



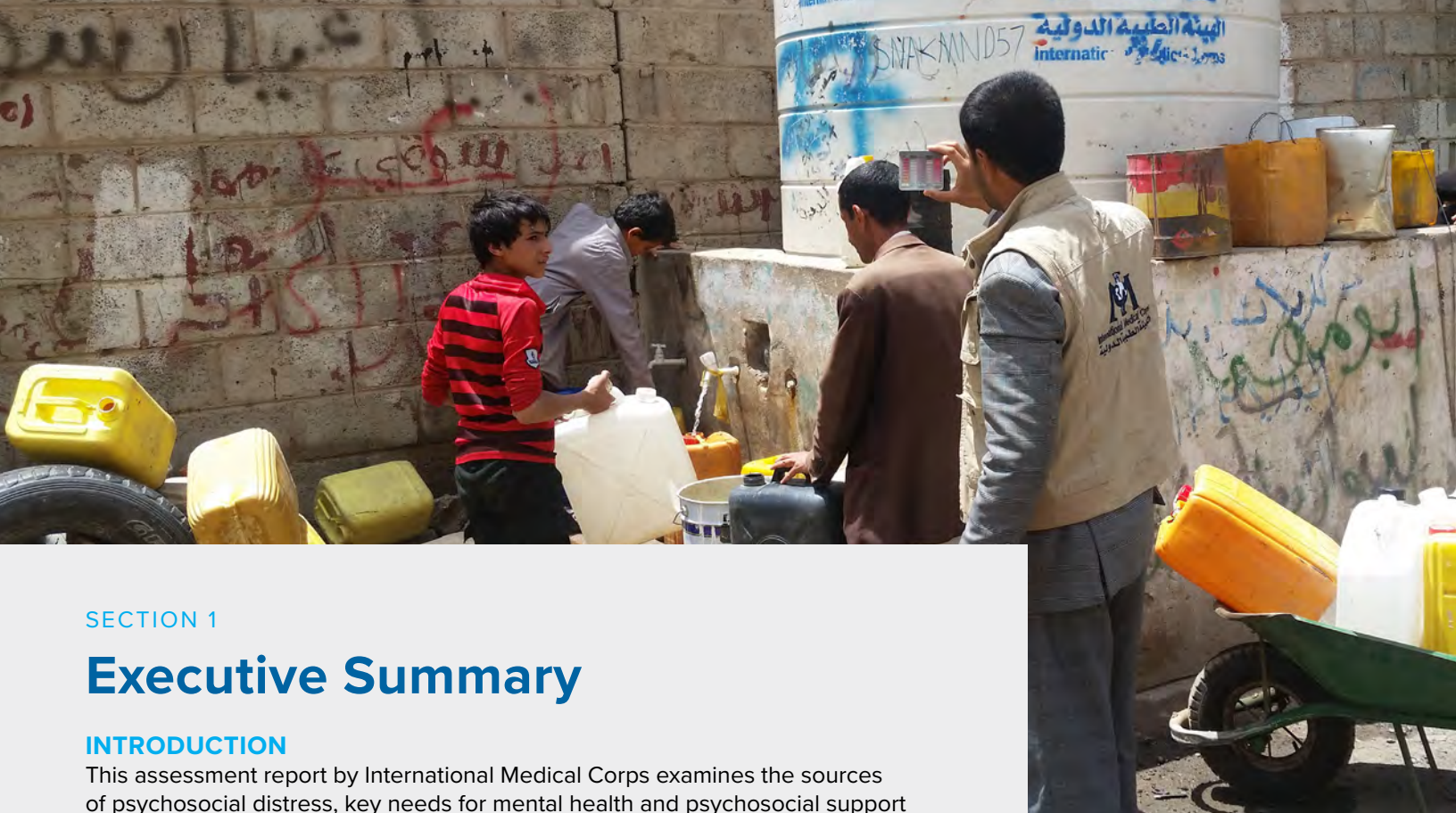
AUGUST 2019

Mental Health and Psychosocial Support Assessment

Needs, services and recommendations to improve the wellbeing
of those living through Yemen's humanitarian emergency

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SECTION 1

Executive Summary

INTRODUCTION

This assessment report by International Medical Corps examines the sources of psychosocial distress, key needs for mental health and psychosocial support services, traditional ways of coping, help-seeking behaviors, barriers to accessing support, existing MHPSS services and critical gaps in services provided. The report then provides recommendations for all key actors and stakeholders, with the goal of improving the delivery of MHPSS services in Yemen—currently acknowledged as one of the world’s worst humanitarian emergencies, where there is a significant dearth of MHPSS services available.

METHODS

The assessment relies on both quantitative and qualitative methods of data collection and analysis, including a desk review, health facility assessments, individual interviews with community residents, focus group discussions and key informant interviews. Data was collected from 71 different health facilities, 15 key informants and approximately 160 focus group participants across different governorates of Yemen.

RESULTS

The results of this assessment underscore how, during the past four-and-one-half years, the people of Yemen have lived through incalculable adversity. They have endured ongoing violence, security and protection violations, multiple forms of loss, displacement, dire poverty, hunger and malnutrition, the largest cholera outbreak in recent memory and a litany of other serious health conditions. This has unfolded amid a fundamental lack of access to the goods and services required to fulfill even their most critical basic needs, resulting in significant emotional distress, feelings of hopelessness and helplessness, worsening of existing mental health conditions, increasing rates of suicide and the problematic use of *qat*.

Simultaneously, the results of this assessment have highlighted the dire gaps in available and affordable mental health and psychosocial support services throughout the country, where nearly no advanced mental health services are available outside a few hospitals.

Furthermore, the assessment highlights a multitude of challenges for mental health service delivery, including a weak national mental health care system, a limited mental health work force, a dearth of recommended psychotropic medications, a lack of non-governmental actors providing advanced mental health services, a shortage of donor funding for comprehensive MHPSS services, the highly stigmatized nature of mental health and mental disorders, and the sheer lack of information, awareness and training of key health and community figures in the mental health field.

This assessment underscores the urgent needed to address and improve the mental health and psychosocial wellbeing of those who have endured so much in Yemen.



