Integration of Mental Health and Psychosocial Support in Primary Health Care

for Children, Adolescents, Pregnant Women and New Mothers in the Middle East and North Africa Region

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Kuwait Country Report 2023

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Acronyms and abbreviations

ADHD	attention deficit hyperactivity disorder
EMRO	Eastern Mediterranean Regional Office (WHO)
GDCE	General Department of Criminal Evidence
HIV	human immunodeficiency virus
KALD	The Kuwaiti Association for Learning Differences
KCMH	Kuwait Center for Mental Health
MENA	Middle East and North Africa
MENARO	Middle East and North Africa Regional Office (UNICEF)
MHPSS	mental health and psychosocial support
MOE	Ministry of Education
MOH	Ministry of Health
MOSA	Ministry of Social Affairs
NGO	non-governmental organization
PHC	primary health care
SCPD	Supreme Council for Planning and Development
SDGs	Sustainable Development Goals
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Acknowledgments

This multi-country implementation research titled "Establishing the Foundations for Integration of Mental Health and Psychosocial Support (MHPSS) in Primary Health Care for Children, Adolescents and Maternal Mental Health" falls under the WHO-UNICEF Joint Programme on Mental Health and Psychosocial Wellbeing and Development of Children and Adolescents.

UNICEF Middle East and North Africa Regional Office (MENARO), as the lead partner in collaboration with WHO Eastern Mediterranean Regional Office (EMRO), embarked on this implementation research to contribute to a deeper understanding of the MHPSS needs of children, adolescents and mothers. This research also serves to examine the available services and critical gaps across the promotion, prevention, and care and treatment interventions within primary health care (PHC), as well as its linkages to social welfare, child protection and the education sector.

The six-country regional implementation research was jointly led by UNICEF MENARO, Burnet Institute and WHO EMRO. Facilitation and coordination with country offices and the Regional Technical Advisory Group was provided by Shirley Mark Prabhu, UNICEF MENARO, the lead focal point for this research. Dr. Elissa Kennedy and Mikka Coppard, Burnet Institute, provided overall technical oversight and support to the country teams. Dr. Khalid Saeed, EMRO, provided technical support and coordination with the WHO country offices.

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The Kuwait study was implemented by Sarah Alkandari of Dasman Diabetes Institute founded by the Kuwait Foundation for the Advancement of Sciences and was overseen by Saji Thomas and Sheku Golfa, UNICEF Gulf Area Office, in coordination with the Ministry of Health, Ministry of Social Affairs, Ministry of Education, Public Authority for Disability and the Supreme Council for Planning and Development.

The study team comprised of:

National team

The authors would like to acknowledge the valuable contributions of the Country Technical Advisory Group and the Regional Technical Advisory Group for the conceptual framework, methodology, interpretation of findings and review of reports.

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Executive summary

This implementation research was facilitated by researchers of Dasman Diabetes Institute of Kuwait in collaboration with the Ministry of Health (MOH) of Kuwait and the United Nations Children's Fund (UNICEF) as part of an established six-country study entitled "Establishing the foundations for integration of mental health and psychological support in primary health care (PHC) for children and adolescents in the Middle East and North Africa region".

Kuwait's New Kuwait 2035 vision has been developed in line with the suggestions of the United Nations Sustainable Development Goals (SDGs), with the aim of achieving national development compatible with international development. New Kuwait 2035 aims to direct Kuwait into becoming a financial and trade hub within the Arabian Gulf Region. The initiation of New Kuwait 2035 was developed based on the vision of His Highness the former Amir of Kuwait Sheikh Sabah Al-Ahmed Al-Jaber Al-Sabah.

SDG target 3.4 is for non-communicable diseases and mental health: "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being". The World Health Organization (WHO) promotes the delivery of mental health and psychosocial support (MHPSS) within the primary care setting.

This research examined the gaps in delivery of MHPSS in primary care services of MOH for children, adolescents, pregnant women and new mothers. Currently, there are no provisions within PHC for these services, and so there is a significant gap in the MHPSS workforce at the PHC level and within MOH as a whole. There is also a lack of cross-sector coordination of MHPSS care.

A MHPSS care plan needs to be developed. This includes policies and procedures for screening, diagnosis and treatment of common MHPSS conditions that present in children, adolescents, pregnant women and new mothers. The Ministry of Education (MOE) operates an independent psychology and psychiatry clinic within its own facilities offering care to governmental school-aged children and adolescents. This clinic is operated by seconded MOH staff, but there is no link with PHC. School health is an underused avenue for bridging the gap, and it can play a significant role in the coordination and implementation of MHPSS for school-aged children.

It is important that MOH and PHC administrations develop a task force to address the gaps and recommendations for implementation presented in this report to provide MHPSS to children, adolescents, pregnant women and new mothers. It is strongly recommended that there be a collaborative effort between MOH and its School Health Department, along with other governmental ministries such as MOE, the Ministry of Social Affairs (MOSA), the Public Authority for Disability and non-governmental organizations (NGOs). One key recommendation is the development of a national mental health strategy along with a centralized national MHPSS working group. This will be a useful tool to direct the development of the MHPSS system.

1. Introduction

The mental health of children and adolescents aged 0–18 years is one of the most neglected health issues globally. Before COVID-19, the World Health Organization (WHO) estimated that 10–20 per cent of children and adolescents worldwide experienced poor mental health, with half of mental disorders beginning by age 14.[1] In the Middle East and North Africa (MENA) region, around 1 in 6 adolescents aged 10–19 years are estimated to be living with a mental disorder, with suicide a leading cause of death of 15–19-year-olds.[2] Additionally, many more children and adolescents experience psychological distress that may not meet diagnostic criteria for mental disorder but has significant impacts on their health, development and well-being.

Poor mental health can have profound impacts on children's and adolescents' health, learning, social well-being and participation, limiting opportunities for them to reach their full potential. This age group encompasses a time of critical brain growth and development. It is the time when social, emotional and cognitive skills are formed, laying the foundation for mental health and well-being into adulthood.[3] In addition to mental disorders arising during this age, many risk factors for future poor mental health also typically have their onset in this developmental stage.[4, 5] In the MENA region, exposure to conflict and violence, displacement and the impacts of the COVID-19 pandemic are likely to be significant contributors to poor mental health.[6, 7]

Despite this significant burden, there is a substantial unmet need for MHPSS for children and adolescents. Globally, government expenditure on mental health accounts for only 2 per cent of the total health expenditure,[8] despite accounting for 7 per cent of the total burden of disease.[9] In low- and middle-income countries, the estimated ratio of mental health specialists with expertise in treating children and adolescents is <0.5 per 100,000 people, and there are fewer than two outpatient facilities for child and adolescent mental health per 100,000 people.[8] These constraints have also been described in the MENA region.[10]

There are also many gaps and missed opportunities to prevent poor mental health and promote well-being. Approaches are often fragmented and small-scale. In addition to inadequate human and financial resources, lack of coordination between sectors (including health, child protection and education sectors) and substantial stigma remain significant barriers to ensuring children, adolescents and their families have access to quality services and support.[2, 11] Additionally, many efforts have been focused on humanitarian settings, with less attention given to addressing child and adolescent mental health and well-being in non-emergency contexts.

