End-line Study
Provision of Mental Health and Psycho-social Support to Refugees, Migrants and Host Communities in Greater Cairo

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List of Acronyms

MdM	Médicine du Monde
CBOs	Community Based Organisations
KII	Key Informant Interviews
PHC	Primary Health Care
FGDs	Focus Group Discussions
NGOs	Non-governmental Organisations
MHPSS	Mental Health and Psychosocial Support
WHO	World Health Organisation
MoHP	Ministry of Health and Population
OECD	Organisation for Economic Co-operation and Development
PHCC	Primary Health Care Centre
GSMHAT	General Secretariat for Mental Health and Addiction Treatment
PSS	Psychosocial Support
IEC	Information, Education and Communication
UNHCR	United Nations High Commissioner for Refugees

Executive Summary

Objectives

The current evaluation was conducted to measure the progress and achievements of the project and enhance learning in improving the access of mental health and psycho-social support to refugees, migrants, and host communities in Greater Cairo.

Methodology

The evaluation methodology included a mix of techniques including: Document Review, site visits of PHCC facilities, Key Informant Interviews (KII) as well as Focus Group Discussions (FGDs) with a sample of partner CBOs and beneficiaries from the various nationalities included in the project

Results

Relevance

The activities implemented within this project were clearly aligned with those identified within the international policies and guidelines. They also followed many of the mental health policies adopted by the Ministry of Health and Population. and worked in areas with high concentrations of refugees and migrants through the support of existing national health structures and systems.

The MHPSS provided in the units addressed the common problems that affect refugee and migrant populations including PTSD, anxiety, depression. The provision of services also respected the culture and needs of the target groups including providing female service providers and an interpreter who spoke their local language.

Effectiveness

As planned, the project had a significant contribution towards the mental health support of both migrant and refugees as well as beneficiaries from the host community. It succeeded in establishing an organized form of MHPSS care in the 12 targeted primary health care facilities. With the service being provided in 12 PHC facilities in geographic locations where some of the highest density of refugee populations reside, the units were easily accessible. In addition, the service was affordable to the target population, as it was provided almost free of charge at the PHC facility.

Currently mental health services are not included in the basic package of primary health care services. This hinders availability and quality of services on various levels including lack of unity of command and clear treatment and referral procedures.

Efficiency:

Resources were used efficiently in the implementation of the project. Appointing facilitators who speak the local languages of refugee and migrant populations allowed them not only to provide awareness to their local communities, but also to act as guides for their fellow citizens during their visits to the clinics. Supervisory visits conducted by the MdM mental health team were extremely valuable in building the capacity of the PHCC staff. Building the capacity of health care providers in PHCCs and on the job training through supervisory visits was an efficient way for integrating the service in PHC.

On the other hand it is worth noting that the resources used to establish treatment rooms in the 12 target PHCCs were not of much benefit as in most cases the room was taken over for other programs/campaigns. This, however, did not disrupt service provision in those centers, which implies that perhaps resources would be better spent on staff development and community outreach.

Building the capacity of NGO staff was beneficial to improving the quality of service of PSS provided by the NGOs' units which were already established and functioning before the implementation of this project.

Networking with grass root CBOs that serve specific geographic locations or nationalities allowed for wider dissemination of awareness raising activities through different platforms. This led to larger numbers of individuals being reached with much needed information.

On the other hand, there was a clear dissociation between the development of the services and the efforts being done within the communities.

Sustainability:

Eleven out of the twelve PHC MHPSS units continue to be functioning and operating well to date. Dedicated staff use the concept of shared clinics - where one room is used for providing different services based the clinic's schedule. All PHC staff interviewed were extremely keen to continue providing services without incentives

There were considerable reservations about the community-based component of this project.

There are numerous activities that are being implemented however efforts appear disjointed and fragmented.

The 3 remaining partner NGOs that continued the project are extremely capable and will continue providing support through their already established mental health spaces and support services

Impact

As observed from the visits performed in the 12 clinics there was noticeable impact on the knowledge and attitude of the staff especially regarding their negative attitudes towards refugees.

Although the agreements with GSMHAT was done shortly before the time of the evaluation which gave no opportunity to interview them, feedback from the PHCCs 'staff who participated in the coordination meetings with the GSMHAT explained that both parties were enthusiastic about this cooperation despite the logistic challenges.

Conclusion

The activities implemented within this project were clearly aligned with the national and international policies and guidelines and addressed the common psycho-social problems that affect refugees and migrants in a way that respected their culture and needs. The structure of the project activities was also sensitive to the needs of women and children.

As planned, the project had a significant contribution towards the mental health support of both migrant and refugees as well as beneficiaries from the host community through establishing an organized form of accessible and affordable MHPSS care in the 12 targeted primary health care facilities. The service however is running in parallel to rather than streamlined with the package of PHC.

Generally, there has been efficient use of resources, however perhaps less resources need to be spent on establishing the treatment rooms in future.

The project's activities have a good potential for sustainability with eleven out of the twelve PHC MHPSS units still functioning and operating well to date. Scaling up and institutionalizing the program should focus on two pillars, first advocating for incorporating MHPSS services in the package of essential services provided by PHC this will have a more significant impact on sustainability than investing in equipping a clinic room as well as investing in continuing staff development.

Recommendations

Advocating for the incorporation of MHPSS in the package of services provided by the PHC.

Screening PHC staff members who will be trained for interest with more focus on nurses and social workers due to lower turnover.

Ensuring that the location for provision of counselling sessions in the PHC facility is child friendly

Improving outreach activities through more involvement of CBOs and community leaders as well as relying more on the social media platforms e.g. WhatsApp where diverse messages can be provided through videos, podcasts for individuals who cannot read.

IEC materials need to be more informative about services provided, more culturally sensitive featuring images refugees and migrants can identify with and relate to. Information pamphlets about common conditions need to be available for distribution to patients.

Establishing communication channels between PHC staff and specialists at the secondary referral level to improve efficiency of referral system.

Integrating the hotline within the package of essential services provided by the MoHP is essential for the long-term sustainability.

Coordination and networking with different organisations working on providing MHPSS may consider pooling certain resources ie common translators to make the process more efficient and cost beneficial.

Facilitators need to be devoted to the project activities. Providing other forms of support to local communities should not hinder their primary role of raising awareness about mental health.

Introduction

The World Health Organization (WHO) defines mental health as;

A state of wellbeing in which every individual realises his or her own potential, is able to cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community[1].

Across the world today many countries are experiencing the arrival of an unprecedented number of refugees and forcibly displaced individuals estimated at nearly 80 million people worldwide[2] . The recognised effects of forced migration or displacement and the consequent stress factors on mental health can be profound and pervasive. While previously perceived as less significant than physical health problems, experts in numerous fields are beginning to appreciate the importance of identifying mental health issues especially among those who have also experienced situations of conflict, trauma or mass displacement

Mental health is not merely the absence of mental disorder. In the situation of refugees and migrants affected by humanitarian crises many frequently suffer various severe and interrelated stress factors including the trauma of conflict, separation perilous journeys to safety, the loss of families, livelihoods, material belongings as well as the compounded stress of being in a new and often insecure environment. Many refugees are also exposed to emotional and physical assault, gender-based violence and various forms of exploitation. This is further compounded among certain vulnerable populations such as children and youth who are also dependent on caregivers and may become orphaned or separated in situations of crises.

Even after the immediate emergency is over, the affected displaced populations often continue to experience varying degrees of stress and hardship due to difficult living, the loss of social support mechanisms, limited access to livelihood opportunities and the lack of basic needs and services for themselves and their families. In many instances crumbling health and social services are forced to endure the additional strain of a refugee and migrant population, poorly organised humanitarian services may contribute to declining situations, further increasing tension and stress among refugee populations[3] . This leads to the hugely challenging task of

[1] World Health Organization. Mental health: a state of well-being 2014. http://www.who.int/features/factfiles/mental_health/en/

[2] UNHCR. Global Trends Forced Displacement in 2019 https://www.unhcr.org/globaltrends2019/

[3] Wessells M, van Ommeren M. Developing inter-agency guidelines on mental health and psychosocial support in emergency settings. Intervention. 2008;6(3):199–218.

attempting to create accessible and acceptable good quality services for refugees and other migrant populations. Furthermore, in many cases, other factors such as cultural and language barriers may further complicate the situation even further.

For many, emotional, physical and behavioural reactions displayed by some are normal adaptive reactions that may be easily resolved through the support of family or community. Unfortunately, in these settings many of these refugees and migrants have also lost their protective community networks. putting them at risk of developing protracted mental health problems Lacking support networks and access to rights and basic services, may lead to some resorting to various negative coping strategies which can present further risks to their health and safety.