Recommendations

Key recommendations include the following:

1. **Advocate for a significant increase in MHPSS programming, awareness-raising and dedicated investment from donors**, to address the severe shortage of MHPSS services and providers throughout the country.
2. **Train first responders in Psychological First Aid.**
3. **Raise community awareness about how to promote wellbeing, reduce emotional distress and treat mental health conditions, to build knowledge and address stigma.** Develop and disseminate MHPSS-related information, education and communication materials; engage local leaders, religious figures and traditional healers; further explore knowledge, attitudes and practices; and support the creation of a group of mental health service users.
4. **Conduct workshops on IASC MHPSS Guidelines for MHPSS in Emergency Settings.**
5. **Urgently address the treatment gap in providing mental health care services.** Integrate mental health into the primary healthcare system; invest in training and supervising non-specialists in evidence-based, scalable psychological interventions that adhere to World Health Organization (WHO) standards; support the Ministry of Health and Population to implement the National Mental Health Strategy; invest in the education, and clinical training and supervision, of psychologists and psychiatrists; advocate for decentralization of mental health care; improve availability and accessibility of psychotropic medications; and advocate for mhGAP-trained and supervised health professionals to have the right to prescribe psychotropic medications.
6. **Ensure that MHPSS programs include activities that promote community cohesion and social support.** Develop community and group-based activities that could establish or strengthen social support.
7. **Establish and strengthen referral pathways** for delivery of MHPSS services.
8. **Integrate MHPSS into additional areas of programming**, such as into protection and nutrition programs, as a cross-cutting theme.
9. **Advocate for dedicated programming and professionals to support children's wellbeing.** Invest in the education and training of professionals in child psychology and psychiatry, and review best practices of disarmament, demobilization and reintegration (DDR) programs.

These recommendations are informed by International Medical Corps' current and previous programming, partnerships, organizational capacities and well-developed relationships in the Yemeni community. The recommendations are interrelated, and should be considered in their entirety.



SECTION 2

Context

The primary objectives of this mental health and psychosocial support (MHPSS) assessment are:

- To understand the perceived and identified sources of psychosocial distress among community members throughout Yemen (with special focus on International Medical Corps areas of operation);
- To identify key needs for mental health and psychosocial support services, traditional ways of coping, help-seeking behaviors and barriers to accessing support services;
- To determine existing MHPSS services, as well as gaps in services;
- To share recommendations for future MHPSS programming as a part of the humanitarian response, and to advocate for increased investment in MHPSS initiatives in this emergency.

This MHPSS situational analysis was conducted by International Medical Corps Senior Global Mental Health and Psychosocial Support Advisor Claire Whitney, with significant support from MHPSS Intern Prachi Kale and the Yemen Monitoring, Evaluation, Accountability and Learning team (with special thanks to Yaman Al Eryani, Hamoud Agha and Amal Al Aghbari).

A desk review of current relevant documents included:

- OCHA 2019 Humanitarian Needs Overview and 2018 Humanitarian Response Plan
- Republic of Yemen NAMCHA¹ 2019 Humanitarian Needs Plan
- World Health Organization (WHO) 2017 Mental Health Atlas for Yemen
- WHO 2015–16 overview on Yemen mental health and psychosocial support emergency response
- Republic of Yemen National Mental Health (2011–2015)
- Mental Health and Psychosocial Support Plan of Action for Yemen (2019)
- Sana'a Center, The Impact of War on Mental Health in Yemen: A Neglected Crisis (2019)
- International Medical Corps internal multisector reports on MHPSS, health and protection concerns in Yemen (2014–2016)
- Various articles and public statements from professional associations and humanitarian organizations, as well as news accounts about the status of mental health in Yemen

¹ In March 2018, the Houthi de facto authorities created the National Authority for the Management and Coordination of Humanitarian Affairs and Disaster Recovery (NAMCHA), a centralized body based in Sana'a that is supposed to be the first point of contact for international NGOs and UN agencies operating in the country.

Methodology

The methodology for this assessment included a rapid assessment of health facilities, interviews with key informants and focus group discussions with community residents throughout the country.

Rapid MHPSS assessments were conducted in 71 health facilities (68 primary health facilities and three hospitals) in numerous districts of Sana'a and Aden Governorates during the last quarter of 2018.

Interviews and general discussions were held with 15 key informants (eight female, seven male) in Sana'a, Ibb, Taiz and Aden between February and June 2019. Key informants included mental health specialists and health professionals at the Ministry of Public Health and Population (MoPHP) and primary healthcare clinics, as well as mental health and psychosocial support focal points at six NGOs, UNICEF, WHO and the International Red Cross and Red Crescent Movement.

Sixteen focus group discussions (with an average of 10 participants each) were led at the community level across six governorates, including Sana'a, Ibb, Taiz, Aden, Lahj and Al Dhalea, between February and March 2019. Participants were adults from different age groups, segregated according to sex given cultural norms and considerations.

The assessment tools used were adapted from the [WHO/UNHCR MHPSS Assessment Guide](#) and included the [International Medical Corps MHPSS Basic Rapid Assessment Tool](#) as well as other participatory tools. The methodological approach was in line with global best practices, including the [Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#).



