A MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FRAMEWORK FOR BANGSAMORO AUTONOMOUS REGION IN MUSLIM MINDANAO, THE PHILIPPINES

AUGUST 2023

ACTION AGAINST HUNGER

A MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FRAMEWORK FOR THE PHILIPPINES

LIST OF ACRONYMS

BARMM	Bangsamoro Autonomous Region of Muslim Mindanao
BHWs	Barangay Health Workers
BOL	Bangsamoro Organic Law
CSO	Civil Society Organization
ECD	Early Childhood Development
IYCF	Infant and Young Child Feeding
LGU	Local Government Unit
MH	Mental Health
MHCP	Mental Health and Care Practice
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health in BARMM region
MSSD	Ministry of Social Services and Development
NGOs	Non-Governmental Organization
PFA	Psychological First Aid
PLW	Pregnant and Lactation Women
RHU	Rural Health Unit
RMNCH	Reproductive, Maternal, Newborn and Child Health
WHO	World Health Organization

INTRODUCTION

The following framework has been developed based on the results of an exhaustive mental health and psychosocial support (MHPSS) assessment conducted in the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) during the month of August 2023. The framework considers the most urgent MHPSS needs, current capacities and gaps at regional, provincial, municipal and community levels and has been aligned with Action Against Hunger's vision of a world without hunger and the Philippines mission's strategy to ensure marginalized and vulnerable women, men, children and communities suffering from conflicts, climate crisis and health emergencies have access to timely, equitable and inclusive humanitarian, rehabilitation, and development assistance in the country.

Even though the framework is structured based on the assessment results for BARMM, the Mental Health program is new for all regions. the proposed modalities designed to address the challenges of the national mental health act implementation have been outlined at three levels: the primary health care facilities, Community, and local governmental and non-governmental agenises. Thus, the modality of interventions could be applied to any region after conducting a rapid assessment to define the specific gaps and respond accordingly.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN OUR BATTLE AGAINST HUNGER

We fight hunger by addressing its direct and indirect causes and consequences. While chronic food insecurity can impact physical and mental well-being, some psychological challenges like depression, anxiety, and somatic disorders, especially among pregnant and lactating women, can affect their health-seeking behaviour, care practices for themselves and their infant and increase pregnancy risks, resulting to malnutrition and delayed growth among children. Besides these, psychosocial hardship can make it harder for people to engage in income-generating activities that can reduce food insecurity so the relationship between hunger and psychological well-being is cyclic.

MENTAL HEALTH DURING EMERGENCIES

According to the WHO, in an emergency, 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 3–4% of the population suffer from a major psychiatric disorder (psychosis, severe depression, major anxiety disorder) and need psychiatric treatment.

Globally one in five (22.1%) people living in areas affected by conflict is estimated to have a mental health condition.[1]. Humanitarian emergencies, regardless of their origins, have a strong psychosocial impact on communities, families, and individuals.

THE PHILIPPINE CONTEXT

The Philippines is a highly populated country with an estimated 113,880,328 individuals (World Bank, 2021) living in approximately 7,600 islands. The latest World Risk Index (2022) positions the Philippines as the most disaster-prone country, with recurrent earthquakes, floods, and volcanic eruptions.

A new poll by the Social Weather Stations shows that an estimated three million families experienced involuntary hunger at least once in the fourth quarter of 2022, with 11.8% of Filipino households experiencing involuntary hunger — being hungry and not having anything to eat — in the last three months of the year.

[1] Charlson F. et al. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. The Lancet 394 (10194), pp. 240-248.

Also, a third of children in the Philippines are stunted, with the country ranking fifth among countries in the East Asia and Pacific Region with the highest stunting prevalence and one of 10 countries with the highest number of stunted children in the world. [2]

relevant mental health statistics from 2017[3] showed that depression and anxiety were the most common conditions in the country, 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).

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 Metro 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 to supervise and support the integration of mental health in primary care and oversee the provision of psychosocial support at the local level.

BARMM REGION VULNERABILITY

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 with total population of 4.4K (as of 2020). 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.

As of January 2023, total of **943,000 individuals were affected by disasters and conflict**, with 122,000 individuals remain displaced in Mindanao, which include **98,000 individuals from BARMM current/protracted conflicts.** IDPs (including from Marawi – Zamboanga siege) were left without durable solutions.

BARMM records the **lowest literacy rate in the country at 86.4 percent**, according to the Philippine Statistics Authority's most recent census. Similarly, with the **poverty incidence rate of 63 percent**, BARMM is one of the poorest regions in the country. 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 four (4) or more antenatal care visits.

Also, **about 49% of people in BARMM suffer from chronic malnutrition, while 45 percent of children under five are affected by stunting – the highest prevalence of stunting in the country**.[5]

[2] Mbuya, Nkosinathi V. N., Gabriel Demombynes, Sharon Faye A. Piza, and Ann Jillian V. Adona. (2021) Undernutrition in the Philippines: Scale, Scope, and Opportunities for Nutrition Policy and Programming.
[3] 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.
[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

ACTION AGAINST HUNGER'S SOLUTION

Action Against Hunger's Philippines Mission aims to mitigate the consequences of crisis on key health, nutrition and care practices outcomes by increasing people's access to MHPSS preventive, integrated and community-based supports. Based on our assessment, we have developed a framework that aims to address the identified challenges and gaps through different interventions. The framework is developed around three main objectives:

Objective 1: Adress the Psychosocial Determinants of Mental Health to Mitigate its Consequences on Key Health, Nutritional and Care Outcomes.

We save the lives of children and their families.	Action Against Hunger provides technical expertise and support to strengthen community health systems, improving local health and nutrition services to ensure sustainable impact.
	We bridge the gaps between remote communities and formal health systems, empowering community health workers and volunteers with the skills and tools needed, in this case, to identify, support and refer mental health and psychosocial conditions.
	We educate mothers, fathers, and other caregivers about the benefits of breastfeeding and improved nutrition to help babies and young children grow up strong and healthy.