Despite the fact that only a small minority of those suffering from distress will go on to develop frank mental illness a large proportion will experience mild or moderate forms of disorders[4]

Table 1:

WHO projections of mental disorders and distress in adult populations affected by emergencies[5]

	Before emergency (12 months	*After emergency:(12 months)*
Severe disorder (e.g. psychosis, severe depression, disabling form of anxiety disorder)	*2–3%*	*3–4%*
Mild or moderate mental disorder (e.g. mild and moderate forms of depression and anxiety disorders, including mild and moderate PTSD)	*10%*	*15–20%*
Normal distress/other psychological reactions (no disorder)	*No estimate*	*Large percentage*

When describing ‘mental health care’ particularly outside the scope of the health sector the terms ‘psychosocial support’ or ‘psychosocial interventions’ have been created to encompass a wide range of activities including those that support both the psychological and social wellbeing of families, groups and communities not just those who suffer from mental illnesses. This has created some confusion among experts and organisations leading to the creation of a

[4] 21. Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: an overview of mental health challenges. World Psychiatry. 2017;16(2):130–9.
[5] World Health Organization, United Nations High Commissioner for Refugees. Assessing mental health and psychosocial needs and resources: toolkit for major humanitarian settings [Internet]. 2012. http://apps.who.int/iris/bitstream/10665/76796/1/9789241548533_eng.pdf?ua=1

composite term ‘mental health and psychosocial support’ (MHPSS) that encompasses all forms of support that promotes and supports psychological and psychosocial wellbeing[6].

Consequently, attention to mental health particularly among people in humanitarian settings has increased substantially and programmes for mental health and psychosocial support (MHPSS) have become routine components of the humanitarian response to the refugee crises[7] More emphasis is being placed on developing a more inclusive approach; which recognises the scope and significance of various types of culturally shaped mental health problems. It also works to build on local strengths and capacities to integrate mental health care within already existing health, social and community structures[8][9]. There is also a growing understanding that all staff involved in the humanitarian response should understand the basics of MHPSS and comprehend how their actions can directly impact the mental health and psychosocial wellbeing of their beneficiaries.

MHPSS also works though a community-based approach directly with affected populations through the recognition of their individual and collective needs as well as resources and attempting to build on them to promote emotional and psychological well-being[10]

[6] Weissbecker I, Hanna F, El Shazly M, Gao J, Ventevogel P. Integrative Mental Health and Psychosocial Support Interventions for Refugees in Humanitarian Crisis Settings. In: Wenzel T, Drozdek B, editors. Uncertain safety: Understanding and assisting the 21st century refugees. Cham: Springer; 2019. pp. 117–53. 10.1007/978-3-319-72914-5_6

[7] Weissbecker I, Jones L. International response to natural and manmade disasters. In: Okpaku S, editor. Essentials of global mental health. Cambridge: Cambridge University Press; 2014. p. 326–35.

[8] Tol W, Purgato M, Bass J, Galappatti A, Eaton W. Mental health and psychosocial support in humanitarian settings: a public mental health perspective. Epidemiol Psychiatr Sci. 2015;24(6):484–94.

[9] Wessells M. A reflection on the strengths and limits of a public health approach to mental health in humanitarian settings. Epidemiol Psychiatr Sci. 2015;24(6):495–7.

[10] UNHCR. A community-based approach in UNHCR operations 2008. http://www.unhcr.org/47f0a0232.pdf

The Project

Médecins du Monde (MdM), in collaboration with the Ministry of Health and Population (MoHP) implemented a three-year project (2017-2020) funded by Swiss Development Cooperation (SDC), with the objective of protecting and promoting the mental health and psychosocial wellbeing of vulnerable groups at both a community and primary health care level through the integration of mental health and psychosocial support (MHPSS) in primary health care. The project was the continuation of a previous project working on the same topic within the host community only Within the second phase of the project, migrants and refugees were also included in the target groups as part of aligning with the MdM strategy that included "Migration rights and health" as a principal theme with mental health and psychosocial support (MHPSS) as its cross cutting approach.

The project model was built on a number of activities aiming to;

- Enhance the quality of mental health services in 12 PHC facilities to project beneficiaries (refugees, migrants and host community)
- Strengthen the resilience of refugee and migrant communities through provision of MHPSS services in 4 areas in Cairo

These included;

- Capacity building of healthcare providers
- Sensitizing PHC staff on cultural differences and stigma towards refugees
- Promote and advocate for the rights of migrant and refugees
- Promote and advocate for the integration of mental health services at PHC level and development of a referral system
- IEC activities to increase mental health literacy
- Logistic support for MHPSS rooms and registries
- Identify and train community healthcare workers (facilitators) to facilitate access to mental health support at community and PHC level
- Conduct support groups for migrants and refugees to enhance support mechanisms and community cohesion
- Promote self-care activities, enhance self-healing, resilience and coping mechanisms
- Provide IEC materials for migrants, refugees and host community about mental health issues including how to access support.

- Provide IEC activities for refugees and migrants about protective mechanisms and access to services
- Implement activities for migrants, refugees and host community youth on life skills training and the development and implementation of community projects.
- Support psychosocial workers of partner NGOs through support and care groups
- Capacity build psychosocial staff of NGO partners to identify basic mental health disorders
- Capacity build NGO partners to appropriately respond to the psychosocial needs of their specific target population (using evidence-based interventions)

The objective of this end line study was to assess the quality of the intervention, results of action of the project and its achievements. The evaluation assessed the evidence of why, whether or not, and how the results were achieved, what were the driving or hindering factors to its progress. It also focused on understanding the cause-and-effect links between inputs, activities, outputs, outcomes and impact. Moreover, the evaluation attempted to identify issues of accountability, decision making and learning how to improve the access of mental health and psycho-social support to refugees, migrants and host communities.

Evaluation Objectives and Chosen Criteria

The evaluation objectives were developed based on OECD essential criteria and were intended to answer and reflect on the following questions:

Was the model relevant?

- *Does the model respond to an actual need for the beneficiaries?*
- *Does the model fit with and is aligned with country priorities and policies?*
- *Does the model fit international policies and guidelines?*
- *How relevant was the project to the local and national needs and priorities?*
- *To what extent are the objectives of the project still valid?*
- *Were the activities and outputs consistent with the overall goal and objectives of the project?*
- *Were the activities and outputs consistent with the intended effects and impact?*
- *To what extent does the program address the needs (perceived needs versus felt needs) and priorities of the target groups (male/female/youth)?*
- *Were the trainings provided for the PHCCs' and NGOs' staff adapted to the actual context? (e.g. turnover, lack of motivation etc.)?*
- *Are the individual mental health consultations adapted to the migrants' culture? How was the project adapted to contextual changes?*

Was the model effective?

- *Were the intended results/outcomes achieved?*
- *Did the project succeed in Improving access to quality mental health and psychosocial support (MHPSS) for refugees, migrants and host communities in Greater Cairo?*
- *Did the project succeed in improving refugees, migrants and host communities' access to quality MHPSS services at PHCC level?*
- *Did the project succeed in improving Refugees, migrants and host communities' access to community based MHPSS services?*
- *Has the project succeeded in building the capacity of local NGOs to provide MHPSS support to refugees, migrants and host communities?*
- *How did the activities implemented contribute to the achievement of the objective?*
- *How were these activities related to the project's theme?*

- *Were there discrepancies between what was planned and what was delivered? Why?*
- *Does the population concerned have access to adequate, good quality mental healthcare and psychosocial support?*
- *How did the capacity building activities improve the stakeholders' interventions?*
- *To what degree are migrants using mental health services of PHCCs?*
- *Do they have another way to deal with mental health issues?*
- *Did the advocacy activities influence the results?*
- *How did each of the following: community, NGOs, PHCCs, and national policies (MoHP, GSMHAT) contribute to the results?*

Was the model efficient?

- *Has the project been implemented in the most efficient way?*
- *To what extent have the project objectives been achieved in an efficient way and on time?*
- *To what extent have the human and technical resources been used efficiently?*
- *To what extent the intervention model used was an efficient way to integrate mental health in primary health care?*
- *To what extent the intervention model used was an efficient way to improve the access of migrants and refugee population to MHPSS services?*
- *To what extent the intervention model used was an efficient way to enhance resilience of refugees and migrants?*

Was the model sustainable?

Are the benefits of the model expected to last? The scope of this evaluation will focus on the assessment of the sustainability of programmatic efforts.

- *Are the PHC MHPSS units still functioning and operating?*
- *Is the community based MHPSS still functioning and operating?*
- *Is referral to the secondary and tertiary level care facilities still functioning and operating?*
- *What are the constraints and challenges to sustainability if any? Are there any lessons learned? What are they and how can they be scaled up and institutionalized?*
- *To what extent will the project's activities continue after the end of the project in August 2020 (within the scope of the national strategy of the Mental Health Gap that is being implemented by MoHP and WHO)?*

- *To what extent were the short-term activities carried out in a way which takes account of the long-term impact?*
- *Are the 12 partner PHCCs and 4 partner NGOs capable of independently pursuing mental health activities?*
- *What additional measures could have been carried out to maximize the sustainability of the intervention?*

Was the model impactful?