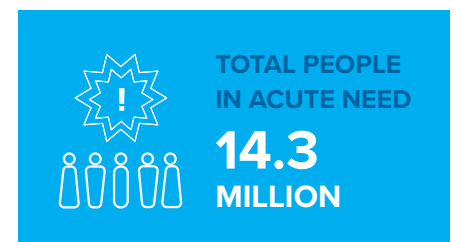
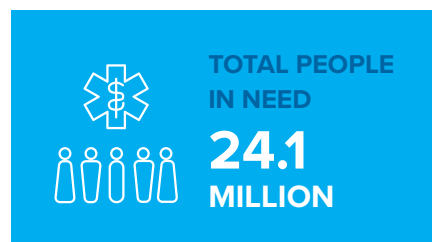
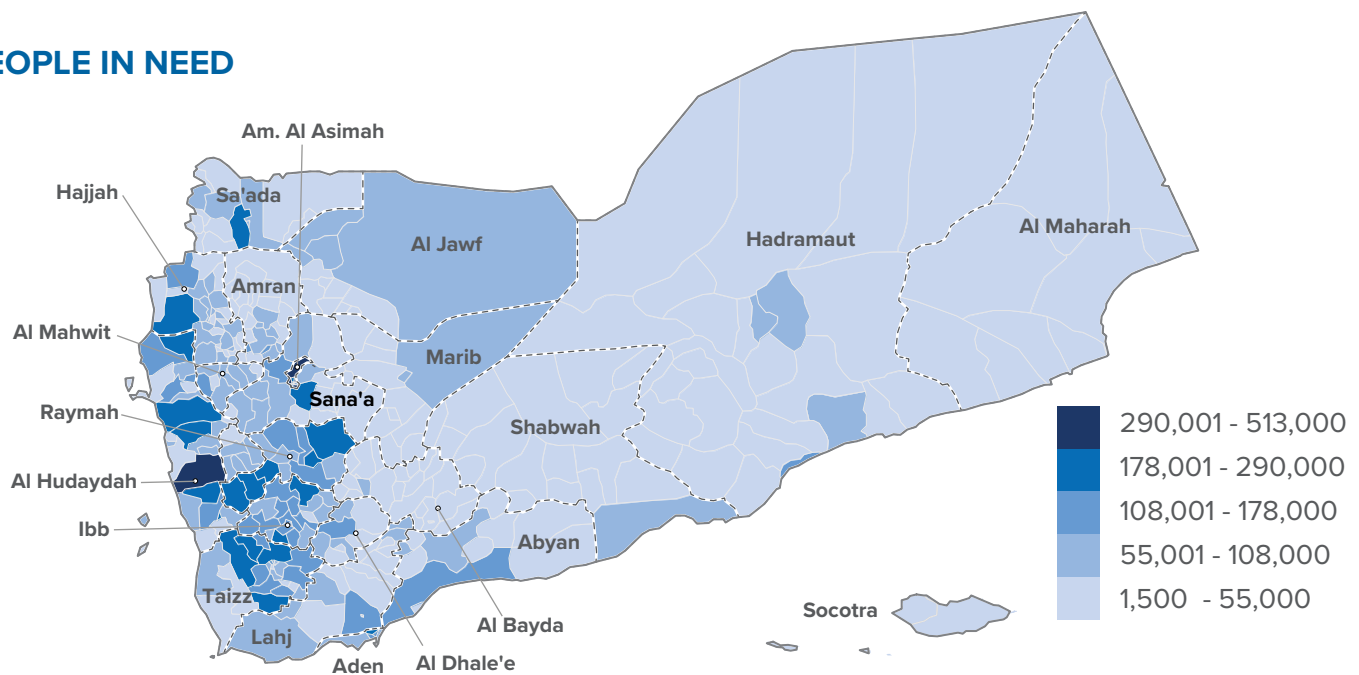


SECTION 3

Background and Context

OCHA 2019 Yemen Humanitarian Needs Overview

PEOPLE IN NEED



Map and Data Source: OCHA 2019 Yemen Humanitarian Needs Overview.

3.1 Humanitarian Context in Yemen

There are an estimated 24.1 million people—80% of Yemen's total population—directly affected by the ongoing conflict and in dire need of humanitarian assistance¹. The war has fueled the world's worst cholera epidemic in memory and the largest food-security emergency on record, with 21.1 million people currently food-insecure.² All of Yemen's ethno-religious communities have been affected negatively by the country's years of conflict—living through violence, loss, poverty and displacement, and the struggle to survive amid precipitous declines in healthcare and nutrition levels have led to a sharp rise of protection risks and significant concerns about mental health and psychosocial support needs.

As the war drags on with little hope of peace anytime soon, the multitude of stressors and risks to wellbeing continue to build, presenting daunting challenges to those addressing basic needs and promoting overall wellbeing.

Lack of Access to Food, Water and Other Critical Resources

Collectively, food shortages, malnutrition and undernutrition pose a major threat to wellbeing and mortality in Yemen, with roughly three-quarters of the population estimated to be food-insecure and nearly half of the country's 29 million people believed to be on the brink of starvation. Since the war began in 2015, some estimates of the number of children who have died of starvation top 85,000. The risk of famine has become increasingly high, and 69% of the country's more than 330 administrative districts are classified as at heightened risk of famine.³

The deterioration of water services in Yemen has led to reduced water supplies, increased environmental pollution, disease and epidemics. Yemen is currently experiencing what is reportedly its worst cholera epidemic in history, which has affected more than 1.78 million people and resulted in more than 3,500 deaths, with a fatality rate of 0.20%⁴. According to the UN, the cause is easily identified: nearly 16 million out of the country's 29 million people lack access to basic sanitation and safe, potable water.

Rise in Unemployment and Economic Insecurity

In the past three years, Yemen's GDP has declined 61%, leaving the government unable to fund even the most basic social services or pay government employee salaries. Almost 1.25 million civil servants—who, along with their families, represent a quarter of the Yemeni population—have only intermittently received a salary, or not received one at all, since 2016. As a result, many Yemenis are simply unable to pay for necessities as prices rise and shortages grow. Basic food prices have nearly doubled, and in some of

the hardest-hit areas, unemployment rates may be as high as 50%.

Lack of Access to Healthcare Services

Approximately 16 million people lack access to basic healthcare, more than half of all government health facilities no longer function and 18% of all districts in Yemen lack physicians. This has led to the cessation of routine medical services in most areas, especially in remote regions, with greatly reduced ability to provide life-saving treatment. The rising cost of medications has also made them inaccessible to most, widening the treatment gap. The most vulnerable populations remain the trauma survivors, abductees and prisoners; the heaviest burdens on these groups include death, disability and impaired psychological health.⁵

The leading cause of the shutdown of healthcare facilities is the non-payment of civil servants' salaries, as well as poor payment from the private sector.⁶ Humanitarian organizations and partners have played an increasing role in providing financial support to pay operating costs for these health facilities, including health worker salaries. The closure of the Sana'a Airport for commercial aircrafts adds to the difficulties for those Yemenis seeking medical treatment abroad.

Displacement

Approximately 3 million people in Yemen are classified as internally displaced—about 11% of Yemen's total population of about 29 million. The destruction of basic infrastructure has resulted in many internally displaced persons (IDPs) selling their properties and using their savings, which has further curbed their opportunity for employment. The largest portion of IDPs are in Hajjah, Taiz, Sa'ada and Sana'a governorates.

Internal displacement is responsible for many confirmed cases of family separation, which can lead to further emotional distress and mental health concerns, as well as significant protection concerns. Approximately three-quarters of IDPs outside of designated hosting sites live in host communities, usually in rented accommodations. This lead to a different set of issues in the long term. Many IDP families find themselves with a large amount of debt due to the rent owed, and host families are placed under a greater burden when sheltering IDPs. About one-quarter of IDPs live in hosting sites, which include dispersed spontaneous settlements, public buildings or collective centers. These locations offer limited services, while protection risks are high.

