health structures.
The assessment is limited in that it covered only 3 of the 6 provinces and did not include the island territories whose casuistry may be different. However, the participation of regional representatives from different agencies and organizations and the similarities in the management of the health system within the region suggests that the challenges and gaps found are also present in the other three provinces.

Next are our main conclusions and recommendation.

MHPSS SERVICES IMPLEMENTATION IN THE HEALTH SYSTEM.

Mental Health Services are newly introduced to the health system especially in BARMM where the region struggles in providing health services like immunization, maternal care and nutrition despite the national support and interest of those programs.

Based on the assessment results, compliance with the MHPSS related Guidelines on the Adoption of Baseline Primary Health Care Guarantees for All Filipinos is at 17%. Also the investment on the individual based services for mental health is more than on the population based ones and even for the individual based services, , only 43% RHUs reported their capacity to diagnose.

The main challenges were defined as a) budget limitations which prevent having the needed human resources and providing technical follow-up to the health staff at municipal level, b) only severe MH cases were identified and reported to the health system due to stigma,lack of standardized assessment tools and insufficient training for health workers at municipal and barangay levels, c) high turnover for health staff and lack of confidence among the newly trained staff, d) there is no psychologist position in the public health system structure, and finally e) the unsystematic or inconsistent support from the LGUs to provide mental health services.

In this context and challenges, we found that investing in early diagnosis and treatment for mild mental health cases and integrating mental health into other health services needs less budget yet will have more impact on the population's health and reduce the stigma and the burden of specialized services unavailability.

Since the Mental Health Unit has already a mhGAP training plan for the doctors, strengthening the capacity of RHU and BHS staff and volunteers to assess cases, provide psychological consultation and referral is key to face the high turnover and insure the service sustainability.

Providing technical support and on-the-job training for mental health focal points will improve their confidence in evaluating the cases and providing psychological counselling.

Standardizing the tools and improving the information system will facilitate the referral and let the RHU along with LGU take informed decision related to prioritizing mental health interventions.

Activate functional referral pathway for mental health cases considering the resources within the health system and other government and non-governmental agencies, will reduce the financial burden of mental health diagnosis for patients and manage the overload on the available psychiatrist.

MHPSS CONTRIBUTIONS BY OTHER GOVERNMENTAL AGENCIES

The role of these agencies has a very meaningful impact in making MHPSS services accessible to the youth, people affected by emergencies and vulnerable groups, but is very much limited by the lack of specific budget. This also hinders the development of specific plans and strategies and makes it difficult for agency workers to receive adequate training on the topic. Despite these difficulties, there is a clear interest in implementing MHPSS activities which results in very relevant initiatives, in great part dependent on partnerships with other national and international organizations.

There is good coordination among these agencies and between them and the RHUs, reinforcing each other's efforts through a referral system. However, they consider this system to be weak. An inter-agency advisory group is currently working on the definition of a unified referral pathway, but it will be essential that knowledge of it reaches all their workers and is accompanied by the tools and standardized operational procedures needed to ensure its effectiveness.

In addition to the referral of cases to other services, synergies between complementary programs of the different agencies should be strengthened, especially among those aimed at school-age children, youth and their caregivers.

MHPSS CONTRIBUTIONS BY NON-GOVERNMENTAL NATIONAL AND INTERNATIONAL ORGANIZATIONS

These organizations largely lead the MHPSS training of health and education staff, thus contributing to one of the main barriers to the implementation of the Mental Health Act. However, more investment is needed to ensure that all staff involved in supporting the Mental Health Act have the necessary knowledge and skills for it. A major barrier here is the sustainability of these trainings due to the high turnover of health and education workers.

They also greatly contribute during emergencies creating safe spaces for children, women and youth which are a basic service to identify vulnerabilities, protect well-being and implement more specialized supports.

Few initiatives seem to be aimed at strengthening existing community structures and networks such as youth, religious associations or voluntary initiatives in the Barangays. These seem quite out of focus and very disconnected from referral mechanisms to other support services.

Also noteworthy is their support, through participation in the BARMM Mental Health consultative group, for the Bangsamoro Mental Health Bill, strengthening the region's capacity to advocate for its own Mental Health Council.

REGARDING QUALITY AND ACCESSIBILITY OF MHPSS SERVICES

Even though the health facilities can be reached people don't use them to seek mental health services, they only visit the health facilities when they are instructed by the barangay health workers to get specific services. Since the barangay health workers are not trained and don't have enough information about MHPSS service availability, they are not contributing to facilitating MHPSS accessibility. Only investing in identification and referral without increasing the RHU capacity to handle the referred cases will overwhelm the psychiatrist at regional level and put financial burden on the identified patients. We recommend benefiting from the trust between the barangay health workers and the local community by capacitating them to provide basic consultation and linking them with the available community based psychosocial services in their areas, where they can contribute to the prevention side of mental health.

Improving the capacity of RHUs to provide MHPSS diagnosis and treatment services is key to increasing the utility of the facility regarding mental health. Efforts must also be increased to

ensure that the tools and methodologies used to intervene are robust and have been validated to work with the target group and in the given context.

COMMUNITIES NEEDS AND CAPACITIES FOR MHPSS PROVISION

While access to targeted psychosocial supports, both within and outside health structures, is virtually non-existent, the composition of barangays and strong community ties present a unique opportunity to focus efforts on facilitating prevention through mutual support and the strengthening of community initiatives.

Combatting the stigma attached to poor health seeking behaviors must be prioritized. The identification of key spaces and alliances with local agents to disseminate messages appropriate to age, gender and culture should be an immediate action. This will reinforce the use of available services in critical times and favor self-awareness and emotional and mental self-care as a prevention strategy.