Impact analysis and evaluation is a broad and complicated process when addressed from the development results point of view. For the purpose of the current evaluation, impact analysis and evaluation will focus on the significant positive or negative, intended or unintended long-term effects at the level of the life of individual beneficiaries.

- *Has the project had significant long-term effects on their life? If yes, what are they and how?*
- *How has the project directly and indirectly affected the overall situation of the beneficiaries and PHCCs' and NGOs' staff trained?*
- *Did the project influence the way the PHCCs work on MHPSS (in terms of human resources, organization, quality)? How?*
- *Did the project influence the staff of PHCCs? (knowledge, workload, self-esteem, coordination between them and their motivation)?*
- *Did the project influence new priorities or plans of decision makers as MoHP and GSMHAT? How did the project influence the capacities of different actors to improve their services?*

Methodology and Limitations

The project aimed to protect and promote mental health and psychosocial well-being among migrant, refugee and host community populations in 4 areas in Greater Cairo. This was expected to be achieved through the capacity building of the staff of 12 PHCCs in Greater Cairo. The project also aimed to strengthen the resilience of the migrant and refugee communities in Greater Cairo through the provision of MHPSS services within the 4 partner NGOs.

The evaluation methodology included a mix of techniques including:

1. Document Review
2. Site Visits of PHCC Facilities
3. In Depth Interviews (KII)
4. Focus Group Discussions (FGDs)

Document review

This included an in-depth review of

- Key project documents
- PHC staff training Modules and Training Reports
- MHPSS clinics records/filing system including referral records
- NGOs staff training modules and training reports
- PHC MHPSS clinics registries and service statistics.

Site visits

The 12 PHC facilities through which the project activities were implemented were visited and assessed by the evaluation team. This included the MHPSS unit established by MdM to assess sustainability of the provisions and maintenance status.

A checklist was used for assessing the MHPSS service (See Annex 5)

Similarly, the PHC mental health service statistics were reviewed, and analyzed to assess the profile of clients, including age, gender, nationality and diagnoses.

During the site visit, key informant interviews with the head of the PHC facility, physicians, nurses, social workers and health educators was also be conducted.

In-depth interviews (KII)

The following key informants were interviewed

1. **MdM Staff:** Staff from MdM that included the Project manager, Technical advisors and Field staff were interviewed about how the implemented project model aligned with MdM policies and strategies as well as the operational details of implementation.

2. **PHC Staff:** Staff in the PHC facilities were interviewed this included the physicians, nurses, social workers and health educators who were trained and/or worked on the project in each PHC site.

3. **Partner NGOs staff:** Staff from the three partner NGOs who collaborated on this project were interviewed on a number of issues including the capacity building they received and its relevance and appropriateness to the services provided

4. **MdM Mental Health Facilitators:** Interviews were conducted with 6 MdM community health workers to assess their roles, challenges and perceptions of the project activities as well recommendations for future programming

Focus Group Discussions (FGDs)

Community Leaders: 8 FGDs were conducted with Community Leaders that work with beneficiaries from the catchment areas of the 12 PHC clinics. They consisted of participants from all 8 nationalities included in the project activities (Sudanese, South Sudanese, Syrian, Eritrean, Ethiopian, Iraqi, , Yemeni and Somali) Each focus group consisted of 8-10 participants from one of the project's target areas (Maadi, Madinet Nasr, Guiza and 6th October).

Meetings

MdM Project Staff: A number of meetings were held with all relevant staff members who were directly involved in the implementation of the project.

Limitations

Although an exit interview with few patients s from each MHPSS unit was planned (see Annex 6), in light of the marked drop in the utilization of the units and services due to the COVID-19 pandemic no clients could be met during the visits to the clinics

The focus group discussions were held with community leaders and volunteers from the various refugee led community organizations. There were a small number of project beneficiaries interspersed in the groups but not enough to give adequate information on the target participants who benefited from the services of the MHPSS clinics.

Results

The data collected provided the following results:

Relevance:

- **Does the model fit with and is aligned with country priorities and policies?**
- **Does the model fit international policies and guidelines?**
- **How relevant was the project to the local and national needs and priorities?**
- **To what extent are the objectives of the project still valid?**

It is worth noting that in light of the COVID-19 pandemic, the need for psychosocial support particularly for the migrant and refugee population has become more important than ever. Research conducted during the pandemic revealed that the general population suffered a higher burden of mental health problems including depression, anxiety and insomnia[11] [12]. This burden is expected to be higher among the vulnerable migrant and refugee population which already suffers from significant economic and social problems predisposing them to numerous mental health issues. According to Peter Ventevogel UNHCR's Senior Mental Health Officer, COVID-19 has been a tipping point for many refugees in distress he states

'Before the pandemic, refugee mental health was severely overlooked. Now it's a full-blown crisis'[13]

The activities implemented within this project follow international policies and guidelines on mental health support for migrants and refugees. The Migration and Health programme at the WHO Regional Office for Europe that was established to support Member States to strengthen the health sector's capacity to provide evidence informed responses to the public health challenges of refugee and migrant health. They have identified 4 areas of intervention including promoting social integration, overcoming barriers to access metal health care, facilitating engagement with services and treating migrants and refugees with mental health disorders[14].

[11] Hossain MM, Tasnim S, Sultana A, et al. Epidemiology of mental health problems in COVID-19: a review. *F1000Res*. 2020;9:636. Published 2020 Jun 23. doi:10.12688/f1000research.24457.1

[12] Wang, Y., Shi, L., Que, J. *et al.* The impact of quarantine on mental health status among general population in China during the COVID-19 pandemic. *Mol Psychiatry* (2021). https://doi.org/10.1038/s41380-021-01019-y

[13] https://www.unhcr.org/news/latest/2020/10/5f7ec72a4/qa-pandemic-refugee-mental-health-severely-overlooked-its-full-blown-crisis.html

[14] Mental health promotion and mental health care in refugees and migrants. Copenhagen: WHO Regional Office for Europe; 2018 (Technical guidance on refugee and migrant health).

Egypt's mental health policy was last revised in 2003 and included organization of services, developing community mental health services, reforming mental hospitals to provide more comprehensive care and developing a mental health component in primary health care. The policy also included development of human resources, involvement of patients and families; advocacy and promotion of mental health, better understanding of human rights to protect beneficiaries and ensuring more equitable access to services. The policy also highlighted the importance of more financing for mental health services ensuring quality improvement and developing a monitoring system[15].

The activities implemented within this project were clearly aligned with those identified within the international policies and guidelines. They also follow many of the mental health policies adopted by the Ministry of Health and Population initially intended for Egyptian Citizens but also lately adopted to include refugee populations as well. Furthermore, UNHCR also works to support the integration of enabling refugees to access national health care including psycho-social and mental health support through the equal access to public primary, secondary, and emergency health care as Egyptian citizens would. They work in areas with high concentrations of refugees and asylum-seekers through the support of national efforts to improve quality of services including strengthening the existing national health structures and systems through capacity-building and provision of equipment.

- **Were the activities and outputs consistent with the overall goal and objectives of the project?**
- **Were the activities and outputs consistent with the intended effects and impact?**

Although the planned objectives and outputs were consistent with the overall objective of the project " Improve access to quality mental health and psychosocial support (MHPSS) for refugees, migrants and host communities in Greater Cairo". Some of the planned results contributed more than others to the achievement of the objective. The establishment of MHPSS units in 12 PHCCs and enhancing the capacity of local NGOs to provide psychosocial support provided a more visible outcome than the community outreach activities conducted by the Mental Health Facilitators. Focus group discussions with the refugee community leaders and members could not remember and did not know of any members who had participated in the proposed support groups or self-care activities.

[15] WHO-AIMS Report on Mental Health System in (Egypt), WHO and Ministry of Health, Cairo, Egypt, 2006.

- **Does the model respond to an actual need for the beneficiaries?**
- **To what extent does the program address the needs (perceived needs versus felt needs) and priorities of the target groups (male/female/youth)?**

Focus group discussions with refugee community leaders revealed that they understand the psychological problems migrants and refugees face in this context. In general, however, they clarified that they perceived these problems to arise mainly as a result of economic, political and the cultural hardships they face. Although they highly value the importance of Mental Health and Psychosocial Support Services, yet they still view addressing the root causes of the problem as more pressing priority than just treating the consequences. Thus with many who suffer from anxiety, stress or depression due to the financial instability they struggle from or issues related to lack of consistent availability of shelter, education, employment or healthcare services, they believe that addressing these issues would greatly alleviate many of their mental health problems

It is worth noting however that the program addressed the needs and priorities of the target groups particularly refugees and migrant populations. The MHPSS provided in the units addressed the common problems that affect the population including PTSD, anxiety, depression. The provision of services also respects the culture and needs of the target group, where a female service provider is always available and an interpreter who speaks the local language of a refugee/migrant.