Though more than 1 million people have returned to their places of origin, they experience difficulties assimilating to normal life after facing the widespread destruction of their assets and property. IDPs are considered among some of Yemen's most vulnerable populations, as long-term displacements result in exacerbated vulnerabilities and

1 <https://news.un.org/en/focus/yemen>

2 2019 Yemen Humanitarian Needs Overview

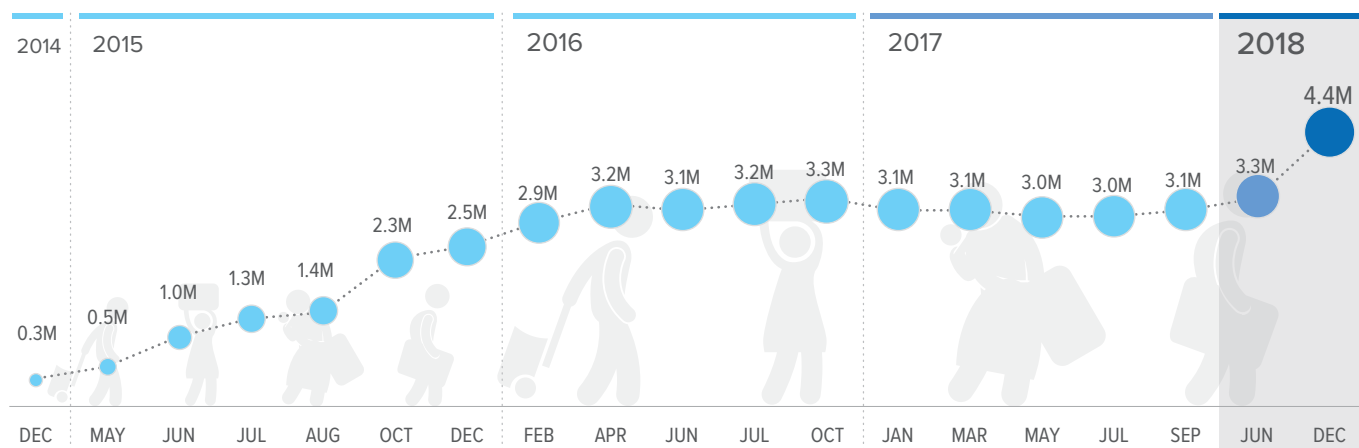
3 2019 Yemen Humanitarian Needs Overview

4 http://applications.emro.who.int/docs/EMROPub_2019_cholera_May_EN_23547.pdf

5 2019 Yemen Humanitarian Needs Overview

6 Ibid

DISPLACEMENT TRENDS (2014 – 2018)



Source: OCHA 2019 Yemen Humanitarian Needs Overview. Taskforce on population movement, Population technical working group, October 2018

decreased resilience, leading to negative coping mechanisms and higher needs.¹ IDP households currently are the most food-insecure, while both IDPs and their hosts are using rapidly dwindling savings to meet their needs in an economy that is collapsing around them.

Marginalized groups have the least access to basic services, often resorting to open farmlands, parks and other public spaces after being refused accommodations elsewhere because of social prejudice. This has further decreased their already limited access to basic healthcare and other services—a step that perpetuates the use of negative coping strategies. The cholera epidemic has disproportionately affected IDPs living in densely crowded areas, those living in poor hygiene conditions and those from marginalized communities.

Protection Risks

The ongoing war and economic blockade of Yemen have left a greater proportion of the population in need of physical and social protection, as civilian casualties continue to grow and basic public services fail to function.² The populations most affected by the widespread fighting and indiscriminate shelling include older persons, children, women, refugees and IDPs. The disabled and the marginalized are thought to be most at risk.³ Those with additional needs have lost many of the service previously provided by the state, including 1.5 million people who no longer receive cash transfers to assist them with providing for basic needs.⁴

As the war grinds on, women and children are at greater risk of violence and exploitation. Increases in GBV have been documented.⁵ Child marriage has become an increasingly common phenomenon, with the documented rate tripling

between 2017 and 2018. According to the UN, as of 2017, there were also 842 verified cases of recruitment and use of children in the conflict, as well as other grave violations such as detention, killing and maiming, and other human rights abuses.⁶

Disruption of Education

Education is another area that has been severely weakened by the conflict. Public education in Yemen effectively ceased to function in 2018 due to the shortage of teachers, who stopped working when their salaries were discontinued. Poverty and malnutrition of the children, the shortage of school supplies and textbooks, and the destruction of many schools during the conflict also have played a role in the shutdown.

Mental Health and Psychosocial Impact of the War

Ongoing war and adversity place affected populations at risk of developing or exacerbating mental health conditions. The latest estimates from WHO indicate that the prevalence of mental disorders in conflict-affected settings is approximately 22%—even higher than previously believed.⁷

An International Medical Corps assessment in 2016 found that the impact of the conflict on mental health could be organized into categories of stress, fear, depression and hopelessness, as well as other more severe mental health conditions. Psychosocial stress can be attributed to many of the factors described above, including conflict, unemployment, food shortages, rising prices with declining or total lack of income, and poor agricultural production. Mental health was found to be both poorly understood and highly stigmatized in Yemen.

1 https://reliefweb.int/sites/reliefweb.int/files/resources/2019_Yemen_HNO_FINAL.pdf

2 Ibid

3 Ibid

4 https://reliefweb.int/sites/reliefweb.int/files/resources/2019_Yemen_HNO_FINAL.pdf

5 <http://www.globalprotectioncluster.org/wp-content/uploads/FINAL-Yemen-HCT-Protection-Strategy-Endorsed-2-Sep-2018-.pdf>

6 <https://childrenandarmedconflict.un.org/where-we-work/yemen/>

7 Charlson et al. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)30934-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30934-1/fulltext)

According to the Yemen Ministry of the Interior, suicide rates between 2014 and 2015 (the first year of the current war) increased by an estimated 40%. A study conducted by the Yemen Children Relief organization found that many children reported increased feelings of anger, fear, anxiety and insecurity. 31% of these children reported such physical symptoms as headaches, chest pain, abdominal pain, fatigue, sleep disorders, panic attacks, bedwetting and difficulty concentrating.¹ Another survey found that nearly 79% of children in Yemen demonstrate signs of serious psychological consequences due to the conflict.^{2,3} The Yemen Humanitarian Needs Overview inter-agency needs assessment from 2018 found that 96% of respondents acknowledged significant changes in the behavior, attitudes and psychosocial wellbeing of both children and caregivers since the start of the conflict.⁴

Substance Use

Within Yemeni society, a plant-based stimulant called *qat* that provides a mild high when chewed, has long been an accepted social and cultural activity. It is often consumed at social gatherings, as well as by those who believe it improves stamina and helps someone stay alert for longer periods of time. While not typically recognized by community members as a drug, many health and mental health professionals categorize it as a substance which can be misused. Extensive literature highlights that habitual use can have adverse effects on mental, physical and social wellbeing.