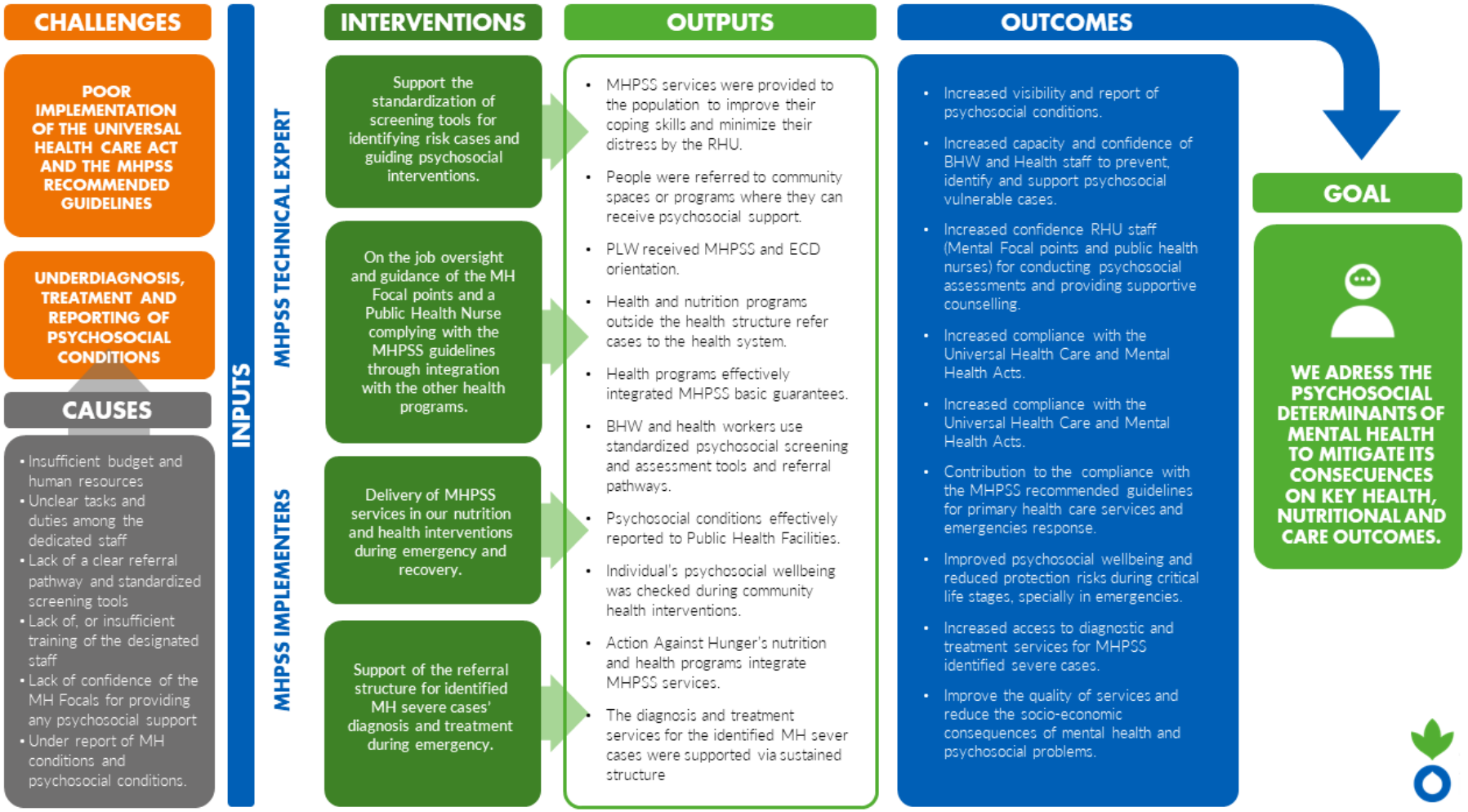
Objective 2: Build Communities' Capacities to Mitigate the Psychosocial Distress and the Protection Risks Generated by Disasters, as well as its Negative Consequences on People's Health, Practices and Livelihoods.

We build resilient communities.	We work at the community level to ensure access to basic services.
	We work with community leaders and organizations to improve their capacity to respond to current and future crises.
	We support community capacities and empower them to protect and promote their psychosocial well-being.

Objective 3: Increase and Strengthen Stakeholders and Local Government's Capacities and Resources to Meet the Basic MHPSS Needs and Expectations of the Population.

We share our knowledge to push for long-term change.	We partner with country governments, humanitarian organizations, and other champions to promote evidence-based policies to effectively tackle hunger and its underlying causes.
	By working with local agencies to plan for long term development, designing and implementing contingency plans that account for psychosocial vulnerabilities, we support the prevention and management of future risks.

OBJECTIVE 1: WE ADRESS THE PSYCHOSOCIAL DETERMINANTS OF MENTAL HEALTH TO MITIGATE ITS CONSECUENCES ON KEY HEALTH, NUTRITIONAL AND CARE OUTCOMES



CHALLENGES

1. **Poor Implementation of the Universal Health Care Act and the MHPSS Recommended Guidelines for the Primary Health Care**
2. **Underdiagnosis and Treatment of Psychosocial conditions**

The Universal Health Care plan for the Philippines states in its Section 6, regarding service coverage that: *All Filipino shall be granted immediate eligibility and access to preventive, promotive, curative, rehabilitative and palliative care for medical, dental, mental and emergency health services, delivered either as population -based on individual-based health services.*

Supporting this plan are the Guidelines on the Adoption of Baseline Primary Health Care Guarantees for All Filipinos was developed and published to make explicit a set of primary health care interventions - both population and individual level - that will ensure healthy lives and promote well-being for all Filipinos at all ages including mental health. Based on our assessment, the specific services for MHPSS across different life stages are being implemented only at 17% at the Rural Health Units (measured by the number of guidelines they reported to be implementing).