The structure of the project activities unintentionally catered more to the needs of women and children than men. This was due to the fact that women access and utilize PHC facilities more than men, given the type of services provided (child care, vaccination, family planning and antenatal care) in addition to the fact that the working hours of the PHCCs are often not suitable for men as it coincides with standard working hours. Focus group discussions with refugee community leaders and members revealed that while women are more comfortable with face to face services when it comes to mental health support, men usually prefer the anonymity provided by telephone consultations through the hotline (this was also the case pre-COVID).

- **Were the trainings provided for the PHCCs' and NGOs' staff adapted to the actual context? (e.g. turnover, lack of motivation etc.)? Are the individual mental health consultations adapted to the migrants' culture?**

Training of the PHCCs staff target a wide range of categories of health care practitioners including physicians, dentists, nurses, social workers and outreach workers. Widening the intake for training was the only successful way to overcome the turnover of staff in the facilities and the lack of motivation of workers. Among a large number of practitioners who were trained in each facility, only a few with genuine motivation and interest continued to work in the facility. providing support even in extremely difficult circumstances. On the other hand, many staff members didn't want to take part in the activities.

The wide intake also ensured at least one practitioner was still working in the MHPSS unit. The majority of staff still working within the project seemed highly motivated and continue to provide support to patients despite receiving no monetary incentives to do so. At the time of the evaluation the referral system had only recently been activated. This did not allow time to evaluate it fairly.

Including various categories of health care practitioners had its positive aspect. While the turnover of physicians is high in PHCC, the turnover of nurses and social workers is much less which ensured stability in the human resources of the Unit. All PHCC and NGO staff interviewed were extremely satisfied with both the quality and duration of the trainings provided. They felt that the content as well as the quantity of the information provided in the initial 2-week training course enabled them to provide counselling and support services to patients. During the interviews however it was clear that there was an element of patient selection bias and staff were predominately referring cases within the context of the fields they worked in ie postpartum depression if the doctor or nurse trained worked in OB/GYN, behavioural issues among children if they worked in the paediatric clinic etc. This was also found to be the case for NGOs thus if they work on GBV then most of their referrals would be of this nature.

A few of the staff members interviewed had joined the project later on in its cycle and had missed the initial training given. These felt slightly underprepared and less informed and were not as confident as their fully trained colleagues.

The consultations provided are tailored to be culturally sensitive and use male or female service providers as needed/requested. If the patient is not an Arabic speaker and there is a language barrier, the facilitator will try to translate for them. If this is not feasible a translator will be requested when possible.

- **How was the project adapted to contextual changes?**

Effectiveness:

- **Were the intended results/outcomes achieved?**
- **How did the activities implemented contribute to the achievement of the objective?**
- **How were these activities related to the project's theme?**

The project had a significant contribution towards the mental health support of both migrant and refugees as well as beneficiaries from the host community. It succeeded in establishing an organized form of MHPSS care in the 12 targeted primary health care facilities. The project succeeded in coordinating the allocation of a physical premise within the 12 facilities (clinics/units) so that services may be provided in a private, safe and confidential space. The PHCC staff were provided with quality training as well as regular follow up support to ensure that they were able to provide quality PSS services in those facilities. They were also provided with follow up support to allow them to express feelings of anxiety and stress experienced on the job and taught about coping mechanisms and stress relievers.

With the service being provided in 12 PHC facilities in geographic locations where some of the highest density of refugee populations reside, the units were easily accessible. In addition, the service was affordable to the target population, as it is provided almost free of charge at the PHC facility. Most facilities (apart from the PHC facility in New Maadi ie Sakr Koreish) were walking distance from their residential areas. Because it is not in a central location, most beneficiaries find transportation expensive. In addition, by the time they reach the facility the one-pound tickets have usually run out which makes the visit to this clinic more expensive that the others.

- **Did the project succeed in improving access to quality mental health and psychosocial support (MHPSS) for refugees, migrants and host communities in Greater Cairo?**
- **Does the population concerned have access to adequate, good quality mental healthcare and psychosocial support?**
- **To what degree are migrants using mental health services of PHCCs?**

All the MHPSS spaces were predominately accessed by refugee, migrant and host communities within the catchment areas of the PHC facilities. These came through referrals from various other clinics visited ie antenatal care, pediatric etc. Most of the patients were screened by the trained health professionals during the provision of their routine care. It was clear however that direct patient flow from the community was very limited pre COVID and had almost completely stopped since the start of the COVID-19 epidemic. The partner NGOs were also predominately using their own mental health clinics and the CBOs did not have a good understanding of the clinics and the services provided so were clearly not referring cases there

This influenced the categories of cases seen in each MHPSS clinic, for instance, in the Maadi (Al Khabeery) clinic where the principal service providers of PSS on the team consisted of an OB/GYN physician and a Nurse Midwife the vast majority of cases were women suffering from post-partum depression. In the New Maadi PHC facility where the resident pediatrician is also the provider of the MHPSS service, the majority of cases being referred to the clinic were children with suspected ADHD and behavioral problems. The ratio of migrants and refugee vs Egyptian patients being referred to each clinic was also clearly proportional to the flow of both categories to the PHC facility in general. Some clinics had high flow of refugees such as Gharb El Mattar, Al Khabeery, El Hossary and El Sades whereby others rarely saw any refugees such as Meet Okba, Sakr Koresih and Kafr Nassar. The nationalities of migrants and refugees attending the clinics was also clearly delineated whereby some of the clinics saw mainly Syrian and other Arab nationalities whereby others were predominately receiving Sudanese and other African nationalities. This demarcation was purely related to their areas of residence and ease of accessibility to the clinics. Facilitators were also assigned specific geographic locations based on the most prevalent nationalities living in those areas to ensure that they were better able to reach and communicate with their respective communities.

In addition to understanding the distribution of access and uptake of clinic services there were various other issues related to access and uptake that were identified through the Focus Group Discussions (FGDs). Several of the community leaders representing different refugee populations revealed that neither themselves nor the majority of the members of their communities were even aware that these clinics existed. This was a clear reflection that an adequate link had not been established through the community outreach services. Furthermore, and aside from mental health support many refugee communities are still extremely reluctant to access any type of government services. Middle Eastern nationalities in particular including Syrians, Iraqis and Yemenis consider it shameful and a cultural disgrace to use what they

consider “overcrowded government health facilities”. They also perceive that the quality of service provided is expected to be of poor quality. One of the Yemeni participants in the FGD clearly stated:

“A Yemeni may go without food to pay for good quality healthcare for himself or his family”

Other refugee and migrant communities particularly those from African nationalities (Sudan, Eritrea, etc.) also face several barriers to access including language barriers and the risk of stigma and discrimination from staff at the healthcare facility.

Various interventions and activities provided throughout the project proved to be quite successful in overcoming some of these barriers including:

- Training and awareness workshops to teach and inform PHC staff about the situation of migrants and refugees and the difficult conditions they face. This helped them become more empathetic and accepting of them and minimized discriminatory behaviour towards them
- Using facilitators of the same nationality as the target population within the community and to act as liaisons with the PHC facilities help then navigate the procedures and overcome any language barriers

These activities did not however help overcome the barriers experienced by the Iraqi, Syrian and Yemeni migrants and refugees related to their perceptions on poor quality and lack of respect.

- **Has the project succeeded in building the capacity of local NGOs to provide MHPSS support to refugees, migrants and host communities?**

The project started off with 4 national NGOs but one of them dropped out after the first year of the project. The 3 remaining partner NGOs (Watan, Etijah and Refuge Egypt) were meant to support the provision of MHPSS services to migrants, refugees and host community. All three partner NGOs had already existing and seemingly well-established PSS units. Watan provides services for Syrians, Etijah provides services to Syrians, population coming from Africans’ countries and Egyptians and Refuge Egypt mainly receiving migrants from African countries.

NGO staff interviewed felt that the training and capacity building they received from MdM (Case managers, psycho-social workers) as well as the monitoring and supervisory visits and

the community awareness sessions and workshops helped them significantly improve the quality of services they were able to provide within their respective facilities. The current set up with the NGOs does not support the referral of cases to the PHC MHPSS. The NGOs have strong well-established clinics that are capable of treating patients who require primary care. These clinics are better equipped (permanent rooms that allow for private consultations) and are manned by trained staff including psychologists as well a part-time psychiatrist.