Considerable time and money go toward buying and chewing *qat*, which can therefore limit time spent at work as well as with loved ones, and potentially can lead to marital and family conflicts. For some, the daily cost of *qat* may exceed expenditure on food for themselves and their families. Furthermore, at the end of a *qat* session, the user may sink into a depressive mood characterized by irritability, loss of appetite and sleep difficulties. It also carries a hangover effect in which lethargy can follow the next morning. In some cases, *qat* chewing can induce symptoms of psychosis, which can rapidly disappear when chewing is discontinued.⁵

3.2 Mental Health Policies and Strategies in Yemen

The National Mental Health Program was launched by the Ministry of Health in the 1980s with the assistance of WHO. This later resulted in a National Mental Health Strategy⁶ developed in 2010 with key objectives for 2011–2015 that aimed to:

- Enhance the capability of the National Mental Health Program
- Integrate mental health into primary care services
- Further decentralize and strengthen secondary mental health care system
- Strengthen links between primary and specialist care
- Ensure basic supply of medications for PHCs, regional psychiatric clinics and inpatient units
- Provide practice guidelines for PHCs, regional psychiatric clinics and inpatient units
- Create communications channels between health, education, higher education, social development, human rights, *auqaf*, media, youth, legislation, planning, justice, police and prisons, NGOs, etc., at national, governorate/regional and district levels
- Support and establish psychological counseling centers in the universities and local communities
- Mobilize the community through media, information for families and NGOs, and health education in schools

The four-year strategy was adopted by the Ministry of Health, but was neither prioritized nor funded and was discontinued once the conflict began.⁸

A Mental Health Act was drafted in 2004 but never approved by the Yemeni Parliament. The revisions to this document resulted in a Mental Health Bill drafted in 2007, which aimed to regulate mental health service provision in Yemen; however, this document also was never approved by the Yemeni Parliament.⁹ As a result of this, no specific mental health plan currently exists in Yemen, legal provisions covering mental health are not mentioned in any other laws or legislations, and there is no available data for Yemeni government expenditure on mental health care.¹⁰

A mental health and psychosocial support plan of action for Yemen was developed by WHO in 2019 that identified priorities for MHPSS training, capacity building, service delivery, awareness-raising and budgetary needs. Efforts are ongoing to secure funding.

3.3 Mental Health Work Force and Associations

As of 2017, there were a total of 40 psychiatrists available in Yemen to serve a population of about 28 million. There are

1 <http://sanaacenter.org/publications/analysis/5119>

2 <https://reliefweb.int/report/yemen/mental-health-yemen-save-children-speaks-children-survived-august-bus-attack>

3 https://carpo-bonn.org/wp-content/uploads/2018/03/10_carpo_brief_final.pdf

4 Humanitarian Needs Overview

5 International Medical Corps 2014 MHPSS Assessment (internal report)

6 Yemen Ministry of Health and Population (2010). National Mental Health Strategy: 2011–2015 <http://sfd.sfd-yemen.org/uploads/issues/health%20english-20121015-132757.pdf>

7 Arabic word that refers to the main regulatory and management body of religious affairs within a country

8 The Impact of War on Mental Health in Yemen

9 Ibid

10 WHO MH Atlas 2017. https://www.who.int/mental_health/evidence/atlas/profiles-2017/YEM.pdf?ua=1

no current figures for the number of psychologists, social workers, other health workers or occupational therapists. According to surveys conducted by the Yemeni Mental Health Association (2002–2006), 3,580 individuals held at least a BA in psychology, with 159 holding a Master's degree and 51 holding a PhD.¹ Though a clinical psychology training program existed at one point at a psychiatric hospital in Sana'a, it has been discontinued. There is also no mental health training or specialization for social workers. Though government health regulations do allow nurses to diagnose and treat mental health disorders within a primary care environment, neither doctors nor nurses are allowed to prescribe or continue prescription of psychotropic medications.

There are four psychiatric hospitals in Yemen that treat mental disorders, specifically for adults.² As of the WHO 2015–2016 report, they include Sana'a's Al Amal Hospital (232 beds), Aden Hospital (150 beds), Hudaida Hospital (120 beds) and Taiz Hospital (200 beds). Additionally, Sana'a Thoura Hospital's mental health unit is identified (23 beds).

In accordance with WHO directives, outpatient mental health clinics have been established in some public hospitals, but are not widespread and can be subject to termination due to budget constraints or staff shortages. There are also about 45 private mental health clinics in Yemen that are run by psychiatrists and that offer psychiatric medications and electroconvulsive therapy as common treatments. Of significance, there are no specialized hospitals or clinics for children.³ Additionally, there is a lack of specialized care for other populations, such as teenagers, older persons and those suffering from chronic conditions and addiction.⁴

Universities offer degrees in psychiatry and medical psychology. Activities under these degrees include teaching, examination and lecturing, but do not include research or service opportunities due to the community stigma associated with such work. A lack of resources and other limitations, including a shortage of trained clinical specialists, also play a role.

The Yemeni Council for Medical Specialization, part of the Ministry of Health, has run academic programs in clinical psychology and psychiatry since 2003.⁵ Though the extent of mental health service training provided to primary care physicians remains unclear, manuals on the diagnosis and treatment of mental disorders may be available in primary care clinics, as well as guidance on referrals to secondary and tertiary care.

There were various mental health associations that existed before the war, such as the Yemeni Mental Health Association (which had a telephone hotline for psychological aid), the

Yemen Psychological Association and the Yemeni Psychiatric and Neurological Association, but our inquiries have led us to believe that these associations discontinued their work once the conflict began.

3.4 Challenges to Providing Appropriate Mental Health and Psychosocial Support Services

The lack of mental health care in Yemen has also been attributed to the lack of funding and/or interest from humanitarian organizations, the dearth of mental health professionals and the deeply entrenched social stigma around mental illness. Furthermore, mental health services are expensive—the vast majority of people requiring treatment and medications pay out of pocket,⁶ and the dire economic situation means it often is unaffordable to most Yemeni families.

“Mental health issues in Yemen have largely been neglected by both domestic authorities and the international community.”

– *The Impact of War on Mental Health in Yemen: A Neglected Crisis*
Sana'a Center for Strategic Studies

Socialization and the collectivist nature of Yemeni culture are also key in understanding identity and help-seeking behaviors. As one Yemeni man summarized in a phenomenological study on help-seeking, “You are not safe to share your emotions and difficulties. Actually, you feel bad to tell others that you're suffering from a problem. From the time I was small, I was brought up ‘to be a man’. You have to be strong to carry this responsibility and no one has to know your weaknesses. Otherwise, people will say you are not a man.” Grey literature reviews corroborate the notion that individuals often will not seek help regarding emotional distress or mental health concerns.