Additionally, and despite the efforts being made for pushing the Mental Health Program in BARMM region, one of the biggest challenges towards its compliance resides in the number of undiagnosed cases, most specifically of the psychosocial conditions. The assessment results show that even 50% of the Rural Health Units have trained staff on mhGAP only 43% were confident to say that they can provide diagnoses of the main MH disorders, while none at the barangays level have been trained to use specific tool for identification and referral.

Psychosocial adversity (defined as life-influencing events that result in significant stress[6]) is widespread in the region due to its high vulnerability to natural disasters, climate, and poverty. This has major impact on stress-related disorders like depression, adjustment, acute and post-traumatic stress or anxiety when they don´t receive timely and quality support to prevent and reduce their suffering.

However, the most recent data facilitated by the Mental Health Unit team for BARMM region shows a very different result with psychosis, epilepsy and schizophrenia leading the number of identified cases.[7]

The assessment has shed light into some of the main causes leading to this underdiagnosis and consequently lack of treatment for patients with psychosocial, non-neurological conditions:

- Lack of budget and staff allocated to the mental health program.
- Unclear tasks and duties among the dedicated staff for the mental health program.
- Lack of a clear referral pathway and standardized screening tools for mental health and psychosocial conditions.
- Lack of or insufficient training of the designated staff.
- Lack of confidence of the Mental Health focal points for providing any psychosocial support to the identified cases.
- Underreport of mental health conditions and psychosocial conditions.

[6] Psychology Dictionary, 2014
[7] Detailed data available in the assessment report

PROPOSED INTERVENTIONS

The trainings offered to date to the mental health program designated staff do not seem to have succeeded in generating sufficient confidence to carry out psychosocial interventions. For this reason, we propose an intervention that goes beyond training to include support in the definition of roles and objectives, the incorporation of research-based MHPSS interventions in the different health programs and the implementation of counseling to support those cases that need it.
Through the allocation of a MHPSS technical expert and team of implementers at field level, Action Against Hunger will:

1. **Support the standardization of screening tools for identifying risk cases and guiding psychosocial interventions.**

- Facilitate and agree on the use of rapid, valid and culturally appropriate screening-tools for the detection of psychosocially vulnerable cases at community level.
- Facilitate the adaptation of the "Psychosocial Assessment Toolkit" designed by Action Against Hunger so that non-specialized personnel can assess the well-being of people in key psychosocial aspects (depression, anxiety, post-traumatic stress, aggression, empowerment, social support, coping skills and attachment).

2. **On the job oversight and guidance of the Mental Health Focal points and a Public Health Nurse complying with the MHPSS guidelines through integration with the other health programs.**

1. Endorsement of the referral pathway designed by the Consultative group on Mental Health in BARMM, supported by the standardized tools designed. It will ensure the referral to community available structures for protecting psychosocial well-being and to specialized services for diagnosis when necessary.
2. Integration of the screening- tool in the daily routines of the Barangay Health Workers (BHW) and signature programs of the Rural Health Unit (RHU): Pregnancy and maternity check-ups, adolescent friendly spaces.
    - The integration of the screening tool will be done through supportive communication and psychoeducation to combat stigma and facilitate acceptance of the screening. Orientation, guidance and shadowing will be secured.
3. Effective use of the "Psychosocial Assessment Toolkit" by focal points and designated nurses, who in no case will issue a diagnosis but will ensure:
    a. confident identification of those who should be referred for specialized assessment.
    b. guidance on the type of targeted, non-specialized support they can provide to individuals and/or refer to other agencies and NGOs.
4. Provision of basic counseling based on the results of the psychosocial assessment and aimed at increasing coping skills and reducing distress symptoms with people in medium-high psychosocial risk. The use of evidence-based interventions for this will be encouraged at all times, which may include: Cognitive behavioral therapy (CBT), stress management, relaxation training, or problem-solving counselling depending on health staff's capacities. Orientation, guidance, and shadowing will be secured.
5. Delivery of MHPSS actions within key health programs. Specifically, we aim to ensure its integration in the Adolescent friendly Spaces, the Family Planning program, Reproductive, Maternal, Newborn and Child Health program.
    - This integrated health and MHPSS programming can significantly impact on some of key challenges contrasted during the assessment, like the high rate of teenage pregnancies, the late attendance to the RHU for pregnancy check-ups, the lack of

awareness on the importance of psychosocial well-being during pregnancy and breastfeeding or the increasing rate of teenage suicides.

- Integration example in the Adolescent Friendly Spaces: Providing on the job orientation and guidance to the RHU for designing and delivering the specific targeted interventions of:
  - Gender and health issues
  - Pre- and post-natal care
  - General Health education
  - Mental health care

6. Establishment of a reporting procedure that accounts for the psychosocial distress cases identified and counselled.

3. Delivery of MHPSS services in our nutrition and health interventions during emergency and recovery.

Action Against Hunger main Health and Nutrition interventions are:

- Restoring the capacity to provide the minimum backage of primary health care services to the affected population, with focus on Reproductive, Maternal, Newborn and Child Health (RMNCH).
- Supporting the screening and identification of malnourished children and secure their treatment.
- Infant and Young Child Feeding (IYCF) program in Emergencies.
- Supporting the early warning, alert and response system for main communicable disease with focuses on community engagement in the reporting mechanism.
- Strengthening community members to conduct community-based health risk assessments and health education.
- Providing technical assistance to the local health personnel and our partners to provide quality health and nutrition services during emergencies.