- **Do Migrants and refugees have another way to deal with mental health issues?**

Although FGDs conducted with community leaders from migrant and refugee populations of different nationalities revealed very limited knowledge about the MHPSS units it identified two main coping mechanisms with mental health issues:

- As mentioned previously, refugee led Community Based Organizations (CBOs) employ qualified psychologists and social workers who try to directly manage cases needing psychosocial support.
- The majority of the FGD participants were aware of the MdM psychosocial support hotline and frequently referred cases to it. They were extremely satisfied with this service and expressed that it also had the following advantages:
    - Anonymity, this ensures that the client feels he is able to express his feelings more freely and seek help without the risk of being judged.
    - Accessible and affordable; Calling in to the hotline spares beneficiaries unnecessary transportation costs which might be an obstacle for some refugees.
    - It is more accepted and more accessible for men. Given the operating hours and services provided (Antenatal Care, Child Care, Vaccinations, Family Planning etc.) it is unlikely that men will frequent the PHC clinics. Men also prefer the extra privacy and confidentiality that the hotline provides that they would not have in a face to face appointment.
    - In the light of the COVID -19 Pandemic, it proved to be an ideal option for accessing the service without exposure to the risk of infection. Understandably during the past several months most refugees preferred to stay at home given the serious consequences of getting infected.

- **How did the capacity building activities improve the stakeholders' interventions?**

It was evident from meetings conducted with both PHC and NGOs staff that the capacity building activities greatly improved their ability to provide quality mental health and psychosocial support to the beneficiaries. In many instances support was being provided through informal chats with patients, After the training, the support provided took on a more structured and systematic approach, Despite this, additional follow-up is needed to measure the outcome of the capacity building provided to NGOs staff to assess whether quality of services had improved. Supervisory visits are a way of objectively assessing the quality of service, yet, a more subjective criteria for assessing the quality of service needs to be developed through more individually tailored staff assessments ie cases seen, outcome of the consultation, did the patient come back for their follow up visit or did they need referral.

- **How did each of the following: community, NGOs, PHCCs, and national policies (MoHP, GSMHAT) contribute to the results?**

An important issue that was observed in the 12 MHPSS units was that the service was running in parallel to rather than streamlined with the service package provided by the PHCC. The organization of service in each PHCC was different depending on its individual circumstances. Some provided the service throughout the week during the health facility's working hours, whenever a place is available whereas other centers provided the service only on specific days during the week – usually after the clinic's official working hours. The variations in service provision indicated that service is provided "informally" based mainly on staff dedication as well as patient demand. This method of service provision carries a risk of interruption of services due to factors such as staff turnover. The MHPSS are not part of the basic package of services provided through the PHCC (e.g Vaccination, antenatal care, etc). The MoHP is responsible for providing these basic services through ensuring the required resources (physical and human resources) are available.

The staff trained in the MHPSS were very diverse ranging from physicians, dentists, nurses, social workers, and outreach workers. This was found to create a significant obstacle to the integration of the service within the PHCC, as there is no unity of command. Each category/profession technically follows a different sector of the health directorate (nursing directorate, dentistry directorate, etc..) which might create a problem in affiliating the unit technically in the future.

It was also observed that there was some variability in the way the service was provided based on the category of the trained staff. Physicians in PHCCs where the physical room of the MHPSS unit was taken for other purposes, were able to continue providing the service in their own clinics (e.g. vaccination, antenatal care, OB/GYN etc..) after the working hours of the clinics. This was not an option for nurses who can't use the clinic rooms without the presence of a physician.

Feedback from the interviewed PHCCs' staff also revealed that securing Psychiatric medications at the primary health care level is not generally welcome. Only physicians can prescribe medications, and nearly all interviewed physicians clearly stated that they do not feel confident enough to prescribe them even if they know the patient needs them. A pediatrician who works in one of the MHPSS units explained that she spent years studying the indications, contraindications, doses, and adverse effects of pediatric medications both theoretically and during her clinical internship to reach a level of confidence that allowed her to prescribe medications. She stated

"I can't take this responsibility for psychiatric medications".

These issues need to be considered carefully when examining the model of integration of MHPSS in PHCCs.

- **Did the advocacy activities influence the results?**

The effectiveness of the advocacy activities of the project were only evident nearer to the end of the project. The main expected outcome was to advocate for the establishment of a coordination mechanism for referral of cases from primary health care. Given the complexity of how mental health services are organized in Egypt in terms of its various affiliations to various governmental bodies, including the Curative Sector of the MOHP, GSMHAT, the General Authority of Teaching Hospitals, the Health Insurance Organization etc.; the task was not easy.

With the recent establishment however of a referral system, additional time is now needed to show evidence of success as well as better understand the limitations and challenges. Some PHC health professionals have numerous concerns about it. Patients who are seen in the PHC setting do so largely because they are familiar and comfortable with the premises and the health providers. If they need to be referred later to a secondary level facility, they often feel insecure or uncomfortable going to a new clinic and discussing their issues with a "complete stranger".

One of the health professionals trained through this project clearly stated that the cases she had previously referred to a psychiatrist did not actually attend the appointment.

Efficiency:

- **Has the project been implemented in the most efficient way?**
- **To what extent have the project objectives been achieved in an efficient way and on time?**
- **To what extent have the human and technical resources been used efficiently?**

Resources were used efficiently in the implementation of the project. Appointing facilitators who speak the local languages of refugee and migrant populations allowed them not only to provide awareness to their local communities, but also to act as guides for their fellow citizens during their visit to the clinics.

Supervisory visits conducted by the MdM mental health team were extremely valuable in building the capacity of the PHCC staff. One of the primary health care physicians explained that those visits reminded her of her internship in OB/GYN where she learned the most from discussion cases with experienced specialists and having recommendations on the management of cases.

- **To what extent the intervention model used was an efficient way to integrate mental health in primary health care?**

Building the capacity of health care providers in PHCCs and on the job training through supervisory visits was an efficient way for integrating the service in PHC. On the other hand it is worth noting that the resources used to establish a physical room in the 12 target PHCCs were not very efficiently used, given the fact that in many of the PHCCs the room was taken by the management to be used for other purposes particularly during the COVID-19 pandemic. This however, did not disrupt the service provision in those centers, which implies that it is better to use resources in developing staff rather than developing the physical facility.

Building the capacity of NGOs staff was beneficial to improving the quality of service of PSS provided by the NGOs' units which were already established and functioning before the implementation of the project activities, an effect that is not as impactful as establishing a service from scratch in PHCCs.

- **To what extent the intervention model used was an efficient way to improve the access of migrants and refugee population to MHPSS services?**

The various project interventions in terms of establishing the clinics, capacity building staff within PHC facilities and NGOs as well as the proposed community outreach activities were all excellent initiatives. Using the PHC facilities as a base for the service worked on attempting to help further integrate migrants and refugees within their host communities. Establishing understanding and empathy among healthcare staff intended to build relations and foster trust between caregivers and beneficiaries. Capacity building staff from established NGOs that serve refugee populations helped to generate more awareness of the mental health services and support that they provide and increase uptake. Networking with grass root CBOs that serve specific geographic locations or nationalities allowed for wider dissemination of awareness raising activities through different platforms. This led to larger numbers of individuals being reached with much needed information.

The telephone hotline has been one of the most beneficial components in this project and even more so due to the current situation with the COVID-19 pandemic. This service has allowed hard to reach and resistant populations the mechanism to access mental health support in a way that is comfortable and acceptable to them. It has also overcome barriers to accessibility and with the support of translators has also helped overcome language barriers. The hotline has also helped overcome restrictions encountered to various community outreach activities as well as limitation of mobility at certain times during the pandemic.

On the other hand, there was a clear dissociation between the development of the services and the efforts being done within the communities. Currently not enough efforts are being made to link the two together. In the vast majority of cases referrals to the MHPSS clinics are currently coming through from other clinics in the PHC facility. Very few cases are being referred through the community outreach efforts. This component of the project is extremely important especially among migrant and refugee communities as it is expected that there are still several limitations to their direct access of the service as well as the expected need among populations who are not accessing the PHC clinics or NGO services such as men and youth.

It was also clear from the interviews with the partner NGOs and CBOs that the link between their work within the community and the MHPSS clinics was not clear. Most of the community leaders interviewed did not even know that the clinics existed or how to send people to get assessed and treated.

- **To what extent the intervention model used was an efficient way to enhance resilience of refugees and migrants?**

One of the most significant contributions of the project to the resilience of migrants and refugee communities was the provision of information and enhancing their knowledge on numerous issues. Many find themselves stranded in a foreign environment forced to cope and navigate issues they don't understand. This can be extremely stressful and difficult in the best of circumstances. The facilitators recruited by MdM were able to create a strong network of community leaders and members and use platforms such as WhatsApp to share information. Awareness messages included topics such as information on positive parenting, coping mechanisms for common issues such as stress and anxiety, sleep therapy as well as information on COVID-19 etc.