Addressing child and adolescent mental health and well-being requires a tiered response. This response should include:

- services and supports to ensure responsive care for mental health conditions,
- preventive interventions to address risk factors and enhance protective factors, and
- actions to ensure safe and enabling environments that promote mental health and psychosocial well-being.

Additionally, there is a need to support the mental health and well-being of parents and carers, including mental health for pregnant and new mothers, to address the significant burden of poor maternal mental health and its impacts on child health and development.[15]

This tiered and multisector approach is at the core of global MHPSS guidance, including UNICEF's Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings,[12, 13] and the Operational Guidelines on Community-Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered support for children and families.[14]

While a comprehensive package of MHPSS requires coordinated action delivered by multiple sectors, the health sector (particularly PHC) provides a critical platform for identifying and responding to mental health needs, delivery of key interventions to address risk factors, and engagement with communities and families to support health promotion and mental health literacy.

Since 1975, WHO has advocated for the integration of mental health care into primary care, shifting from the over-reliance on highly specialized and institution-based services. Most mental health conditions can be effectively diagnosed and managed by non-specialist providers through primary care, and these services are also likely to be more accessible, affordable and acceptable to children and their families, less stigmatising, and have greater capacity to provide person-centred care and support.[16, 17] There are also critical opportunities to identify and address risk factors (such as exposure to family violence) and integrate mental health promotion.

The need to strengthen primary and community-based mental health care has also been emphasized in the WHO Mental Health Action Plan,[18] UNICEF's Global Multisectoral Operational Framework,[13] and Scaling up mental health care: A framework for action for the Eastern Mediterranean region.[19] Despite this, effective integration of mental health into PHC remains an unrealized goal in many countries and contributes to significant unmet need for services. Common challenges globally include:

- insufficient training and support for primary-level health providers,
- high caseloads and time constraints,
- inadequate coordination and referral with specialized services,
- insufficient financial resources, and
- lack of clear guidance and protocols for integration of MHPSS into primary care services (including maternal and child health care).[17]

Kuwait is a major supplier of crude oil, holding 7 per cent of global reserves.[20] Oil export accounts for nearly half of the country's Gross Domestic Product, around 95 per cent of exports and approximately 90 per cent of government export revenue. Since the nationalization of the oil industry in 1975, Kuwait has seen significant economic growth. Kuwait's population is 4.25 million, with 32.59 per cent being Kuwaiti citizens.[21] Twenty-five per cent of Kuwaiti citizens are younger than 15 years of age.[22] Literacy rate among nationals is at 95 per cent, and there is very high access to sanitation facilities and clean water.[23] Kuwait provides all citizens with state-funded health care, education, retirement income, marriage grants, housing, food subsidies and guaranteed employment. State-funded health care is provided and managed by MOH. The federal government provides subsidized health care to non-nationals through a national health insurance scheme.

There are PHC centres and specialized governmental hospitals dispersed within the six governates. Over the past 10 years, Kuwait has invested significantly into the state health care sector, with new governmental hospitals being built and extensive renovations done on existing infrastructure. There is a robust and expanding public health care sector. Private employers provide health insurance, but this does not include mental health services.

Between 2010 and 2014, MOH spending on health care grew by 67 per cent, which is triple the growth of the period between 2008 and 2014.[24]. The World Bank found that in 2017, the state was responsible for 82.5 per cent of health care expenditure, and 15.8 per cent of private health care expenditure.[25] The state government spends a significant amount on financing health care treatments of citizens abroad (through MOH, the Ministry of Defense and the Kuwait National Petroleum Company). MOH focuses its health care delivery on responsive health care, which accounts for 85 per cent of governmental health care spending. There is a lack of preventive health care and health promotion.[23]

The prevalence of non-communicable diseases is growing in Kuwait, and as a result the health of Kuwaiti citizens is declining. The life expectancy decreased from 77.7 years in 2011 to 74.6 years in 2015.[26]

Mental health care for adults has already been integrated into the PHC setting. Family medicine practitioners have been trained to deliver MHPSS care. However, care is not provided to children, adolescents, pregnant women or new mothers. Currently the PHC administration is working through its Mental Health Committee and Committee for Children and Adolescents Health to develop policies and protocols aimed at integration of MHPSS for children and adolescents.

Kuwait is a high-income country with the capacity to provide adequate MHPSS to all residents. The national MOH expenditure on MHPSS is unclear. The main challenges are a lack of health care policy makers dedicated to MHPSS within MOH and bureaucratic hurdles.

2. Aim, objectives and approach

2.1. Aim

The **aim** of this project was to understand how MHPSS for children, adolescents and mothers can be effectively integrated and delivered through PHC in MENA.

2.2. Objectives

The specific **objectives** were to:

- **In 20 countries in MENA[1] (regional analysis):**
  - Synthesize available national-level and comparable data to describe the mental health needs (outcomes and risks) of children and adolescents aged 0–18 years, pregnant women and new mothers.
  - Review national mental health policies and plans to identify the current (or potential) roles and responsibilities for PHC in delivering MHPSS for children, adolescents and mothers (mapped against global and regional MHPSS frameworks).
- **In six focal countries (country-level analysis):**
  - Explore current challenges and opportunities to strengthen integration and delivery of MHPSS in PHC (including maternal and child health).
  - Identify the structural and systems supports, and capacity-building steps, required for implementation of MHPSS in PHC through a systems-strengthening lens.
  - Explore linkages between PHC and other key sectors (including child protection and education) needed to support MHPSS.

This report presents the findings for the country-level analysis.

2.3. Methodology

The purpose of this phase was to explore, in-depth, how MHPSS could be effectively integrated and implemented through PHC. It included three main components:

- desk-based review of existing national policies,
- plans and legislation, and
- literature.

Through these components, the project explored the extent to which MHPSS is integrated into PHC, education and child protection policies. The project also reviewed existing approaches, barriers and enablers to the integration of MHPSS for children, adolescents and mothers in PHC.

[1] Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates, Algeria, Djibouti, Egypt, Iran, Jordan, Lebanon, Morocco, Sudan, Tunisia, Iraq, Libya, Palestine, Syria, Yemen.