Some community members believe that mental health needs indicate the presence of a jinn inside them, prompting them to go to sheikhs to cure them of this. Some lack knowledge and awareness about the causes and symptoms of mental illness, believe that only those who are “crazy” seek psychiatric treatment or prefer traditional treatments to mainstream medical care. Due to these stigmas, many of those who exhibit symptoms often avoid seeking treatment.⁸

Finally, there are ongoing challenges pertaining to humanitarian access and security.

1 Maan A. Bari Qasem Saleh (2008). “Psychology in Yemen.” <https://www.apa.org/international/pi/2008/05/yemen>

2 <https://www.cambridge.org/core/services/aop-cambridge-core/content/view/2F6080907180CF8B9BE1296B6C9D0360/S1749367600002277a.pdf/div-class-title-mental-health-in-yemen-obstacles-and-challenges-div.pdf>

3 Ibid

4 The Impact of War on Mental Health in Yemen

5 Ibid

6 WHO 2017 Mental Health Atlas

7 Conn, Sarah Elizabeth Sharon (2016). *A phenomenological study of help seeking behaviours and coping strategies of international students of non-European backgrounds*. DProf thesis, Middlesex University. Available at: http://eprints.mdx.ac.uk/21172/6/SConnThesis_UCCarticleremoved.pdf

8 <https://nationalyemen.com/2015/04/04/mental-illness-in-the-streets-is-a-tragedy-especially-for-women/>



SECTION 4

Assessment Results

4.1 Current Problems and Stressors Among the Affected Population

GENERALLY

- **Poverty and lack of employment:** extremely limited and diminishing financial resources; inability to work or earn income; loss of agriculture due to displacement, armed conflict, drought; rising prices make it difficult to meet basic needs
- **Lack of access to basic needs:** severely limited or no access to clean drinking water, food, medication, fuel for transportation
- **Burden of caring for multiple family members:** feeling overwhelmed by trying to provide and care for an entire family when facing significant economic challenges
- **Loss, bereavement, and grief:** including traumatic loss
- **Barriers to proper grieving when a loved one dies:** economic insecurity and lack of money often prevents individuals from ensuring that traditional rituals are conducted or from being with loved ones during times of bereavement
- **Displacement and safety concerns:** difficult living conditions lead to distress and family separation; safety concerns result in the carrying of weapons
- **Greater family stress and conflict:** increased conflict between spouses and with children

- **Protection risks:** higher rates of domestic violence and other forms of GBV, and abuse and exploitation of children
- **Sense of abandonment:** feeling as if there is no sense of community, that everyone fend for themselves

"Because there is no hope, there is no future."

– Male, Al Radeah

Identified Signs of Mental Health and Psychosocial Distress

- **Despair and depressed mood:** sadness, hopelessness; thinking too much; insomnia; feeling tired on psychological and physical levels; decreased self-care
- **Anxiety/worry:** caused by fear as well as uncertainty about the future; no peace of mind
- **Fear:** a pervasive sense of concern and discomfort regarding personal safety and the safety of loved ones
- **Isolation:** not participating in the community; not leaving the house or experiencing a sharp decline of contact with others
- **Anger:** irritable; losing temper; highly stressed
- **Violent behavior:** taking out anger in violent ways, often toward loved ones (e.g., men being violent toward wives and/or children; women being violent toward children)
- **"Madness"/psychosis**

WOMEN

- **Special considerations for women who no longer have husbands for support:** needs for widows and those separated from their husbands, whom they relied on for support, protection and income
- **Challenges of supporting family members** during difficult circumstances; worry about children's wellbeing
- **Financial stressors:** need for employment or income-generating opportunities, to be able to provide for family

"My daughter died at the age of 18. She was sick, and I had no money to help her. On the way to the hospital, she died. I came back to the village, dug the grave and buried her. Nobody could save her until she died."

– Female, Maqbah

Additional Signs of Mental Health and Psychosocial Distress

- **Isolation:** remains in the house; not friendly to neighbors
- **Crying**
- **Aggression:** beats children; screams
- **Less attention to appearance and self-care**

"Usually I don't find food for me and my children; therefore, my children cry of hunger, and I give them bread and tea, and I tell them 'That is what I can give you.' There is not any other food. In some times we don't find even bread and tea."

– Female, Maqbah

MEN

- **Financial stressors:** need for employment or income-generating opportunities to be able to provide for their family
- **Burden of not being able to provide for family:** sense of helplessness and frustration at the inability to support their family and fulfill their role as the head of household

"We are desperate without jobs, without money; we don't have anything."

– Man, Wadi al Ajbar

Additional Signs of Mental Health and Psychosocial Distress

- **Aggression:** violent behavior; quick to fight; trouble with wife/family; beats children
- **Change in sleeping habits:** difficulty sleeping, or sleeping more than usual
- **Difficulty concentrating:** lack of focus in discussions; consumed with thoughts
- **Substance use:** excessive use of *qat*

CHILDREN

- **Education-related concerns:** diminished interest among children in attending school, and difficulties concentrating on studies; severe shortage of teachers and the declining ability of parents to convince their children to go to school
- **Children's play has changed:** Play becomes more aggressive and mimics war; children may carry real or pretend weapons; parental security concerns prevent children from playing outside; lack of money prevents the purchase of toys or games
- **Children joining the army or carrying weapons:** concern for children being told to drop out of school to join the army

Identified Signs of Mental Health and Psychosocial Distress

- **Acting out:** disobeying and not listening to parents; shouting; lying
- **Aggressive behavior:** fighting often with others (neighbors, friends), especially among boys
- **Internalizing behavior:** quiet or talking less; social withdrawal, isolation
- **Fear and crying:** especially when linked with the sounds of shelling

"The child is not a child anymore."

– Female, Bani Hamoud

4.2 Conceptualization of Wellbeing, Emotional Distress, and Mental Disorders

There are significant cultural considerations that contribute to how wellbeing, distress and mental disorders are understood, discussed and addressed in Yemen. Some key informants described how Yemeni culture is very collectivist (where identity is linked to tribal affiliations), adding that wellness is linked to the “we” and individuals are often not socialized to focus on or prioritize the “me.” This outlook may influence help-seeking behaviors.

Additionally, there is widespread stigmatization surrounding mental disorders, often linked to a belief that they are

punishment for wrongdoing or not being pious enough. Some explanatory models for mental disorders are linked to traditional and religious practices, rather than scientific understanding of the reasons for such disorders.