Specific action for MHPSS will be reinforced to be included into health and nutrition services like:

- Psychosocial assessments and referral to basic services, including protection and more focused MHPSS when required, during providing the RMNCH services.
- Peer support groups.
- Psychoeducation on stress management, problem solving and healthy coping strategies.
- Orientation on nurturing care, psychostimulant and early child development.
- Positive parenting skills.
- Individual or group counselling when needed.
- Awareness raising on protection issues.

These should be done by ensuring the training and orientation of our staff and partners to conduct these activities from a perspective that promotes the psychosocial well-being of caregivers, minimizing the impact of the emergency on their own and their babies' nutrition and care practices. This includes increasing capacity to identify cases that require referral to community or RHU support, provision of psychological first aid, psychoeducation, or support groups among caregivers to:

- Prevent the increase of malnutrition, morbidity and mortality rates.
- Help the family to adapt care practices to the emergency and post-emergency context.
- Improve the well-being of pregnant women, infants, young children and their mothers/caregivers, taking into account life experiences, past and present difficulties.
- Provide a safe and private space for pregnant, lactating women and their infants.
- Help families to facilitate child development and survival.
- Prevent or reduce the negative effects of unsolicited and unmonitored distributions of breast milk substitutes.

- Provide appropriate and sustainable solutions for infants for whom breastfeeding is not an option to promote their well-being.

4. Support of the referral structure for identified MH severe cases' diagnosis and treatment during emergency.

In many cases, the diagnosis of mental and psychosocial conditions is not confirmed and in turn not treated due to the difficulty of accessing the personnel who can do it especially at the public health system. Some agencies, such as the MSSD are able to provide financial and logistical support to enable these patients to access the service.

During emergencies, we will ensure close collaboration with these agencies to strengthen their capacity to continue providing assistance to cases in need and support the local referral system wherever possible.

In those cases where the emergency makes it impossible for these agencies to surge capacity, we will directly provide financial support so that the person identified as being at high psychosocial risk can be accompanied by a family member to the nearest psychiatric professional, covering the necessary travel and accommodation expenses. After the diagnosis, we will ensure the reception of the case in the corresponding RHU and link the cases with local support system that can follow up on the treatment continuity.