Studies investigating MHPSS on children, adolescents and new mothers in Kuwait were systematically reviewed and analysed. To account for scarcity of results, the search was conducted for the period of 2000–2023. The review was conducted and reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses. To identify the relevant literature, five databases were searched (PubMed, ProQuest, PsycINFO, MEDLINE and Google Scholar). Search terms used in the initial search were: "Mental health" OR "Mental health disorder" OR "Mental ill" OR "Depression" OR "Anxiety" OR "Self harm" OR "self-harm" OR "suicide" OR "psych" OR "post-traum" OR "post traum" AND "Kuwait" OR "Child" OR "Adolescent" OR "Youth" OR "Teen" OR "Boy" OR "Girl" OR "Maternal" OR "perinatal" OR "postpartum" OR "postnatal" OR "antenatal" OR "prenatal" OR "pregnancy" OR "pregnant". A search was also performed on Google Scholar to account for any remaining studies that may have still been under review. Grey literature was also collected via professional networks within MOH and other governmental organizations. Finally, the reference lists of the studies included in the review were scanned for additional studies. Thirty-three studies were identified.

Key informant interviews

Key informant interviews were held with key stakeholders (government, non-government, private sector, youth representatives) from health, child protection and education sectors to explore how MHPSS for children, adolescents and mothers can be integrated into PHC. Specifically, the interviews aimed to understand:

- what MHPSS are already being provided through PHC and how they are delivered (through which types of services or facilities, by which types of providers and for which populations),
- what additional services could be provided (including preventive and promotive services) and how these might be delivered,
- what existing linkages and referral mechanisms exist with secondary and tertiary-level mental health care and allied health services, and how could these be strengthened,
- what existing linkages, referral mechanisms or collaborative care models exist with other sectors (child protection, education) and how these could be strengthened, and
- what the challenges and enablers are which impact the implementation of MHPSS through primary care.


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2.4. Study limitations

A major study limitation was the lack of ability to engage the correct stakeholders from the relevant government ministries. The Kuwait government operates a highly bureaucratic system that often takes more time than estimated to navigate. Prior to research protocol implementation, significant time was spent seeking engagement and approval from the required ministries. The same applied to engaging with NGOs in Kuwait. It is important to factor this issue into future projects.

Table 1: Key informant interviews by sector

Sector	Number of key informant interviews
Primary health care (MOH)	4
Kuwait Center for Mental Health (MOH)	4
Ministry of Education (MOE)	2
Ministry of Social Affairs (MOSA)	1
Supreme Council for Planning and Development	1
Public Authority for Disability	1
Non-governmental organization (NGO)	1
Total	14

2.5. Stakeholder consultation workshop

The stakeholder consultation workshop was conducted on 27 July 2023 in Kuwait.

The workshop was attended by 20 participants. Participants included representatives from MOH, MOE, the Supreme Council for Planning and Development (SCPD), community representatives (including new mothers) and UNICEF.

Specific representatives:

- MOH
  - Administration
  - PHC
  - Mental health services
- MOE
- SCPD: Kuwait Public Policy Centre
- UNICEF
- The Kuwaiti Association for Learning Differences (KALD)
- New mothers and service users

Participants were presented with the desk report findings as well as preliminary recommendations for the development and implementation of MHPSS care for children, adolescents and new mothers within PHC in Kuwait. Participants also were involved in two structured group activities aimed at collecting data to further supplement this report (Appendix D).

Scope of the workshop

The workshop consisted of a presentation of the research aims, summary of the desk review and preliminary findings of the research to date. It also included three group activities aimed at obtaining feedback from the participating stakeholders. The first activity addressed the gaps in MHPSS within PHC, the second activity addressed the gaps in MHPSS in relation to PHC levers developed by the WHO, and the third activity entailed a detailed worksheet that encouraged participants to develop a plan to address the barriers uncovered in activities one and two. The workshop concluded with a group discussion, which provided a substantial amount of data in the form of feedback.

Analysis

All key informant interviews were recorded and analysed using the Consolidated Framework for Implementation Research. Interviewers immediately coded their interview notes into an Excel matrix with pre-defined codes based on the conceptual framework and topic guide. A second researcher reviewed the matrix and listened to the audio recording of the interview, adding any additional detail. New inductive codes were added to the matrix as required, with the country team meeting weekly to discuss and refine the matrix. Matrices were then reviewed by the research teams to identify key themes and sub-themes and prepare a synthesis of findings.

Workshops were also recorded and a written summary of the discussion completed. These findings and recommendations were similarly thematically analysed and integrated with the findings from the key informant interviews. The preliminary findings and recommendations were validated by the Country Technical Advisory Group during a participatory workshop, where the recommendations were finalized.

3. Conceptual and policy framework

This project adopted the WHO and UNICEF definitions of mental health and psychosocial well-being (Box 1), emphasising mental health as a positive state rather than the presence (or absence) of a mental disorder.

Box 1: Definitions

'Mental health and psychosocial well-being' is a positive state in which children and adolescents are able to cope with emotions and normal stresses, have the capacity to build relationships and social skills, are able to learn, and have a positive sense of self and identity.

'Mental health conditions' is a broad term that encompasses the continuum from mild psychological distress to mental disorders. Any disorder may be temporary or chronic, fluctuating or progressive. During childhood and adolescence, common mental health conditions include: difficulties with behaviour, learning or socialisation; worry, anxiety, unhappiness or loneliness; and disorders such as depression, anxiety, conduct disorder, psychosis, bipolar disorder, eating disorders, substance use disorders, attention deficit hyperactivity disorder (ADHD), intellectual disability, autism and post-traumatic stress disorder.

Mental health and psychosocial support (MHPSS) refers to any support, service or action that aims to protect or promote psychosocial well-being or prevent or treat mental disorders.

Similarly, MHPSS is not limited to services and supports for children, adolescents and mothers with mental health conditions. In keeping with UNICEF's Multisectoral Operational Framework and other key global frameworks, MHPSS also includes a strong focus on actions needed to prevent poor mental health by addressing risk factors or enhancing protective factors, and actions to promote psychosocial well-being.

Global and regional frameworks, guidelines, plans and other guidance documents outline key actions to support the mental health and psychosocial well-being of children, adolescents and caregivers broadly related to responsive care, prevention and mental health promotion. All guidance documents include key actions to prevent poor mental health by addressing risk and protective factors through the health sector – not only a focus on clinical care and management of those with mental health conditions.

Many actions for MHPSS can be effectively delivered through PHC – either as stand-alone mental health programmes or integrated into other service delivery platforms (such as maternal and child health care, nutrition programmes and physical health services). These include services and supports related to:

Responsive care for those with mental health conditions

- Identification, screening, assessment and diagnosis of mental health conditions, including self-harm or suicidal behaviour.
- Psychological first aid and emergency care for acute mental disorders or suicidal behaviour.
- Provision of care and management (including psychosocial interventions and pharmacological interventions, where indicated).
- Multi-disciplinary/collaborative care models to provide person-centred care and support that promotes recovery and rehabilitation.
- Strong referral mechanisms for specialist mental health services and supports.
- Strong referral mechanisms with other sectors (social welfare, child protection, justice, education) to ensure timely assessment and care through health services, and also for health services to refer individuals and families for other supports.
- Identification and care for parents' and caregivers' mental health (including maternal mental health).