Coping with distress

Participants in focus group discussions were asked to identify the various ways they cope with difficulties they faced, as well as their current ability to practice these coping strategies, and any challenges faced. Participants were also asked what might help support their coping abilities. We should note that there is no direct translation for the word “coping.” Participants were instead asked how they “adapt” to these challenges.

GENERALLY

Traditionally	Current Ability or Challenges in Using this Coping Method	Requested Support for Coping
Talking with and supporting others, especially in groups; visiting with neighbors and participating in the community	Limited; feeling that there is no support and that everyone is looking out for themselves	
Religion/prayer; reading from the Qu’ran	Possible	
Going to a sheikh or traditional healer	Limited; lack of transportation prohibits this	Ability to receive psychological support and medications
Activities to occupy time, e.g., watching TV, listening to the radio, sewing	None; high price of fuel; stress to provide for family override the ability to relax with recreational activities	Having employment; having basic needs met
Educational and vocational opportunities	Very limited opportunities	Would like such opportunities
Chewing <i>qat</i>	Ongoing use, despite financial challenges	

AMONG WOMEN

Traditionally	Current Ability or Challenges in Using this Coping Method	Requested Support for Coping
Family and household duties—caring for children and husband	Limited; difficult to provide basic needs for family and few employment opportunities; increased conflict with family due to stress	Having sources of employment; providing food, medicine, other basic needs
Visiting neighbors/family; participating in the community	Not possible; limited transportation; most looking out for themselves	

AMONG MEN

Traditionally	Current Ability or Challenges in Using this Coping Method	Requested Support for Coping
Working; doing something of value; ability to provide for family	Not possible; no income-generating opportunities; no cash assistance	Request for employment and/or cash assistance
Social solidarity/support	Not possible; limited transportation; most looking out for themselves	

AMONG CHILDREN

Traditionally	Current Ability or Challenges in Using this Coping Method	Requested Support for Coping
Basic needs met	Limited food, water, medication, psychological support	Money for families to provide the basic necessities; training for families to be able to provide support to their children
Playing, singing, recreational activities	Limited; games and toys are expensive and many families are not able to provide these; few safe spaces for children to play	Having safe spaces for children to play; toys, games
Going to school (education, structure, rules and values)	Limited; few opportunities for children to attend school due to lack of money, teachers and transportation; children leaving school to work; children leaving school to join the army	Would like for this to be possible again for children

Community Treatment of Individuals with Mental Disorders

Community members expressed the following views in treatment of men and women with mental disorders:

- Women with mental disorders are generally thought to be treated with more compassion and receive more support, while men are more likely expected to be able to help themselves.
- Women with mental disorders are believed to be more likely confined to the house, while men with mental disorders are thought to either be referred for treatment or put on the streets.

At-Risk Community Members

In addition to the risks identified above that community members face, the following people in the community have been identified to be particularly at-risk:

- Children, especially due to limited coping mechanisms, lack of educational opportunities, the fact they are

more likely now to carry weapons or join the army at a young age. So-called street children are especially at risk.

- Older people.
- Marginalized groups, including the Al Akhdam minority group and refugees.

4.3 Delivery of Mental Health Services

There is a critical lack of mental health services throughout the country, with existing services highly centralized at the secondary healthcare level—either psychiatric hospitals or psychiatric units of general hospitals.

Primary healthcare centers are woefully unprepared to offer any type of MHPSS support. The results of the assessment of 71 health facilities across the country found that only 10% had staff trained on the identification or treatment of mental disorders. Furthermore, 75% of health facilities reported that they never have had WHO essential psychotropic medications available; 24% reported that they sometimes

had some essential medications, while never having others; and only psychiatric units or general hospitals reported sometimes having essential medications. Notably, not a single assessed facility reported usually having all essential medications.

Furthermore, none of the health staff interviewed across all 71 facilities could identify any local or international organization providing mental health or psychosocial support services aside from the Yemeni Ministry of Population and Public Health (MoPHP) psychiatric treatment centers. Because these few centers are located in urban areas, there is a significant barrier to accessing services for those living in rural areas. For facilities in the south, the closest referral point could be between 50 to 300 kilometers away (with the average distance greater than 100 km away); for facilities in the north, this could be within 25 to 150 km away (with an average of less than 50 km away).

Linked to all of this is the shortage of skilled mental health specialists. According to the Head of the Mental Health Department at the MoPHP, there are approximately 40 psychiatrists currently practicing in all of Yemen, a total close to the last data cited by the 2016 WHO Mental Health Atlas.

4.4 MHPSS Coordination and Actors

Over the past five years, there have been dedicated efforts by the Health and Protection clusters to operationalize an MHPSS Technical Working Group (TWG) for MHPSS actors in Yemen. In May 2018, an initial taskforce meeting of key actors was convened, which developed a terms of reference for the group that was finalized in November 2018.

The objectives of the TWG are to:

- ensure an effective, coordinated and focused inter-agency response, provide ongoing strategic direction, promote adherence to standards of best practice and global interagency recommendations, and develop relevant guidelines or tools for MHPSS sectors when needed;
- strengthen the safe and ethical collation, analysis and transparent sharing of data and information pertaining to MHPSS needs, priorities and activities in Yemen, including gap identification;
- inform inter-agency efforts and planning by highlighting key MHPSS issues, collectively representing the TWG interests and perspectives, and advocating for MHPSS needs and priorities;
- ensure that quality standards are upheld by actors working in the MHPSS sector, maintaining equity in coverage; and

- coordinate the planning and implementation of joint initiatives, including training and capacity-building activities; promote the engagement and leadership of the government; and encourage the representation of diverse MHPSS partners and stakeholders within the TWG, including the government, UN agencies, and international and local NGOs.

In 2018, a 4Ws MHPSS Service Mapping was completed by the MHPSS Technical Working Group.¹ Of note, the vast majority of services identified were offering various types of psychosocial support services. There is a pronounced dearth of specialized mental health services available throughout the country.

In February 2019, mental health-focused organizations in the country formed the Mental Health Core Group to coordinate and harmonize mental health assessments and interventions.

¹ To obtain a copy of the mapping, contact Hussam Alhakimi at h.alhakimi@hi.org



SECTION 5

Summary and Recommendations

Global standards outlined in the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) include recommendations on different levels of mental health and psychosocial interventions using a pyramid approach, with basic needs and social considerations at

the foundation, and increasingly advanced mental health services moving upwards. The following recommendations are made to address the various MHPSS needs and gaps identified in Yemen pertaining to the humanitarian response, and to enhance the quality and comprehensiveness of MHPSS services.