The facilitators also served as a crucial liaison between members of their respective communities and the PHC facilities. They assisted in introducing them to staff at the clinics, helped them navigate difficult or confusing procedures and supported them overcome any language barriers. This directly contributed to beneficiaries from the migrant and refugee communities feeling empowered enough to access various services being offered within the PHC clinic as well as promote an understanding and sense of acceptance among healthcare staff towards refugees and migrants.

<u>Sustainability:</u>

- **Are the PHC MHPSS units still functioning and operating?**

Eleven out of the twelve PHC MHPSS units continue to be functioning and operating well to date Kafr Nassar has had some operational and logistical issues for some time. Dedicated staff use the concept of shared clinics to continue providing their service to clients even after the room has been overtaken by other programs. It was evident from the visits that the sustainability of service was not dependent on maintaining a physical premises (room assigned for the MHPSS unit) as in most of the centers and due to the COVID19 emergency situation the room was taken by other emergency programs, yet the service was still provided to the beneficiaries.

The organization of PHC is unique and fosters sustainability even with the constraint of the limited availability of a dedicated clinic. Services provided in the PHC center use shared clinics

– where one room is used for providing antenatal care, obstetric and gynecological, pediatric consultations etc based on a certain schedule. This has proven to be an excellent model for sustainability whereby trained staff are not limited to whether the assigned MHPSS room is available or not.

All PHC staff interviewed are extremely keen on continuing to provide the counselling and support sessions to the beneficiaries. They have not been paid incentives for these services during the duration of the project which provides a better chance for future sustainability

- **Is the community based MHPSS still functioning and operating?**

As mentioned previously there are considerable reservations about the community-based component of this project. There are numerous activities that are being implemented however efforts appear disjointed and fragmented.

In addition, the COVID-19 pandemic sheds light on the significant concerns raised in times of crisis and how lack of available contingency measures will lead to limitation or complete suspension of activities

- **Is referral to the secondary and tertiary level care facilities still functioning and operating?**

When required, cases that require further or more specialized care are still being referred to secondary care facilities. In most instances there is no further exchange of communication about the follow up care of the patient. There is therefore no way to determine which if any cases ended up requiring tertiary care or how they were managed

- **What are the constraints and challenges to sustainability if any? Are there any lessons learned? What are they and how can they be scaled up and institutionalized?**

This highlights two important issues:

First of all, investing in advocating for incorporating MHPSS services in the package of essential services provided by PHC is significantly more impactful on sustainability than investing in equipping a room for the clinic.

Second, investing in staff development is the second pillar for sustainability.

- **To what extent will the project's activities continue after the end of the project in August 2020 (within the scope of the national strategy of the Mental Health Gap that is being implemented by MoHP and WHO)?**

Provided that trained staff continue to work within the respective PHC units the services will be provided. It is therefore better for long term sustainability to focus capacity building activities on nurses and social workers rather than doctors as the latter tend to move around much more.

The workshops and awareness sessions provided directly through MdM in the clinics however will probably not be continued once the project ends

- **To what extent were the short-term activities carried out in a way which takes account of the long-term impact?**

- **Are the 12 partner PHCCs and 4 partner NGOs capable of independently pursuing mental health activities?**

Except for the Kafr Nassar PHC unit which already had issues conducting its activities while the project was still running the remaining 11 PHC units are keen to continue providing mental health and psychosocial support services to patients.

The 3 remaining partner NGOs that continued the project are extremely capable and will continue providing support through their already established mental health spaces and support services

- **What additional measures could have been carried out to maximize the sustainability of the intervention?**

More efforts could have been made to advocate for the integration of MHPSS into the primary health care structure. This will ensure that whether MdM is still active in these sites, the service will continue to be provided and will be measured against national targets. The hotline has proven to be an extremely effective component of the project and provides an excellent service to patients who are struggling to use the service available within the PHC. This allows it to reach a much larger target audience. The hotline service also provided a good contingency plan during the COVID crisis and allowed many patients to access much needed services at a particularly difficult time without the risk of infection. Many of the efforts conducted through this project can be used as ‘model’ strategies on which to build future work

Impact

- **How has the project directly and indirectly affected the overall situation of the beneficiaries and PHCCs' and NGOs' staff trained?**

- **Did the project influence the way the PHCCs work on MHPSS (in terms of human resources, organization, quality)? How?**

In light of the simplicity of cases (most were diagnosed as mild) addressed in the PHC's MHPSS unit and in the absence of a structured efficient referral system for cases to secondary level of care, it was difficult to observe a significant effect of the project on the situation of the refugee or the host community.

Interviewed NGOs staff explained that the project was a good opportunity to improve their skills specially with the supervisory visits. They clarified that their participation enabled them to provide a better quality of service for their beneficiaries. The visits provided them an opportunity to discuss more difficult cases they felt ill-equipped to deal with and seek advice on how to best handle them. The visits also provided much needed personal support and allowed them to vent and destress during their own periods of stress or feeling overwhelmed

As it was observed from the visits performed to the clinics in the 12 PHCCs targeted by the project, the activities implemented with the staff of the PHCCs had some impact on the knowledge and attitude level. The interviewed staff working in the MHPSS unit – particularly physicians - acknowledged the impact the trainings they received in understanding the holistic approach of health and disease. A pediatrician in Sakr Koreish clinic expressed how valuable the training she received was in better addressing the patients problems from a holistic approach, how she used to address only the illness of the child but now she could deal with the psychosocial roots of the problem particularly in certain cases like nocturnal enuresis and behavioral disorders due to negative parenting.

The PHCCs staff also experienced a general shift in negative attitudes towards refugees. The seminars, workshops organized for the staff made them better understand the problems of refugees in Egypt and feel more compassionate with them, which was reflected directly on the way they treated clients from refugees seeking service in the PHCC – and indirectly led to a significant improvement of the quality of service provided to them. One of the nurses in the Gharb El Mattar clinic stated;

"I used to think refugees received a lot of support from different agencies but once I learned of their true situation and the struggles they face I have a lot of empathy for them. We must help and support them"

- **Did the project influence the staff of PHCCs? (knowledge, workload, self-esteem, coordination between them and their motivation)?**

- **Did the project influence new priorities or plans of decision makers as MoHP and GSMHAT? How did the project influence the capacities of different actors to improve their services?**

Although the agreements with GSMHAT was done shortly before the time of the evaluation which gave no opportunity to interview key informants from there, feedback from the PHCCs 'staff who participated in the coordination meetings with the GSMHAT explained that both parties were enthusiastic about this cooperation despite the logistic challenges. One of the Physicians working in the MHPSS unit expressed some concerns including the lack of personal link with the practitioners in the secondary level enabling a better follow up of referred cases. She said that with the sensitivity surrounding the issue of mental health, a client referred to the secondary level already has confidentiality and anxiety communicating with a new physician, those will be compounded by the fact that the referring physician himself does not know who will be the secondary care provider to whom the patient will be referred to alleviate those concerns.

It is worth noting however, that bringing together the PHC and the secondary level practitioners is a good eye opener for both parties for a future mechanism of referral

An issue that also stands out as an obstacle to having an impact on priorities of decision makers include the complexity of organization of Mental Health Service in the Egyptian Health system. Mental Hospitals affiliated to GSMHAT, Mental Health and Psychiatric departments in General Hospitals affiliated to the curative sector of MOHP, Psychiatry departments in teaching hospitals and Health Insurance hospitals have different affiliations. This lack of unity of command makes it a bit difficult to influence the decision-making process.

Conclusions

The activities implemented within this project were clearly aligned with the national and international policies and guidelines and addressed the common psycho-social problems that affect refugees and migrants in a way that respected their culture and needs. The structure of the project activities was also sensitive to the needs of women and children.

As planned, the project had a significant contribution towards the mental health support of both migrant and refugees as well as beneficiaries from the host community through establishing an organized form of accessible and affordable MHPSS care in the 12 targeted primary health care facilities. The service was however running in parallel rather than streamlined with the package of PHCC.

Overall, resources were used efficiently during the implementation of the project. However, the resources used to establish a physical room in the 12 target PHCCs were not very efficiently used, given the fact that in many of the PHCCs the room was taken by the management to be used for other purposes particularly during the COVID-19 pandemic. This, however, did not disrupt service provision in those centers, which identified that it is more beneficial to use resources to capacity build staff rather than on the physical structure of the facility.

The structure of the current system does not yet consider mental health as an essential service as it does family planning or immunizations etc. Until it becomes part of the essential package of services it will always be pushed aside to make room for the current campaign or the clinics own priorities. In addition huge staff turnover means that unless capacity building is provided at regular intervals some service providers will continue to find themselves without any trained staff who can provide the service .The project's activities have a good potential for sustainability with eleven out of the twelve PHC MHPSS units continuing to function and operating well to date. Scaling up and institutionalizing the program should focus on two pillars, first advocating for incorporating MHPSS services in the package of essential services provided by PHC will be significantly more impactful on long term sustainability than investing in equipping a room for the clinic. Second, investing in continuous staff training capacity building and development.