Prevention of poor mental health by addressing risk and protective factors

- Delivery, referral to and/or support for positive parenting programmes (universal, targeted for families at risk and indicated for families with children living with poor mental health conditions).
- Identification, screening, psychosocial interventions and referral for substance use.
- Identification, screening, psychosocial interventions and referral for exposure to or witnessing violence, including family violence, intimate partner violence, sexual violence, maltreatment and neglect, and peer victimisation. This also includes integration of MHPSS into services for survivors of violence and strengthened linkages with child protection.
- Support to programmes that build social and emotional learning and interpersonal skills (including integration into early childhood development programmes), and delivery (or referral) of psychosocial interventions and other support to build social and emotional learning and skills for those at risk of poor mental health (pregnant adolescents and adolescent caregivers, those living with HIV, chronic illness or disability, and those affected by conflict or disaster).
- Support and linkages with schools and other settings to create safe and enabling learning environments (school health services, teacher well-being, referral mechanisms, support for education staff capacity in mental health and behavioural management).

Mental health promotion

- Support for stigma-reduction campaigns and consideration of stigma in the design and delivery of mental health services (including efforts to reduce stigma and discrimination in health settings).
- Raising awareness and supporting programmes to improve community mental health literacy.
- Creating opportunities and mechanisms that enable and encourage participation of children, adolescents and their families in the design, planning, delivery and evaluation of MHPSS – including adolescent-responsive health services.
- Linkages, collaboration and coordination with other sectors (including social welfare/social protection) to address social determinants of mental health and well-being.

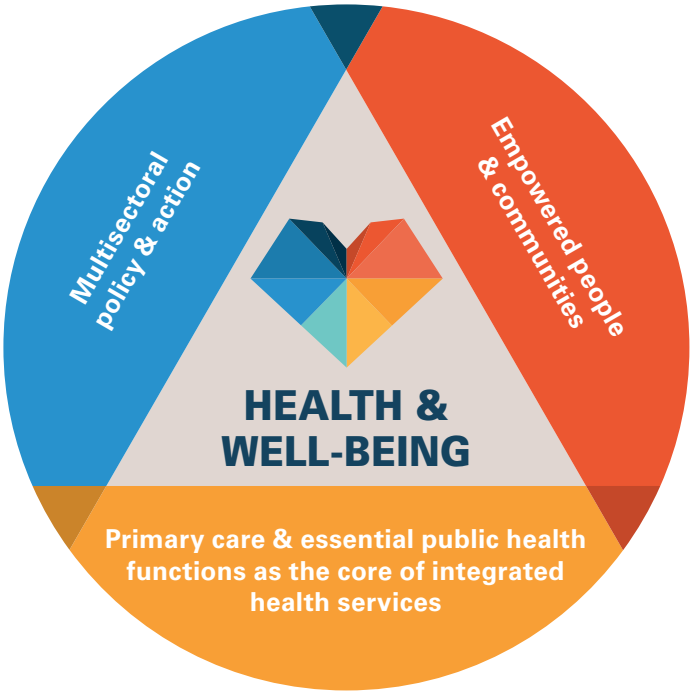
The 2022 WHO *World Mental Health Report,* in particular, defines key priorities for PHC, including:

- strengthening the capacity of general health providers to identify, assess and manage common mental health conditions,
- embedding mental health providers into PHC services,
- establishing collaborative care models,
- integrating mental health into disease-specific services (e.g., HIV), and
- integrating mental health into population-specific services (e.g., perinatal care, reproductive health care and adolescent health programmes).

PHC has the aim of addressing the majority of a person's health needs throughout their lifetime.[27] This includes services and supports to address physical, mental and social well-being that is person-centred rather than disease-centred, with the aim of achieving the highest attainable level of health while maximising equity. It also includes the continuum of health promotion, disease prevention, treatment and rehabilitation. The components of PHC include:

1. **Integrated health services** with an emphasis on primary care and public health functions including meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course.
2. **Multisector policy and action:** systematically addressing the broader determinants of health, including social, economic and environmental factors, as well as individual characteristics and behaviour, through evidence-informed policies and actions across all sectors.
3. **Empowered people and communities:** empowering individuals, families and communities to optimize their health as advocates of policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers (see Figure 1).

Figure 1: WHO-UNICEF PHC components[27]



While this project focused particularly on the delivery of MHPSS through PHC, it also sought to understand current linkages between PHC and communities, as well as key sectors (education, social welfare) to address broader determinants of mental health and improve collaborative, coordinated care and prevention programmes.

The systems-level challenges and actions needed to strengthen implementation were examined using the WHO-UNICEF PHC levers:[27]

Core strategic levers

- Political commitment and leadership
- Governance and policy frameworks
- Funding and allocation of resources
- Engagement of communities and stakeholders (including adolescents)

Operational levers

- Models of care
- Workforce
- Physical infrastructure
- Medicines and other supplies
- Private-sector engagement
- Purchasing and payment systems
- Digital technologies
- Quality of care
- Research, data, and monitoring and evaluation

4. Mental health and psychosocial well-being: The current situation for children, adolescents and mothers

4.1. Mental health and well-being of children and adolescents

Mental health outcomes

Within the MENA region, children and adolescents have been reported to exhibit poor mental health. Data has shown that 16.6 per cent of adolescents in the MENA region aged 10–19 years experienced at least one mental health disorder. Anxiety and depression were the most common mental health disorders among adolescents aged 15–19 years. Among children and early adolescents, anxiety, conduct disorders and developmental disorders were the most common mental health disorders. There is a lack of primary data related to MHPSS for children, adolescents, pregnant women and new mothers in Kuwait. This makes it difficult to define the prevalence and risk factors of MHPSS conditions.

Depression

A study conducted on 704 children between the ages of 11 and 16 examined the link between 25-hydroxyvitamin D and depressive symptoms in adolescents, and found that 17.06 per cent had depression symptoms based on the Children's Depression Inventory.[28]

Anxiety

There were no findings regarding anxiety in children or adolescents during desk review.