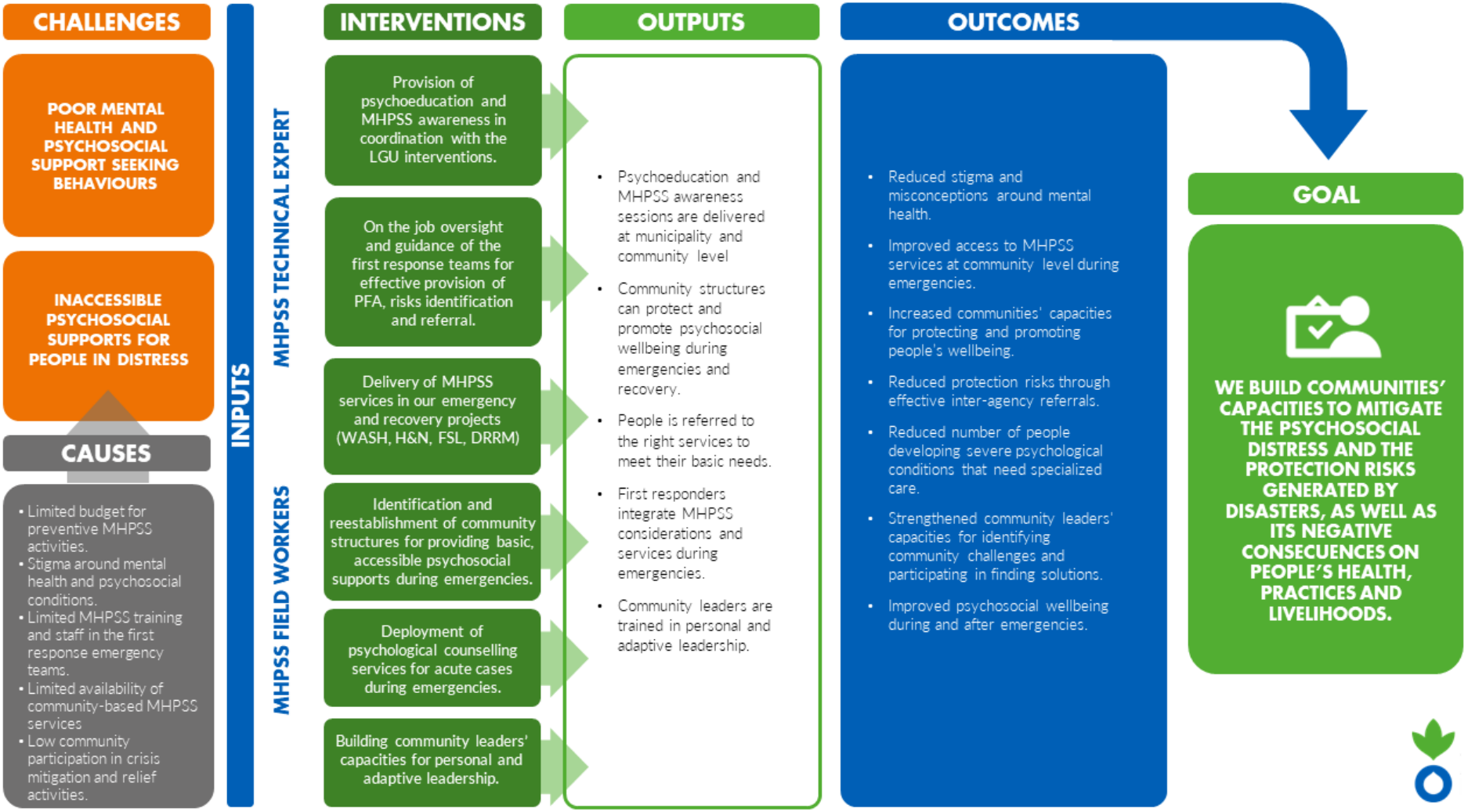
EXPECTED OUTPUTS

- MHPSS services were provided to the population to improve their coping skills and minimize their distress by the RHU.
- People were referred to community spaces or programs where they can receive psychosocial support.
- PLW received MHPSS and ECD orientation.
- Health and nutrition programs outside the health structure refer cases to the health system.
- Health programs effectively integrated MHPSS basic guarantees.
- BHWs and health workers use standardized psychosocial screening and assessment tools and referral pathways.
- Psychosocial conditions effectively reported to Public Health Facilities.
- Individual's psychosocial wellbeing was checked during community health interventions.
- Action Against Hunger's nutrition and health programs integrate MHPSS services.
- The diagnosis and treatment services for the identified MH sever cases were supported via sustained structure.

EXPECTED OUTCOMES

- Increased visibility and report of psychosocial conditions.
- Increased confidence RHU staff (Mental Focal points and public health nurses) for conducting psychosocial assessments and providing supportive counselling.
- Increased compliance with the Universal Health Care and Mental Health Acts.
- Contribution to the compliance with the MHPSS recommended guidelines for primary health care services and emergencies response.
- Increased access to diagnostic and treatment services for MHPSS identified severe cases.
- Improve the quality of services and reduce the socio-economic consequences of mental health and psychosocial problems.

OBJECTIVE 2: WE BUILD COMMUNITIES' CAPACITIES TO MITIGATE THE PSYCHOSOCIAL DISTRESS AND THE PROTECTION RISKS GENERATED BY DISASTERS, AS WELL AS ITS NEGATIVE CONSEQUENCES ON PEOPLE'S HEALTH, PRACTICES AND LIVELIHOODS



CHALLENGES

1. **Poor Mental Health Seeking Behaviours**
2. **Inaccessible Psychosocial Supports for People in Distress**

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.[8] According to these, they prefer seeking help from close family and friends due to barriers 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 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.[9]

Along with our assessment, stigma has been one of the most mentioned barriers towards effective integration of MHPSS actions.

At the Rural Health Units, nurses acknowledge that in many cases people with obvious mental disorders are hidden, as it is perceived shameful to have this condition in the family. This stigma was also reported during focus groups discussions held with the community. The fact that many cases are being identified based on observation also limits the understanding of mental health conditions as only the neurological ones oversee other more common ones.

The inaccessibility to mental health and psychosocial services is another issue hindering the unreported cases and the limited treatment they receive.

Despite the efforts made by the Ministry of Health in BARMM (MOH BARMM) for training primary health care physicians in mhGAP, our assessment notes that very few felt confident identifying cases and even less providing a psychosocial intervention beyond medication. While at barangay level, only 15% of health workers between staff and volunteers reported that they received training related to MHPSS but it was mainly an orientation without defined task after it.

Since the mhGAP program has not yet fully succeeded in ensuring the availability of diagnostic services at every rural health unit within the region, the individuals seeking mental health diagnosis may need to travel to Cotabato City or Davao City to consult with a psychiatrist and subsequently enroll in follow-up services within their municipality upon medicines availability. The associated transportation expenses pose a financial burden, as they are not covered by public health insurance.
While all mental health services that are available in the public sector are limited to diagnosis and provision of medicine to the severe cases, the unmedicated cases that need psychosocial intervention are left without proper evaluation, counseling, follow up or even reporting.

Ensuring the availability of psychosocial support at community level by integrating it in other programs that are already well accepted by the population can allow us to reduce both barriers:

[8] 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,
[9] 2017. Bressington D, Ho GW, Lam C, Leung SF, Leung AY, Molasiotis A et al. Mental health literacy and health seeking behavior in the Western Pacific. Manila: WHO Regional Office for the Western Pacific;

- Reducing stigma: psychosocial support is not seen as curative and therapeutic, and the person is not ashamed of accessing it.

Accessibility: by integrating them into programs that people in vulnerable situations already knowand have access too.

Achieving this requires working from a community-based approach to ensure that supports to protect and promote well-being continue beyond the emergency. Hower, the tendency in emergency response is to provide more person-focused supports for which we suggest the following actions:

PROPOSED INTERVENTIONS

1. Provision of psychoeducation and MHPSS awareness in coordination with the LGU interventions.

We consider psychoeducation as one of the main weapons against stigma and lack of recognition of psychosocial symptoms. Working in coordination with LGU's, we aim to:

- Identify key programs and initiatives in municipalities and barangays, where we can access key groups (adolescents, caregivers, pregnant women...).
- Integrate key messages on psychosocial well-being and available support services.
- Raise awareness of key psychosocial conditions and eradicate false beliefs around mental health.
- Promote healthy psychosocial habits as prevention: problem management, seeking support, physical exercise, etc.
- Develop sessions focused on the recognition and management of symptoms such as stress, anxiety, aggression, isolation.

With greater openness and knowledge about mental and psychosocial health, we can increase the number of people who self-report negative symptoms and turn to the services they know are available for support.

During the assessment we could pre-identify some key interventions and programs with potential for the integration of these activities, which include:

- Women friendly spaces.
- Adolescent friendly spaces at RHUs.
- Group sessions of the Women Welfare program and Family and Community Welfare program.
- Immunization sessions at RHU.
- Community kitchens/nutrition initiatives.

2. On the job oversight and guidance of the first response teams for effective provision of PFA, risks identification and referral.