Recommendations

Staff Capacity Building &Training

One of the main elements of both strength and sustainability of services is ensuring the right staff members are trained adequately. It is therefore advisable.

- Screening staff members who have attended the first round of training to identify those who seem to be the most enthusiastic and committed to providing the services afterwards.
- Nurses and social workers are less likely to be reassigned to other locations unlike doctors who have a high turnover rate. It is therefore more efficient and sustainable to train nurses and social workers.
- Doctors must be trained as part of the team, as they will act as a reference point for more complex cases. They will also be crucial once the referral system is functioning efficiently.

PHC Clinics

Beneficiaries attending MHPSS clinics must feel safe, secure and assured that their privacy and confidentiality is maintained. Even in the most ideal circumstances it is extremely difficult to ensure that the room secured and furnished for the mental health clinic will not be occasionally used for other activities.

- Counselling sessions must be conducted in a closed room preferably away from the routine clinic crowds
- The room should be appropriately decorated and furnished so that the session may be held comfortably.
- Toys and activities for children visiting with their parents or brought in for assessment/care should be provided to give their caregiver the opportunity to receive the service.

Outreach

Migrants and refugees on the move may suffer a number of direct and indirect traumas such as loss of family and friends, their homes and livelihoods in addition to the trauma of conflict, disaster or persecution. They often struggle with lack of access to basic needs and social support

leading to numerous psychological consequences Outreach activities are an essential component of creating the link between target beneficiaries and the services provided in the MHPSS clinics. Adequate provision of support and access to services will result in normalcy, fostering the healing process and resilience of affected populations This basic support need not be provided only by specialised professionals but rather by lay community members who are knowledgeable of their culture, language and living conditions.

- CBOs must be made aware of the available mental health support services whether within governmental PHC facilities, or NGOs/ agencies providing services.
- Community leaders need additional training so that they are better able to support their respective communities
- For MHPSS to be effective additional means of social support must be provided to the target beneficiaries in the form of social care, economic livelihoods and assistance with accommodation and education. This can be arranged through the coordination mechanisms discussed previously.
- Whatsapp and other platforms have proven to be extremely efficient means of provided large numbers of people with information. This however limits certain age groups who are not users of social media ie young children and the elderly from being included. These age groups must be targeted through other forms of activities that are face to face including sports events trips etc.
- The whatsapp messages currently being disseminated must be more diverse including using visual aids, videos or podcasts especially for the individuals who can't read.
- Future assessments must identify and youth and adolescents as a vital group that may suffer from various mental health issues as well as their coping mechanisms and strategies so that future planning ensures they are adequately addressed.
- As the COVID pandemic continues equipping local community centres with basic aids such as computers or tablets can be an efficient means to support children academically especially during the COVID-19 crisis. These devices may also provide them with emotional and social support and can be a good medium to provide awareness through.
- Establishing psychosocial support offices/clinics in the community centres and local CBOs would be a huge support to their local communities and would allow for patients in need to be given immediate support

IEC Materials

- Posters available in the clinic should be larger and more durable to minimize the risk of damage.
- Posters should be more informative especially regarding support activities available to them. This includes the number to the hotline
- Posters should be more culturally appropriate to the various nationalities targeted. The pictures displayed must reflect images that they can identify with and relate to.
- Information pamphlets or flyers of the most common conditions can be developed and distributed among patients wanting to receive additional information about their condition and how to deal with it.

Referral System

Although it is still premature to provide recommendations addressing the referral system, the feedback of some health providers in the PHCC to communicate with the specialist at the secondary referral level and discuss directly the referred cases. This will help the patients feel more comfortable when reaching out to the secondary level care.

Hotline

The telephone hotline is an essential component of the provision of mental health support particularly to the refugee and migrant communities it serves

- The hotline must either be converted to a freephone number or continue to work through an efficient call-back system whereby beneficiaries are not left waiting too long for their calls to be returned.
- Integrating the hotline within the package of essential services provided by the MoHP is essential for the long-term sustainability of the service.
- Pooling translation resources with other agencies who use their services may be an efficient way to maintain this service. A roster of volunteer translators of different nationalities could be compiled to be called on when needed for translation services by any partner agency.

- Regular audits of the calls coming into the hotline must be conducted to better understand the target accessing the service and any additional needs that may be required.

Coordination and Networking

- Different agencies targeting migrants and refugees must coordinate their efforts in a more efficient way to share information, avoid duplication, fill gaps and advocate for best practices Coordination can also help ensure that different aspects of the humanitarian response are implemented in a way which promotes mental health and psychosocial wellbeing
- Ensure that all relevant key players and partners including MOHP, INGOs and UN Agencies are included and allowed to be actively involved in the existing MPHSS working group chaired by PSTIC. The group may also be closely linked to other groups working in different related fields such as health, protection, and education. In addition to ensuring efforts are coordinated, these groups should also work on producing inter-agency briefs which include key points about best practices and guidance. They can also serve as a platform through which MHPSS interventions may be discussed to ensure that efforts follow global best practice guidelines.be appropriate and that organisations would collaborate in developing.
- Different organisations working on providing MHPSS may consider pooling certain resources to make the process more efficient and cost beneficial. This for example can be done using common translators as and when their services are required, establishing a single common hotline or through the development of unified referral mechanisms and pathways.

Advocacy for policy change

- The most valuable measure for ensuring the sustainability of the project interventions is to advocate for the incorporation of MHPSS in the package of services provided by the PHC. This will ensure that the resources will be created for the provision of service.

Facilitators

Selection of facilitators should be more specific to address the needs of their specific communities including, language, understanding of cultural barriers as well as socioeconomic limitations or challenges. Facilitators need to be devoted to the project activities. Providing support to the local communities to access services in general should not hinder their primary

role which is raising community awareness about Mental Health and overcoming stigma associated with mental illness.

Training of the facilitators should be focuses on their role, avoiding involving them into provision of support group facilitation, as this sometimes gives them a false sensation of overconfidence to address cases requiring referral to a specialist.

Annexes

Annex 1: Interview Guide – PHC Staff

Introduction

Good morning, please allow me to introduce myself, my name is "……." and I have been hired by MdM to help conduct this evaluation for their Provision of mental health and psycho-social support to refugees, migrants and host communities in Greater Cairo" project " If I may, I would like to ask you a few questions. Please be assured that any personal information you share today will be used with the strictest confidentiality. (If the interviewee refuses, please end the interview)

With your permission, I would like to audiotape this conversation to ensure that we retain and transcribe your comments accurately. (If the participant is not comfortable with this please stop recording).

Interview guiding questions

- *Did you receive any training withing the scope of this project? If yes, can you tell me what were the trainings you had?*
- *Did you ever provide any kind of services to clients of the MHPSS clinic? If yes, what are those services? are you continuing to provide those services? why?*
- *Were those trainings useful in supporting you to provide quality services to the clients in the MHPSS unit?*
- *How do you rate the quality of services provided in the MHPSS unit? What are the main factors that hinder the provision of quality services?*
- *How is the service organized within the primary health care facility?*
- *Do you know about the supervision visits? Do you know why they were conducted? Was it useful and needed? How can it be improved?*
- *Do you know about the activities conducted by the community health workers and NGOs within the scope of this project? What do you know?*
- *How do you describe the relationship between the Community health worker and the MHPSS unit? How do you think this relationship can be improved?*
- *Did you ever refer a case to a secondary or tertiary level hospital? How do you describe the referral mechanism? What do you think can be done to improve it?*
- *Do you think the service provided in the MHPSS unit is needed by the community? Why?*
- *Do you think the service has positive or negative effect on target population's life? Can you please explain*

Annex 2: Interview Guide – Partner NGOs Staff

Introduction

Good morning, please allow me to introduce myself, my name is "……." and I have been hired by MdM to help conduct this evaluation for their Provision of mental health and psycho-social support to refugees, migrants and host communities in Greater Cairo" project " If I may, I would like to ask you a few questions. Please be assured that any personal information you share today will be used with the strictest confidentiality. (If the interviewee refuses, please end the interview)

With your permission, I would like to audiotape this conversation to ensure that we retain and transcribe your comments accurately. (If the participant is not comfortable with this please stop recording).