ADHD

A study conducted on children and adolescents between the ages of 5 and 15 years attending a child psychiatric outpatient clinic of Kuwait Center for Mental Health (KCMH) for ADHD found that the most prevalent ADHD subtype was the combined subtype (65.7 per cent), followed by the inattentive subtype (20 per cent), and the hyperactive impulsive subtype (14.3 per cent). It was also found that 51.4 per cent of the patients had a history of perinatal problems, and 70 per cent had a family history of ADHD. Children and adolescents with ADHD were found to have highly impaired executive function. They were reported to be disruptive in school (68.6 per cent), unable to complete school homework (90 per cent), were on probation or had been dismissed from school (12.9 per cent), repeated a school grade (25.7 per cent), and have problematic relationships with family members and peers (72.9 per cent).[29]

Psychological distress

A study found statistically significant correlation between four hours or more of daily smart device use and stress, anxiety and depression in children and adolescents.[30]

Suicide

In Kuwait, suicide is legally deemed an unnatural death and all instances are referred to the forensic unit of the General Department of Criminal Evidence (GDCE). A study conducted on data from 2003–2009 recorded seven deaths by suicide for adolescents between the ages of 10 and 19 years [31]. A further study conducted on data from 2014–2018 recorded eight deaths by suicide for adolescents between the ages of 10 and 18 years [32]. A study conducted on adolescents between the ages of 13 and 16, based on data from the Kuwait Global School-Based Student Health Survey, reported suicidal ideation, planning and attempts to be 20.0 per cent (95 per cent confidence interval (CI) = 18.5–21.6 per cent), 14.0 per cent (95 per cent CI = 12.7–15.4 per cent), and 18.1 per cent (95 per cent CI = 16.6–19.5 per cent), respectively. Twenty-six per cent of adolescent participants in this study reported at least one suicidal behaviour, and 8.5 per cent experienced all three.[33] This study also reported suicidal planning at 17.4 per cent.[34] Correlates to suicidal behaviours were reported to include school bullying, tobacco use, subjection to physical violence, feelings of loneliness and non-empathetic parents.[33] A study examining physical fighting at school in adolescents found a correlation between suicidal ideation and being involved in two or more physical fights. They found suicidal planning correlated with a 100 per cent increase in the chance of being involved in physical fighting at school.

Risk factors

Disordered eating

One study showed that male adolescents in Kuwait showed a higher prevalence of disordered eating (47.3 per cent) than females (42.8 per cent).[35]

Diabetes

A study conducted on 100 children aged 8–11 years with type 1 diabetes mellitus found a significant correlation between having type 1 diabetes mellitus and negative well-being. It was found that children with this disease exhibited depression, generalized anxiety, eating disorders, low self-esteem and social phobia according to the Revised Children's Anxiety and Depression Scale (RCADS). [36]

Physical and emotional maltreatment

Historic physical and emotional childhood maltreatment was reported by 22.5 per cent of adults and 18.6 per cent of adolescents in a 2018 study conducted on university students. Hitting by hand or by hard object and slapping of the face were the most reported methods of physical maltreatment. Verbal humiliation, intimidation, threatening behaviour and negative treatment to decrease self-worth accounted for 65 per cent of reported cases of emotional maltreatment. The median age of onset was 7.0 years for physical maltreatment, and 8.5 years for emotional maltreatment. Of the participants, 12.4 per cent reported ongoing physical maltreatment, and 37.0 per cent reported ongoing emotional maltreatment. Fathers were the most frequently reported offenders (50.6 per cent), followed by mothers (43.5 per cent). The study also found that exposure to childhood physical or emotional maltreatment was an independent significant predictor to adverse mental health status later in adult life.[37]

A study conducted on students at the University of Kuwait reported students experiencing at least one type of physical, emotional or sexual child abuse at 35.6 per cent, 53.5 per cent and 19.8 per cent, respectively.[38] About 25.2 per cent of adolescent males reported being involved in two or more physical fights in a school setting, and 30.6 per cent reported being subjected to bullying.[34] A cross-sectional survey was conducted to ascertain levels of child maltreatment as recorded by paediatricians in Kuwait. Approximately 69 per cent of paediatricians reported encountering at least one incident of child abuse and up to three cases of child neglect over the 12 months prior to the study. Of participating paediatricians, 80 per cent reported their belief that child maltreatment is common or very common in Kuwait. More than 80 per cent of participating paediatricians did not know whether there was a legal obligation to report child abuse, or which legal authority to report to.[39] National guidelines and policies are lacking and should be developed to guide health care professionals encountering child neglect and abuse. Training is also required to enable health care professionals to identify situations of child neglect and abuse.

Sexual abuse

A study examined the prevalence of physical, psychological and sexual abuse among high school students aged 14–23 years, and the association with anxiety, depression, low self-esteem and quality of life. Of the respondents, 12–28 per cent reported psychological abuse from a parent. Around 8.6 per cent reported a sexual attack, and 5.9 per cent reported the threat of a sexual attack. The correlation between psychological and physical abuse with prevalence of anxiety and depression was highly significant.[40].

Tobacco and drug use

A study utilising data from the Kuwait Global School-Based Student Health Survey reported on the prevalence of smoking (26.6 per cent) and illicit drug use (7.4 per cent) among male adolescents aged 13–15 years in Kuwait. Another study conducted on adolescents aged 15–18 years reported current tobacco use at 8.5 per cent and 50 per cent having tried tobacco before. Average age of tobacco use initiation was 14 years old for 21 per cent of the participants. Cannabis was the most commonly reported illicit drug, with 3.7 per cent of participants reporting to be current users and 5.3 per cent reporting to have tried it before. Smoking and illicit drug use was also found to be associated with suicidal ideation, with psychosocial factors contributing to smoking and illicit drug use.[41] Lifetime cannabis use in adolescents aged 13–17 years was reported at 3.2 per cent. Cannabis use was found to be influenced by parental tobacco use. Lifetime amphetamine use in children and adolescents aged 13–17 years was reported at 1.0 per cent. Amphetamine use was found to be associated with suicidal ideation, being a victim of physical assault, and anxiety.[42] A separate study conducted on male university students reported the total prevalence of illicit drug use to be 14.4 per cent. The most frequently used illicit drug was cannabis. There was significant difference in use between private universities (18 per cent) and public universities (10 per cent).[43]

4.2. Mental health and well-being of mothers

Overview of maternal mental health

There is a high prevalence of depression for women who are pregnant or new mothers, and awareness regarding the screening process is low. Screening for perinatal depression is extremely low.[44]

Pregnant women

A study has shown that one in five pregnant women in Kuwait experience antenatal depressive symptoms on the Edinburgh Depression Scale. These symptoms are comorbid with other mental health conditions such as post-traumatic stress disorder, stress and anxiety. Antenatal depression was also linked to low income and to self-reported depression prior to pregnancy. Women later in pregnancy were also more likely to develop depressive symptoms later in pregnancy.[45] Depression has been reported in 40 per cent of women who have never had a child, and 60 per cent of women who have had children. Of the women who were pregnant during the COVID-19 pandemic, 77.5 per cent reported pregnancy-related anxiety.[46]

New mothers

Studies have reported postnatal depressive symptoms at 11.7 per cent and 19.5 per cent. [47, 48] Among those with depressive symptoms, 4.2 per cent also reported thoughts of self-harm.[45] The studies also found that antenatal depressive symptoms were the strongest determinant of postnatal depressive symptoms. Women who did not report antenatal depressive symptoms did report other indicators of psychological distress such as stress, post-traumatic stress disorder and symptoms of isolation.[47]