Women and young people are the groups at greatest psychosocial risk. This also puts adolescent girls in the spotlight, considering the high rates of teenage pregnancy and marriage. Effective collaboration between spaces and programs dedicated to these groups must be ensured, guaranteeing that health or education support is accompanied by actions aimed at increasing mental health awareness, identifying vulnerable cases, providing healthy coping strategies, and integrating necessary protection and safeguarding process.

At the same time, the main causes of concern and distress in people living in this disaster and conflict-ridden region are clearly rooted in the lack of livelihoods and access to basic needs. For this reason, it is essential to support humanitarian emergency and recovery projects that effectively integrate MHPSS actions and jointly address the multiple impacts of crises and adversity.

ANNEX 1 "ADOLESCENT MENTAL HEALTH WORKSHOP"

In the Municipality of Upi, where teenage suicidal attempt cases are on the rise, the team of the RHU coordinated to implement a dedicated workshop in a total of 10 schools during the first semester of the year, and it was an initiative supported by the mayor.

The main objectives of this one-day activity were to:

- ✓ Understand Mental health. Psychoeducation.
- ✓ Share emotions through "What Makes you Happy and Sad" Activity. Gathering insights on their feelings through simple and practical questions.
- ✓ Define stress and identify ways to cope up.
- ✓ Seek help through HEADDSSS assessment.

The HEEADSSS assessment is a structured psychosocial interview tool used in healthcare settings to gather information about the psychosocial and developmental aspects of adolescents' lives. In the country, it is used at the RHUs but also in the education system to understand the various factors that may be affecting an adolescent's health and well-being. The acronym "HEEADSSS" stands for different domains that the assessment covers:

Home and Environment: Exploring the adolescent's living situation, family dynamics, relationships, and home environment.

Education and Employment: Examining the adolescent's school performance, educational aspirations, and employment status.

Eating and Exercise: Assesses the adolescent's eating habits, exercise routines, and body image concerns.

Activities and Peer Groups: Looking into the adolescent's interests, hobbies, extracurricular activities, and involvement in peer groups.

Drugs: Focusing on the adolescent's use of legal and illegal substances, including alcohol, tobacco, and recreational drugs.

Sexuality and Sexual Activity: Addresses the adolescent's understanding of sexuality, sexual activity, contraceptive use, and sexual health.

Suicide and Depression: This domain examines the adolescent's mood, emotional well-being, and any signs of depression or suicidal thoughts.

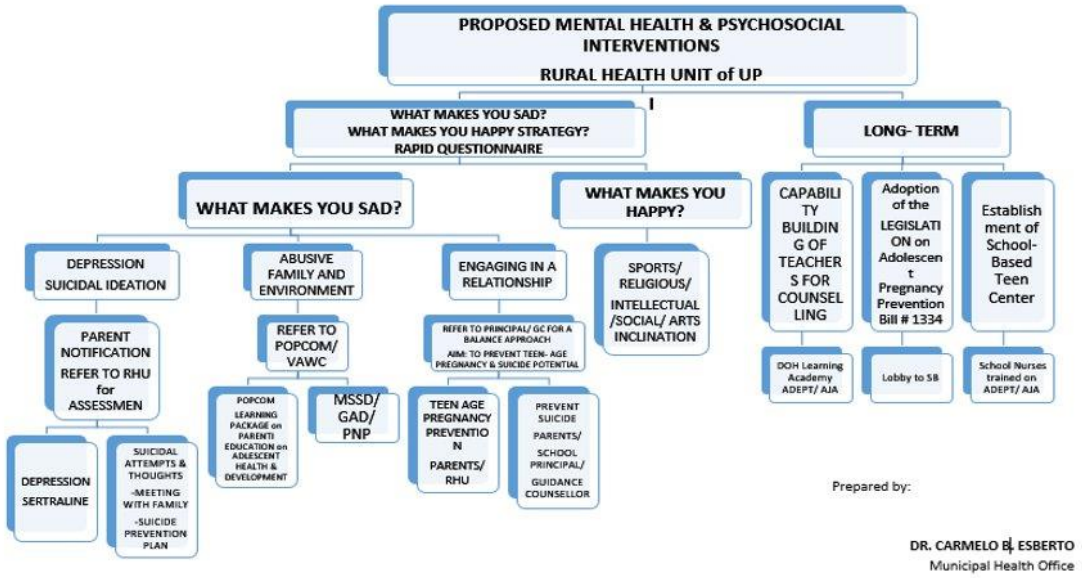
Safety: It assesses the adolescent's exposure to risky behaviors, accidents, injuries, and any history of violence.

The workshop was framed in three parts:

TIME FRAME	ACTIVITY	RESPONSIBLE PERSON
PART I 30 MINS 45 mins to 1 hour	Activity 1: Introduction to Mental Health Activity 2: Heart to Heart Talk (Small Group Activity) Rapid HEADDSSS WHAT MAKES YOU HAPPY AND SAD Inputs on Stress and Coping Mechanism	10 Facilitators 1 Time Keeper 1 Logistic
PART II	Full HEADSSS	Adolescent Health & Practical Training (ADEPT) - Adolescent Job Aid (AJA) trained staff
PART III	Counselling, further evaluation and	

The activity was targeted at teenagers between 10-19 years old and reached a total of 1268 students.

Based on its results, the Municipal Health Officer elaborated a referral pathway to be followed in the municipality and it was endorsed by the mayor. Even though this pathway is only for youth and only adopted in Upi municipality, it shows how good coordination between the LGU and RHU can enhance good practices.



ANNEX 2: "REFERAL PATHWAY, DRAFT"