The "Guidelines in the Provision of the Essential Health Service Packages in Emergencies and Disasters", approved in 2017, state that in emergencies the following should be given:

1. Provision of support to staff who experienced extreme events upon manifestation of significant behavioral changes.
2. Referral of more severe, complex or high-risk cases to specialists and facilities within 12 hours.
3. Utilization of existing communal, cultural, spiritual and religious healing practices as approaches to MHPSS, as appropriate within 12 hours.
4. Community Mental Health Education through fliers, fora and other information, education, and communication (IEC) materials within 24 hours.
5. Coordinated assessment of mental health and psychosocial issues using global assessment tools and guidelines.
6. MHPSS interventions for survivors of sexual violence if requested by the survivor and supported with significant signs and symptoms based on the assessment tool.
7. Protection and promotion of responder's well-being during preparation, deployment, and follow-up phases.
8. Provision for psychotropic medications and sedatives when necessary.[10]

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

9. 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 support 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.

Our assessment has highlighted the insufficient training and psychosocial response capacity of first responders in emergencies.

We aim to provide specific training to these response teams, to improve their ability to:

- Implement self-care strategies.
- Be able to identify people in need of basic support and know how to refer them to protective services, MHPSS or other sectors.
- Provide supportive communication and psychological first aid.
- Disseminate key psychosocial messages and information.

The training will be reinforced by accompanying these teams during the response, adding resources and ensuring the proper implementation of psychosocial care.

3. Delivery of MHPSS services in Action Against Hunger's emergency and recovery projects (WASH, H&N, FSL, DRRM)

- Action Against Hunger's technical team will Identify programs and interventions with potential for the integration of MHPSS activities taking into consideration gender and protection mainstreaming. These may include:
  - Health and Hygiene promotion.
  - Menstrual health activities.
  - Livelihoods programs.
  - Mother and Baby Friendly spaces.
  - Protection activities
  - Preparedness interventions.

- Integration of MHPSS key considerations into the programming.

Depending on the program capacities, this can be more or less specialized. Some common recommended actions include:

- Psychosocial assessments and referrals.
- Design and delivery of culture, age and group appropriate materials and workshops for the recognition of common reactions to crisis or critical life events (puberty, pregnancy, loss of a family or friend…), symptoms of distress, key strategies for problem solving, healthy thinking and coping and information on available services for social or psychosocial support.
- Facilitation of peer and group support: sessions for identification of solutions and supports to common challenges and difficult feelings, focusing on building skills for mutual support. Examples can be:
- Caring for caregivers' sessions: aimed at reducing parental stress and encouraging nurturing care practices. Activities aim at supporting the well-being of caregivers and encourage support-seeking behaviors.
- Youth peer-support: providing youth with key listening, empathy, non-judgmental support and building healthy relationships.

4. Identification and re-establishment of community structures for providing basic, accessible psychosocial supports during emergencies.

- Identification of community leaders and support initiatives in the targeted areas: youth and religious groups, community saving groups, community kitchens.
  - Normalization of feelings, validation and empathy
  - Outreaching and engagement of vulnerable individuals in their community.
  - Considerations for building inclusive, supportive and sensitive spaces.

- Understand psychosocial protective and risk factors.
- Identifying and referring adults in need of additional services and supports.

Pre-identified initiatives during the assessment are:

Women Friendly Spaces.

- Providing on the job orientation and guidance to the LGUs, MSSDs and NGOs coordinating these spaces.

Community nutrition initiatives

- In some Barangays, volunteers work on these activities aimed at providing regular nutritious food to community children. Guidance for integrating key messages on the wellbeing of caregivers, care and nutrition practices or child stimulation through IEC materials, delivering psychoeducation or group sessions with caregivers before food delivery, informing on available services for caregivers MHPSS support can have positive impacts on caregivers' wellbeing as well as in care and nutrition practices.

The stigma and the very conceptions of psychosocial well-being and psychology in the Filipino culture make it essential that the people who provide the first supports are peoplethey trust. Thus, ensuring that these are provided by community leaders can have a major impact.

But, given the lack of confidence of the staff trained in MHPSS and mhGAP in their skills,it is important that these actions are developed from an approach based on mentoring, shadowing and accompaniment, avoiding one-sided information transmission approaches.

Including certification or recognition of people trained as psychosocial support agents or psychosocial advocates in the community is something that can have an influence on increasing the feeling of legitimacy of these people to support their community and will be included as part of the intervention.

5. Deployment of psychological counselling services for acute cases during emergencies

For the cases where, after the first few weeks following the emergency, people still have clear difficulties in resuming their normal functioning, specialized service will be offered where there are no psychologist or trained health workers on psychological counselling.

After the pre-assessment at community level by trained BHW and the barangay nurses and midwifes a mobile psychologist service will be provided at community level, covering these more acute cases in different areas. Pregnant, lactating women, adolescents and caregivers will be prioritized.

The counselling will be provided through evidence-based psychological interventions like:

- Cognitive behavioral therapy (CBT).
- Stress management
- Relaxation training
- Problem-solving counselling

6. Building community leaders' capacities for personal and adaptive leadership.

Action Against Hunger has an intervention program for Personal Leadership, that can be implemented to build the community leaders' capacity based on a set of training workshops aimed to improve the exercise of leadership of key community leaders.
The training actions of this approach are aimed to **develop leadership at two different levels:**

Personal leadership (PL): **as an approach that** provides the self-direction and self-motivation necessary to **achieve personal and performance goals.** Through **behaviour-focused, natural reward and constructive thought strategies**, PL fosters behaviour change and enhances self-confidence when facing new tasks and challenges.

Adaptive leadership: **rather than leading one's own behavior towards personal goals,** this approach focuses on enabling people and organisations to **adapt and thrive in challenging situations**. Adaptive challenges require learning and differ from technical challenges, which can be addressed using previously established approaches. The methodology proposed allows to:

- Find the root cause of a stubborn and recurring challenge of an organization, team or community.
- Partner with leaders, authorities, and people in power
- Recognize individuals and communities' role in the challenge and use it to get to a solution.
- Lead adaptively.