Another study on pregnant women in Kuwait reported the probability of developing depression during pregnancy at 32.9 per cent. It was also reported that 65.1 per cent of study participants who reported perinatal depression were not screened for depression by their obstetrician. Women reporting perinatal depression also did not feel they had adequate familial support. They also felt they were unable to "easily talk about their problems and thoughts with their friends".[44] Prevalence of postpartum depression was reported at 45.9 per cent. A history of postpartum depression was identified as a significant correlate to reporting postpartum depression (57.6 per cent). Mothers who reported an unplanned pregnancy were twice as likely to report postpartum depression. Postpartum depression was reported to be high in mothers who had difficult births (51.7 per cent) and was higher in mothers who did not breastfeed at all (60.0 per cent) compared to mothers who employed mixed feeding methods (44.9 per cent) and mothers who exclusively breastfed. Health-related quality of life was reported to be lower in new mothers who were experiencing postpartum depression. Mothers with lower education levels were more likely to report postpartum depression.[49]

4.3. Current responses

National policies, plans and strategies.

National mental health legislation

The Kuwaiti government passed Law No. 14 of 2019, known as the 'Mental Health Law', consisting of 40 articles. This is the first governmental legislative law aimed at protecting people with mental health conditions in Kuwait. While this legislation cannot impact levels of poor mental health, it can address the stigma surrounding mental health in Kuwait, as well as provide protection to people who deal with mental health conditions.

The law defines mental health as *"the state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community."* The law further defines mental illness as *"the state of psychological or mental disorder resulting from the impairment of any psychological or mental function to the extent that limits the individual's adaptation to his or her social environment. It does not include the use of or addiction to alcohol, drugs, psychotropic substances, or medications without apparent mental illness."*

The law included the development of the Mental Health Coordinating Council which consists of 11 appointment members who are tasked with overseeing the application of the law, and the development of its respective policies and procedures.

The Mental Health Coordinating Council also oversees the Monitoring and Evaluation Committee. This committee consists of a medical consultant, a psychiatric therapist and a legal consultant. The purview of the committee is to process complaints that have been made regarding mental health treatment, decide on compulsory medical treatment for patients, decide on compulsory admission to mental health facilities, consider the validity of medical care, consider patients' ability to make decisions, and consider the continued detention of patients under judicial orders.

The law addresses the requirements and procedures of the psychiatric assessment and diagnosis of patients, voluntary and compulsory admission into psychiatric facilitates, and compulsory treatment of mental health conditions.

Prior to the issue of Law 14 of 2019, patients could not be compulsorily admitted into psychiatric facilities in any scenario. Article 11 of Law 14 of 2019 allows for 72 hour holds on patients from leaving psychiatric facilities if deemed medically necessary by the attending medical doctor. This is deemed an assessment period. Valid reasons for a psychiatric hold are if the patient is a danger to themselves or others, the patient is unable to care of themselves, or the patient voluntarily admits themselves for assessment. In cases where a judicial order has been issued, the patient may be admitted and subjected to a psychiatric assessment without their consent.

To be admitted compulsorily to a mental health facility, a psychiatrist who is not the original referrer must conduct a separate psychiatric assessment where they deem compulsory admission is necessary due to severe mental illness. The law describes severe mental illness as: (i) severe and imminent deterioration of the patient's mental or health condition because of symptoms of mental illness; or (ii) where mental illness signifies a serious and imminent threat to the safety, health or life of the patient or others.

An exception to this admission process is in emergency or urgent cases. If such a case presents, the law states that a patient may be compulsorily admitted if a preliminary diagnosis report and rationale for emergency admission is submitted to the Monitoring and Evaluation Committee within 24 hours, and to the Public Prosecution Office within 48 hours.

If the patient has the capacity to comprehend and provide informed consent to treatment, then consent should be obtained prior to treatment. In the instance when a legal guardian of a mental patient refuses to consent to treatment, or there is no legal guardian for a patient incapable of making treatment decision, the Monitoring and Evaluation Committee may approve treatment until a legal guardian is appointed by the courts.

The Mental Health Law also addresses law violation punishments in articles 30–40. Punishments include financial and criminal sanctions. False admission to a psychiatric hospital can incur a custodial sentence of one to three years and a financial fine of KD3,000–10,000 (approximately US$10,000–30,000). The law also states that assisting or enabling a person to evade compulsory treatment or sectioning is subject to a custodial sentence of one to three years, and a financial penalty of KD1,000–5,000(approx. US$3,000–15,000). The law also addresses the breach of confidential mental health information to be punishable by a custodial sentence of one to three years, and a financial penalty of KD1,000–5,000 (approx. US$3,000–15,000).

The law encourages patient rehabilitation. It states that MOH will establish shelters for patients who are not required to be admitted to psychiatric hospitals but do not have social support systems in place. The law allows for MOH to grant private shelter licences for this purpose.

The law also dictates that a person undergoing treatment in a mental health facility or with a mental diagnosis should not be precluded from obtaining a job in the government sector. By ensuring that there is no employment discrimination within the governmental sector for those who are being treated for mental health conditions, it contributes to the prevention of stigma and isolation.

The law also implements strict penalties for those who violate the law. Five out of the 40 articles of the law describe the penalties for violation. While this law is still in its early stages, it is a big step in developing the MHPSS system in Kuwait.

The Kuwait Labour Law (No. 6 of 10 February 2010) gives protection to pregnant women and new mothers. MOH Medical Council provides pregnancy leave when required for medical necessity, which entitles pregnant women to unlimited paid leave prior to birth.

Pregnant women are given 70 days of maternity leave. After maternity leave, new mothers are entitled to 100 days of unpaid leave if required for medical reasons. New mothers are then also offered up to four months of unpaid maternity leave. Once a new mother has returned to the workplace, they are entitled to two hours leave a day for maternal care (referred to as breastfeeding care).