5.1 Advocate for a significant increase in MHPSS programming, awareness-raising and dedicated investment from donors, to address the severe shortage of MHPSS services and actors throughout the country.

- ▶ Advocacy is needed at every level, from the national ministerial level and national actors, to international organizations and various donors funding the humanitarian response in Yemen.
 - [See](#) *IASC 2011 MHPSS Advocacy Package*
 - [See](#) *WHO 2003 Investing in Mental Health*

5.2 Train first responders in Psychological First Aid.

- ▶ IASC MHPSS Guidelines recommend training for first responders in Psychological First Aid to ensure that they have the appropriate skills to provide basic support to those affected by adversity, are able to communicate effectively, can connect people to needed services, and practice self-care.
 - [See](#) *Psychological First Aid: Facilitator's Manual*
 - [See](#) *Psychological First Aid Guide for Field Workers*

5.3 Prioritize community awareness-raising on wellbeing, emotional distress and mental health conditions to promote community knowledge and address stigma.

- ▶ **Develop and disseminate MHPSS-related information, education and communication materials**, such as materials on stress responses following distressing events, as well as on positive coping mechanisms.
 - [See](#) *IASC Guidelines Action Sheet 8.2 on providing access to information about positive coping methods*.
- ▶ **Engage local leaders, religious figures and traditional healers** to explore collaboration for awareness-raising and anti-stigma campaigns.
- ▶ **Further explore knowledge, attitudes and practices** on mental health and mental disorders at various levels of the community, from health staff to local leaders, religious figures and traditional healers, building on preliminary findings from this report.
- ▶ **Support the creation of a group of mental health service users** who, as individuals with lived experiences, could promote awareness-raising and advocacy for mental health services.

5.4 Conduct workshops on IASC MHPSS Guidelines for MHPSS in Emergency Settings.

- ▶ Ensure that all actors are aware of global guidelines and best practices for providing MHPSS services.

5.5 Urgently address the treatment gap in providing mental health care services.

- ▶ In consideration of the dearth of specialized mental health services, **integrate mental health into the primary healthcare system**. WHO advocates that every primary healthcare center should have at least one health professional trained in how to identify and manage mental disorders. Mental health integration is part of the national strategy in Yemen that has yet to be implemented.
 - [See](#) *WHO Mental Health Gap Action Program (mhGAP)—Humanitarian Intervention Guide (HIG)*, and [see](#) *accompanying mhGAP Operations Manual*
 - [See](#) *International Medical Corps' Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings*
- ▶ Given the lack of trained psychologists, **invest in training and supervising non-specialists in evidence-based, scalable psychological interventions such as WHO materials**, so they can safely deliver a basic level of psychological support.
- ▶ **Support the Ministry of Health and Population** in efforts to implement the National Mental Health Strategy, and ensure that the work of various mental health actors is conducted in line with existing national mental health policies and plans.
- ▶ **Invest in the education and clinical training and supervision of psychologists and psychiatrists**, to enable them to better deliver comprehensive and specialized mental health services.
- ▶ Advocate for **decentralization of mental health care, and for improved availability and accessibility of psychotropic medications**.
 - [See](#) *WHO Essential Medicines List for adults and children*
- ▶ Review the national health policy stipulation regarding authorization for doctors and nurses to prescribe or continue prescription of psychotropic medications, **advocating for mhGAP-trained and supervised health professionals to be given the right to prescribe**, as part of efforts to address the treatment gap.

5.6 Ensure that MHPSS programs include activities promoting community cohesion and social support. Given the collectivist nature of Yemeni society, there should be an emphasis on promoting community cohesion and social support, as well as fostering traditional mechanisms of coping and resilience on individual, family and community levels.

- ▶ Through MHPSS coordination mechanisms, encourage actors in each camp or urban setting to **develop community- and group-based activities** that could establish or strengthen social support. This could include community centers, group-based initiatives centered on activities, and self-help and support groups facilitated by trained MHPSS professionals, as well as educational and vocational training opportunities.
 - [See](#) *IASC Guidelines Action Sheet 5.2 on facilitating community self-help and social support*

5.7 Establish and strengthen referral pathways, based on the MHPSS 4Ws service mapping, between humanitarian actors to promote community access to comprehensive services spanning mental health and psychosocial support, health, protection and social services.

- ▶ Ensure continued MHPSS representation at Health and Protection Coordination Group meetings, and sharing of mapping and referral policies and procedures.

5.8 Integrate MHPSS into additional areas of programming, as a cross-cutting theme:

- ▶ **Integration of MHPSS into protection programs.** As gender-based violence was reported as a significant concern by focus group participants and key informants, ensure that MHPSS staff are trained on best practices for supporting GBV survivors and for making referrals for protection services in collaboration with protection actors. Ensure that GBV actors are trained on Psychological First Aid, and on the identification and referral of mental health cases.
 - [See](#) *IASC Guidelines on Integrating Gender-Based Violence Interventions in Humanitarian Action*
 - [See](#) *WHO Mental Health and Psychosocial Support for Conflict-Related Sexual Violence: Principles and Interventions*

- ▶ **Integration of MHPSS into nutrition programs** (e.g., infant and young-child feeding programs, early childhood development programs), to promote strengthened bonding of caregivers and babies, healthy children's development and improved wellbeing of caregivers.
 - [See](#) *Save the Children and UNHCR Infant and Young Child Feeding in Refugee Situations: A Multi-Sectoral Framework for Action*
 - [See](#) *Interagency guidance note on Integrating Early Childhood Development Activities into Nutrition Programs in Emergencies*
 - [See](#) *WHO Mental Health and Psychosocial Wellbeing Among Children in Severe Food Shortage Situations*

5.9 Advocate for dedicated programming and professionals to support children's wellbeing.

- ▶ **Invest in the education and training of professionals in child psychology and psychiatry**, given the lack of specialists and the critical need for qualified professionals to offer advanced mental health services.
- ▶ MHPSS actors should **review best practices of disarmament, demobilization and reintegration (DDR) programs** that have previously been implemented, to determine the universality of best practices in identifying and meeting the needs of former child soldiers, such as the **promotion of psychosocial adjustment and social reintegration and the need for holistic, integrated systems of care for all war-affected youth**.¹
- ▶ Additional efforts will be needed to ensure the **contextual and cultural adaptation of recommended programming** in Yemen, as well as for securing the funding and support required for such initiatives.

1 Psychology Beyond Borders (2008). "Psychosocial Adjustment and Social Reintegration of Children Associated with Armed Forces and Armed Groups: The State of the Field and Future Directions." https://www.essex.ac.uk/armedcon/story_id/CAAFAG.pdf



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