Given the community structure of the Barangays, they are usually composed of community leaders, youth leaders, religious leaders, women's groups, and other community-organized groups. This program can enhance disaster risk reduction management efforts through the active participation of these leaders in the identification of vulnerabilities and the development of community supports that can mitigate them.

This action is planned to be coordinated with the LGUs and the teams dedicated to developing contingency plans, favoring greater community participation in decision making.

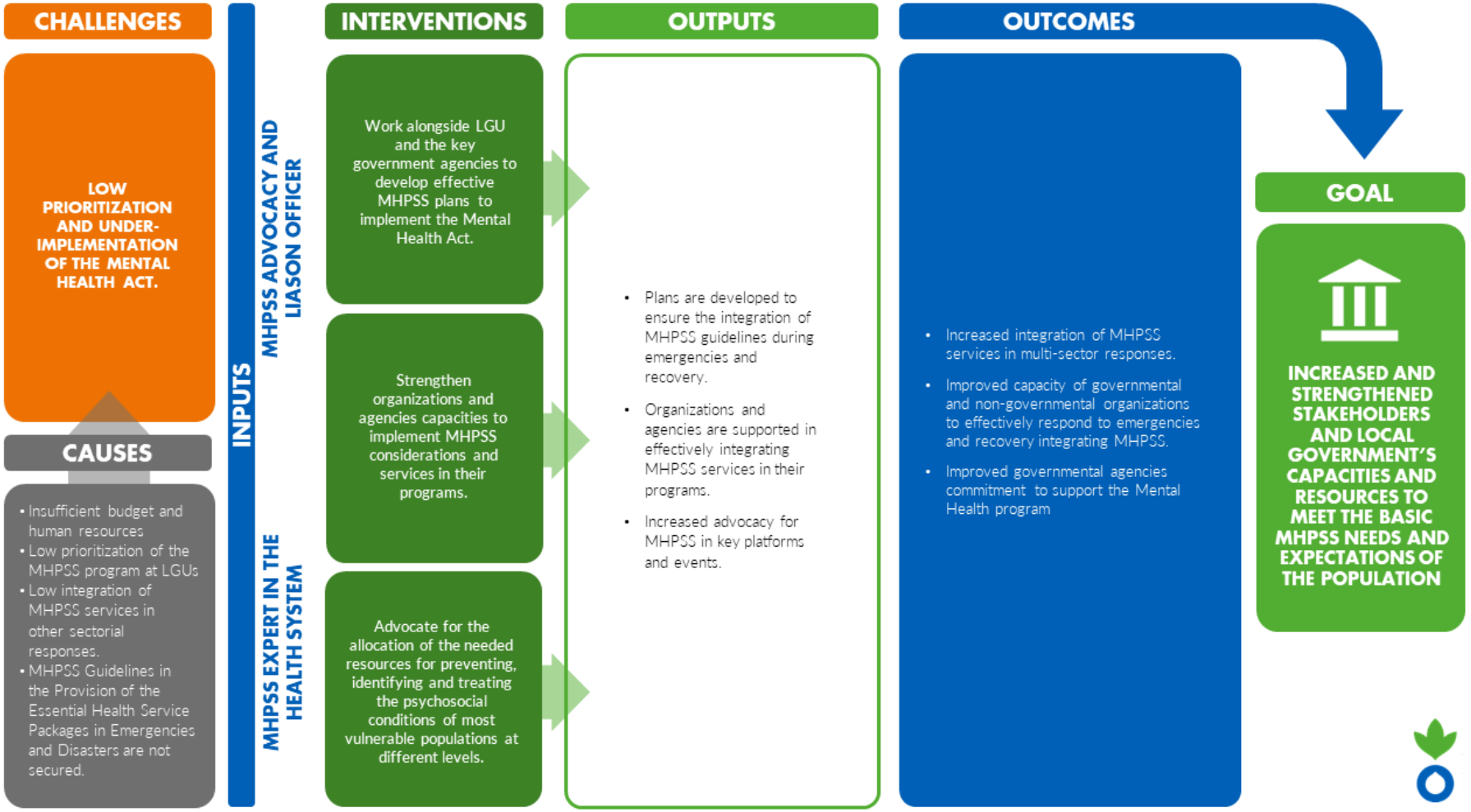
EXPECTED OUTPUTS

- Psychoeducation and MHPSS awareness sessions are delivered at municipality and community levels.
- Community structures can protect and promote psychosocial wellbeing during emergencies and recovery.
- People are referred to the right services to meet their basic needs.
- First responders integrate MHPSS considerations and services during emergencies.
- Community leaders are trained in personal and adaptive leadership.

EXPECTED OUTCOMES

- Reduced stigma and misconceptions around mental health.
- Improved access to MHPSS services at community level during emergencies.
- Increased communities' capacities for protecting and promoting people's wellbeing.
- Reduced protection risks through effective inter-agency referrals.
- Reduced number of people developing severe psychological conditions that need specialized care.
- Strengthened community leaders' capacities for identifying community challenges and participating in finding solutions.
- Improved psychosocial wellbeing during and after emergencies.

OBJECTIVE 3: INCREASED AND STRENGTHENED STAKEHOLDERS AND LOCAL GOVERNMENT'S CAPACITIES AND RESOURCES TO MEET THE BASIC MHPSS NEEDS AND EXPECTATIONS OF THE POPULATION



CHALLENGES

1. Low prioritization and under implementation of the mental health act.

The main identified reasons hindering the implementation of the National Health Act are:

- Insufficient budget and human resources allocated for the mental health program.
- Low prioritization of the MHPSS program at Local Government Units.
- Low integration of MHPSS services in other sectorial responses.
- MHPSS Guidelines in the Provision of the Essential Health Service Packages in Emergencies and Disasters are not secured.