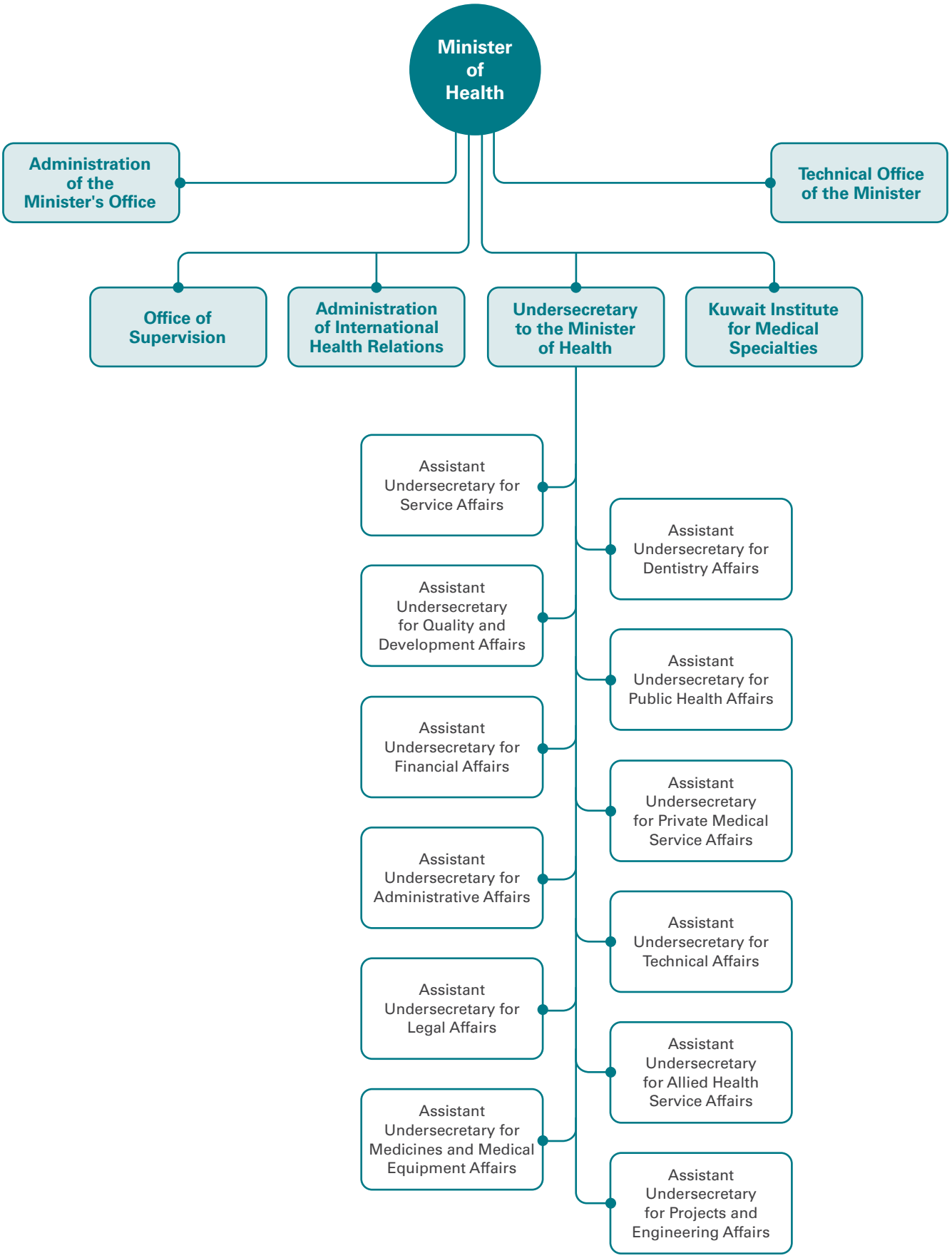
Overview of MOH

MOH in Kuwait operates a mental health care system within the secondary and tertiary setting. The Minister of Health is appointed by the Council of Ministers under direction of the Amir of Kuwait. Organizationally, the Minister of Health is supported by the Undersecretary to the Minister of Health, and 12 assistant undersecretaries.

Health care delivery is structured in three levels of care delivery: primary, secondary and tertiary health care. Kuwait has six health regions, where each region is served by a dedicated general hospital and several PHC centres and specialized clinics. PHC centres are dispersed to cover all residential areas within the health region, where each centre serves the residents of the area.

MHPSS falls under the jurisdiction of the Assistant Undersecretary to Technical Services and within the purview of KCMH.

Figure 2: Flow chart depicting hierarchy of MOH administration in Kuwait



Overview of the mental health system in Kuwait

KCMH

The main arm of the psychological and psychiatric care of MOH is KCMH, which operates in the Al-Sabah health region. It is divided into several specialisations including inpatient and outpatient psychological and psychiatric services treating adults, children and adolescents. KCMH also operates a specialized autism clinic, which provides care to adolescents and young adults.

Al-Manara Child Psychiatric Hospital - tertiary setting

Al-Manara is an outpatient child psychiatric clinic in KCMH, located at Al-Sabah Medical Area. Al-Manara is the only child psychiatry unit in Kuwait and deals mostly with referrals from primary care centres and other tertiary hospitals, as well as self-referrals from the community. The catchment area covers all six governorates of Kuwait. The child psychiatric clinic works three days a week (Sunday, Tuesday and Thursday) with an average of six to eight patients (one to two new referrals and five to six follow-ups) attending the clinic each day. It is open mornings only, which is not convenient for children due to school.

MOE

MOE in Kuwait operates independent child and adolescent mental health clinics within the MOE complex under the Department of Mental and Social Health Services. The MOE also provides psychologists and social workers to each governmental school in Kuwait.

There clinics are run by seconded MOH psychiatrists (from KCMH). Children and adolescents are referred to these clinics by MOE psychologists operating from within each governmental school. The aim of this clinic is to provide accessibility, reduce the stigma associated with obtaining MHPSS from MOH, and preserve anonymity for students and their parents.

Overview of the PHC system

Kuwait is divided into six health regions: Kuwait City, Hawalli, Ahmadi, Jahra, Farwaniya and Al-Sabah. Each region operates as decentralized administrative unit. Health care is administered through PHC centres, general hospitals and specialized hospitals dispersed within the six health regions. There are 115 PHC clinics operational in Kuwait to date. They are dispersed within the six governates of Kuwait. Kuwait City has 26 clinics, Hawalli has 11 clinics, Ahmadi has 26 clinics, Jahra has 14 clinics, Farwaniya has 22 clinics and Mubarak Al-Kabeer has 16 clinics.

PHC is overseen and implemented by the MOH through the Central Directorate of PHC.

Within PHC, MOH also operates specialized mental health clinics. These are referred to as non-communicable disease clinics in some PHC centres to address the possibility of perceived stigma patients might experience.

Kuwait Institute of Medical Specialities is affiliated with the Royal College of General Practitioners of the United Kingdom, which maintains a five-year Kuwait Family Medicine Residency Program established in 1983. The programme was awarded accreditation by Members of the Royal College of General Practitioners in 2005. The Kuwait Family Medicine Residency Program has graduated 514 residents to date. Family medicine residents undertake a mandatory three-month placement in paediatric departments within MOH.

The School Health Department within MOH operates independently from the PHC administration. Their focus is immunization and dental care of school-aged children.

PHC has a running mental health committee which has established policies and procedures to provide MHPSS support to adults within the PHC setting. There are currently 48 operational clinics within Kuwait. Some clinics have a visiting psychiatrist, but there is a challenge to provide this as there is a shortage of psychiatrists within MOH. Often, patients are referred to psychiatrists within the secondary and tertiary health care services.