Interview guiding questions

- *Can you please explain the role of your NGO in the project?*
- *Did you receive any training withing the scope of this project? If yes, can you tell me what were the trainings about?*
- *Were those trainings useful in supporting you to provide quality services to the clients?*
- *How do you rate the quality of services provided in the MHPSS unit? What are the main factors that hinder the provision of quality services?*
- *Do you know about the activities conducted by the community health workers within the scope of this project? What do you know?*
- *How do you describe the relationship between the NGO and the Community health worker and the MHPSS unit? How do you think this relationship can be improved?*
- *Did you ever refer a case to PHC or to a secondary or tertiary level hospital? How do you describe the referral mechanism? What do you think can be done to improve it?*
- *Do you think the services you provided is needed by the community? Why?*
- *Do you think the service had positive or negative effect on target population's life? Can you please explain.*

Annex 3: Interview Guide – Secondary Level Referral Hospital Staff

Introduction

Good morning, please allow me to introduce myself, my name is "……." and I have been hired by MdM to help conduct this evaluation for their Provision of mental health and psycho-social support to refugees, migrants and host communities in Greater Cairo" project " If I may, I would like to ask you a few questions. Please be assured that any personal information you share today will be used with the strictest confidentiality. (If the interviewee refuses, please end the interview)

With your permission, I would like to audiotape this conversation to ensure that we retain and transcribe your comments accurately. (If the participant is not comfortable with this please stop recording).

Interview guiding questions

- *How was the mechanism of interaction between you and PHC facilities?*
- *Have you ever received referrals from the PHC MHPSS or project partner NGOs? If yes, did you receive any referrals from the PHC MHPSS Unit over the past few months?*
- *How do you rate the quality of services provided in the MHPSS unit? What are the main factors that hinder the provision of quality services?*
- *Do you know about the activities conducted by the community health workers and NGOs within the scope of this project? What do you know?*
- *How do you rate the referral mechanism? What do you think can be done to improve it?*
- *Do you think the service provided in the MHPSS unit is needed by the community?*
- *Do you think the service (Community based and PHC based MHPSS) has positive or negative effect on target population's Mental Health status? Can you please explain*
- *To what extent do you think this program was effective in promoting MHPSS particularly among refugees and migrants?*
- *Do you think this mode will be sustainable? Why?*

Annex 4: Focus Group Discussion guide – Project Beneficiaries

Introduction

Good morning, please allow me to introduce myself, my name is "……." and I have been hired by MdM to help conduct this evaluation for their Provision of mental health and psycho-social support to refugees, migrants and host communities in Greater Cairo" project " If I may, I would like to ask you a few questions. Please be assured that any personal information you share today will be used with the strictest confidentiality. (If the interviewee refuses, please end the interview)

With your permission, I would like to audiotape this conversation to ensure that we retain and transcribe your comments accurately. (If any of the participants is not comfortable with this please stop recording).

Please allow each participant to express their views freely. All opinions are welcome, and we encourage everyone to participate in the conversation. Please put your mobiles on silent during the discussion.

FGD questions

Community based MHPSS services

Have you benefited from the community based MHPSS services? what services did you use? How do you rate this service? Was this service needed by you? What were the challenges/drawbacks? What do you recommend making this service better in the future?

PHC MHPSS Services

Have you benefited from the services of PHC MHPSS? what services did you use? How do you rate this service? Was this service needed by you? What were the challenges/drawbacks? What did you like/dislike most about the service? What do you recommend making this service better in the future?

Referral

Have you been referred to a secondary or tertiary level hospital? what services did you use? How do you rate the referral service? What were the challenges/drawbacks? What did you like/dislike most about the service? What do you recommend making this service better in the future?

Impact

Did any of the services you received from the project affect your life positively or negatively? How? Please explain

Annex 5: Focus Group Discussion Guide – MdM Community Health Workers

Introduction

Good morning, please allow me to introduce myself, my name is "……." and I have been hired by MdM to help conduct this evaluation for their Provision of mental health and psycho-social support to refugees, migrants and host communities in Greater Cairo" project " If I may, I would like to ask you a few questions. Please be assured that any personal information you share today will be used with the strictest confidentiality. (If the interviewee refuses, please end the interview)

With your permission, I would like to audiotape this conversation to ensure that we retain and transcribe your comments accurately. (If any of the participants is not comfortable with this please stop recording).

Please allow each participant to express their views freely. All opinions are welcome, and we encourage everyone to participate in the conversation. Please put your mobiles on silent during the discussion.

FGD questions

Capacity building

How and why did you join the project?

Have you received any kind of training? If yes, what were they about? Was it useful? Why and how? How did you use it?

Role in the project

Can you please explain what was your role in the project? How well do you think you performed this role? What were the challenges you met? What were the bottlenecks? How do you suggest those can be avoided in future programming?

How did you reach to beneficiaries and identify those who need to be referred? What was your role with the PHCC?

Impact

Did any of the services you provided affect the life of beneficiaries positively or negatively? How? Please explain

How did your participation in the project affect your life if any?

Annex 6: MHPSS Assessment Checklist

Name of the Facility	
Location	
Date of the visit	
Visitor	
Key informant name and title	
Is there a functioning MHPSS service?	*Yes - No*
If yes what is the type	*Clinic – Unit – Program – other specify*

Health Information System

Does the MHPSS unit have patient registry	*Y*	*N*
Is the registry used?	*Y*	*N*

	Egyptians			*Non-Egyptians*		
	Male	*Female*	*Children*	*Male*	*Female*	*Children*
How many cases of Anxiety recorded during the past 2 weeks						
How many cases of Depression recorded during the past 2 weeks						
How many cases of Psychosis recorded during the past 2 weeks						
How many cases of Epilepsy recorded during the past 2 weeks						
How Many cases of ADHD recorded during the past 2 weeks						
How many cases of other Psychiatric disorders recorded during the past 2 weeks						
How many cases were prescribed medications during the past 2 weeks						

Access to Psychotropic Medicines:

During the past two weeks were any of these medications available in the PHC unit?			*During the past two weeks Were Any of those medications prescribed?*	
Medication Group	*Yes*	*No*	*Yes*	*No*
Anti depressants				
Anti Anxiety				
Anti Psychotics				
Anti Epileptics				
Anti parkinsonism				

Referral Indicators

During the past two weeks how many referrals did the PHC unit receive	
From Mental Health Specialist Care	

Community health workers, other community workers, schools, social services and other community social supports	
During the past two weeks how many mental health related cases were referrals did the PHC unit make to	
Mental health specialist care (secondary, tertiary, or private care)	
Community health workers, other community workers, schools, social services and other community social supports	

Quality of Service Parameters

Is the facility within a walking distance from residence of clients?	*Y*	*N*
Is service affordable?	*Y*	*N*
The service provision site lies in a quiet place	*Y*	*N*
Signs indicate working hours		
The service provision site is adapted for children		
Waiting area is shaded and comfortable		
Patient entry to the exam room is organized		
Is there a female Mental health care provider?	*Y*	*N*
Migrants languages is spoken by at least one clinic staff member	*Y*	*N*
Health care provision is organized in a way that respects r there is a curtain around the consultation area	*Y*	*N*
The examination room has a door that can be closed and locked		
There is a complaint or suggestions box in the service provision areas		
Procedures are there to ensure consent is provided by patients before major medical procedures	*Y*	*N*
Patient information is kept in a specific room	*Y*	*N*
Patient information is kept in a locker with a lock and key		

Staff

Number of physicians(manpower) available in PHC		
Number of Nurses(manpower) available in PHC		
Number of Physicians available in MHPSS Unit		
Number of Nurses available in MHPSS Unit		
Number of other staff working in the MHPSS unit		

Staff Capacity

Mental Health training and clinical supervision received by staff during the past two years	
Physicians	
Nurses	
Others	

Annex 7: Exit interview with MHPSS Facility

Introduction

Good morning, please allow me to introduce myself, my name is "……." and I have been hired by MdM to help conduct this evaluation for their Provision of mental health and psycho-social support to refugees, migrants and host communities in Greater Cairo" project " If I may, I would like to ask you a few questions. Please be assured that any personal information you share today will be used with the strictest confidentiality. (If the interviewee refuses, please end the interview)

Gender

Age

Visit type: first/ Follow-up

How did you know about the unit? During routine visit/referred by community worker/referred by NGO/referred by Hospital /other specify

Was the facility easily accessible? No/to some extent/Yes

Was the service affordable? No/somehow/Yes

Was the waiting time reasonable? No/yes

Was the patients access to the examination room organized? No/Yes/ Comments_____

Did the service provider spend enough time with you? No/Yes/ Comments_____

Did the service provider explain to you what is your problem? No/Yes/ Comments_____

Have you been prescribed any medications? No/Yes/ Comments_____

If yes, can you afford to buy them? No/Yes/ Comments_____

Have you been referred to a secondary level facility? No/Yes/ Comments_____

If yes, why? _____, were you able to access the service at the secondary facility? No/Yes/ Comments_____, If, yes, how long did it take you from the time you were referred to the time you received the service?_____

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