At the national level, mental health represents an estimated 2.65% of the health budget, which is 0.47 USD per capita. However, most of the funds go to mental hospitals and there is no specific allocation for mental health in the health budget [11]. For 2023, the MOH-BARMM allocated about 15million PHP for mental health and 50M PHP for the non-communicable disease cluster, 0.25% and 0.85% respectively from the total ministry budget.

The mental health unit management team reported that despite the success in the allocated budget it is still not enough to enforce the establishment of the program and meet the mental health act requirements, since the psychotropic medicines are very expensive.

A World Health Organization Regional Office for the Western Pacific case study related to the investment on mental health shed some light on the return from the investment in evidence-based, cost-effective mental health interventions.

- For the package of depression interventions, every peso invested will yield 5.3 PHP in return over 10 years (8.6 PHP over 20 years). The overall cost is 7.4 billion PHP (16.9 billion PHP over 20 years).
- Additionally, other interventions with a great return on investment over 10 years are anxiety disorders, universal school-based SEL (Social and Emotional Learning) interventions and alcohol use/ dependence. The packages would cost 10.4 billion, 7.5 billion and 9.8 billion PHP over 10 years, respectively.

Promoting this investment and accompanying the effective development of plans and strategies for MHPSS interventions by government and other private agencies should be a priority and that is why we propose the following interventions:

PROPOSED INTERVENTIONS

1. Work alongside LGU and the key government agencies to develop effective MHPSS plans to implement the Mental Health Act.

At this time, there are still no defined and effective plans for the various agencies on how to implement or contribute to the implementation of the Mental Health Act mandate.

[11] 2020. Philippines WHO Special Initiative for Mental Health Situational Assessment.

In addition to the low compliance at the health system level with the guidelines, there is also a lack of compliance with the *Guidelines in the Provision of the Essential Health Service Packages in Emergencies and Disasters*, largely because they are not part of the contingency and emergency response plans of the various agencies.

To facilitate this process, we propose to work hand in hand with these agencies, especially with the Ministry of Health, MSSD, Local Government Units, and the Disaster risk reduction management operation center (Bangsamoro Readi), supporting the development of plans and procedures that support their MHPSS response in both emergency and recovery.

2. Strengthen organizations and agencies capacities to implement MHPSS considerations and services in their programs.

Just as we intend to integrate MHPSS actions in all our programs at different levels, it is essential to guarantee the capacities of other agencies active in the care of vulnerable populations so that they can do so.

To this end, we offer training and guidance on how to ensure integrated MHPSS programming that favors accessibility to psychosocial services through other spaces.

This includes:

- Orientation and guidance for developing the most suitable integrated programs according to gender, age, special needs and objectives.
- Incorporation of additional psychosocial resources, when necessary, to ensure implementation of these services.
- Coordination and joint delivery of psychosocial activities with the leaders of the targeted programs or spaces tobuild their capacity for replicating similar activities in the future.

3. Advocacy for the allocation of the needed resources for preventing, identifying, and treating the psychosocial conditions of most vulnerable populations.

Advocacy is a key point to ensure the identified gaps receive attention, prioritization and resources needed to be closed. Especially at a time when the Bangsamoro Mental Health Act of 2023 has just been submitted to the parliament for a first reading, suggesting the creation of Bangsamoro Council on Mental Health, Action Against Hunger's active participation in the main decision-making structures and contribution to the proposals for the implementation of the Bangsamoro Mental Health Act can make a difference.

- Action Against Hunger's representative participation in the consultative meetings on Mental Health in BARMM, composed by BARMM Ministries, CSO, NGOs and Stakeholders.

Specifically, Action Against Hunger's contribution to the following initiatives are under development by the Consultative group:

- BARMM Inter-agency MHPSS Referral Pathway
- MHPSS Service Mapping and providers (Levels 1-4)
- Action Against Hunger's participation in the under-creation Technical Working Group to advocate for the Mental Health Act and mental health programs in BARMM.

KEY ACTION AGAINST HUNGER ADVOCACY POINTS

- A fair share of the budget and human resources allocated to the mental health program in BARMM should go to preventive actions focused on the identification, diagnosis and treatment of psychosocial conditions of the most vulnerable individuals.
- Actions aimed at promoting the psychosocial well-being of pregnant and breastfeeding women should be prioritized, strengthening not only their own coping capacities but also those of care, nutrition and stimulation of their children as a key tool to combat child malnutrition and promote early development.
- Disaster Risk Reduction and Management plans must be aligned with MHPSS principles. This should ensure that MHPSS standards defined in the Administrative *Order Guidelines in the Provision of the Essential Health Service Packages in Emergencies and Disasters* are complied with, coordinating the emergency plans of the different agencies and allocating the necessary resources for this purpose.
- Psychosocial wellbeing should be protected and promoted through the reinforcement of existing community structures: Barangay health workers, community, youth and religious leaders should be provided with the skills and resources to protect the welfare of their communities.
- Commit to psychosocial interventions integration as part of all programs targeting vulnerable people as a key to reaching more people, reducing stigma.

EXPECTED OUTPUTS

- Plans are developed to ensure the integration of MHPSS guidelines during emergencies and recovery.
- Organizations and agencies are supported in effectively integrating MHPSS services in their programs.
- Increased advocacy for MHPSS in key platforms and events.

EXPECTED OUTCOMES

- Increased integration of MHPSS services in multi-sector responses.
- Improved capacity of governmental non-governmental organizations to effectively respond to emergencies and recovery integrating MHPSS.
- Improved governmental agencies' commitment to support the Mental Health program.