The PHC administration operates Well Baby clinics, which were established in the 1980s. There are currently 73 operational clinics within PHC centres in Kuwait, to date. These clinics provide care for children from birth up to five years of age. The Well Baby clinics are under the overview of MOH PHC Committee of Children and Adolescent Health. This committee operates Well Baby clinics for children under the age of five years, and is also in the process of developing guidelines for general adolescent health. The clinics do not formally screen for postpartum depression, but practitioners will refer new mothers who exhibit signs of postpartum depression to the adult mental health clinic within the PHC setting.

The PHC setting also provides general medical care for children above the age of five and adolescents. It does not provide MHPSS for children and adolescents, and the current procedure is to provide a referral to the local secondary care hospital, or to tertiary care administered within KCMH (Al-Manara hospital). The PHC setting offers MHPSS care for new mothers within PHC specialized mental health clinics from six months after birth. Prior to this, new mothers are referred to obstetricians who will then refer them onto secondary and tertiary psychiatric care within MOH.

There is no collaboration between PHC and MOH School Health or MOE with regard to mental health in children and adolescents.

Current approaches and integration of MHPSS through PHC

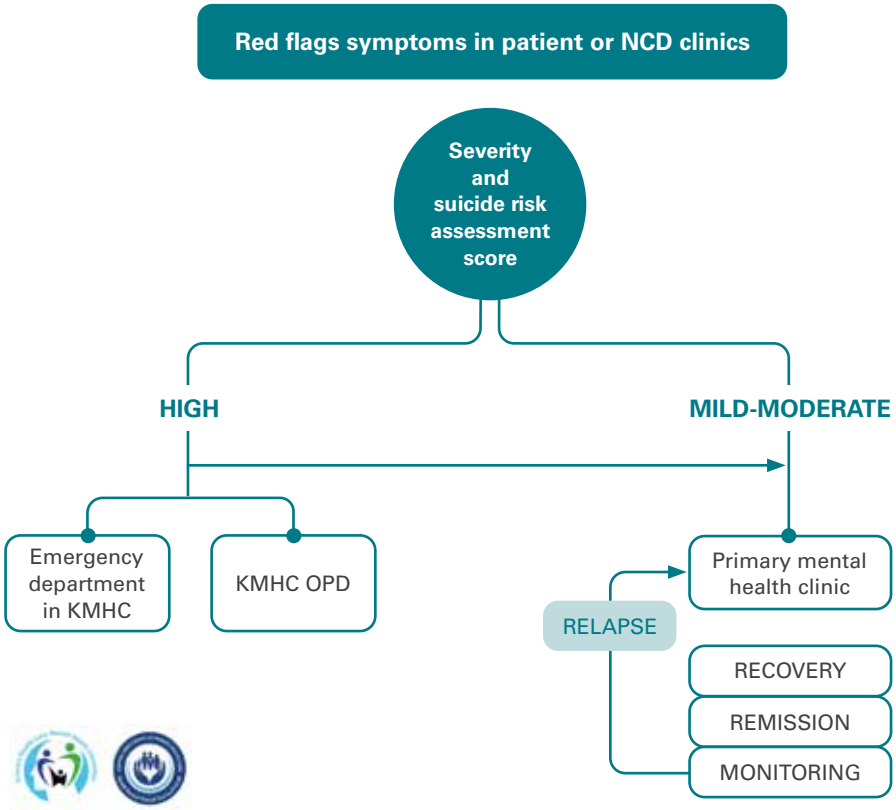
MHPSS is currently being provided to adults within PHC settings. This is delivered through 48 dedicated mental health clinics dispersed within the six health care regions of Kuwait. There are six more mental health clinics to be opened within 2023.

These clinics were developed and are overseen by the MOH PHC Mental Health Committee. The committee is dedicated to primary prevention through identification and modification of risk factors to the development of mental health conditions, secondary prevention through early diagnosis and management to mitigate progression and worsening, and tertiary prevention to prevent complications and recurrences in established conditions. The service also promotes self-management by patients through personalized care plans.

The clinics are operated by dedicated family medicine specialists who have undergone a 12-month training course implemented by the Mental Health Committee. The clinics use the stepped care model and have developed an internal protocol of diagnosis, treatment and integrated referral mechanisms. Patients are referred to the clinics by PHC practitioners and are also able to obtain self-referral appointments either online via the dedicated MOH health services application or in person.

There is no clear encompassing plan for MHPSS health promotion. Several clinics administer their own ‘open day’ events within the local neighbourhood, usually in collaboration with the local municipal mayor. Patients are able to obtain appointments via MOH ‘Seha’ application.

Figure 3: Pathway of care for patients with psychiatric illness: Red-flag symptoms



Pathway of care for patients with psychiatric illness: Red-flag symptoms				
Red flags symptoms in patient general or NCD clinics				
Severity and Suicide Risk Assessment Score				
High		Mild-Moderate		
Emergency department in KMHC	KMHC Outpatient Department (OPD)	Relapse	Primary Mental Health Clinic	
			Recovery	Remission
				Monitoring

Engagement with other key sectors

Kuwait Institute for Medical Specialization

The Kuwait Institute for Medical Specialization operates 25 five-year medical Residency Training Programs. The programmes consist of structural medical training courses and examinations. The Kuwait Institute for Medical Specialization also operates seven fellowship programmes (subspecialty).

The Kuwait Board of Psychiatry at the Kuwait Institute for Medical Specialization trains medical doctors in psychiatry. Upon completion of the five-year medical board, residents graduate as Specialists in Psychiatry. The Kuwait Board of Family Medicine provides training on psychiatry to family medicine residents within PHC settings.

National Society for Protection of Children, Kuwait

Governmental Law No. 21 of 2015 concerning the rights of the child was drafted with collaboration from the National Society for Protection of Children. The National Society for Protection of Children collaborated with the Supreme Council for Family Affairs and the National Association for Family Security to develop a family and social counselling team. This team develops annual plans for organizing family and social counselling lectures and training courses. They also work on building institutional partnerships in psychological and social family counselling.

Child Protection Office, MOH

The MOH Child Protection Office in Kuwait was established by governmental decree in Law No. 645 of 2014 to provide direction to medical professionals in incidents of child abuse or neglect. Its functions include:

- the monitoring of specific cases,
- processing of complaints and reports of children at risk of abuse or neglect,
- conducting inspections and assessments of certain cases,
- conduct of a clinical diagnosis of a child when required, and
- developing and monitoring specific treatment plans when required.

They are also tasked with preparing final reports on children reported to suffer from abuse.

The office also conducts informational courses aimed at medical doctors, social workers, psychologists and law enforcement officials. The courses aim to provide a foundation of knowledge to assist them in instances of encountering child abuse. To date, the Child Protection Office reports having conducted 60 training courses for 1,500 participants. The Child Protection Office operates a hotline to report child abuse and to provide callers with advice, guidance and counselling.

Kuwait Supreme National Child Protection Program, MOH

The Kuwait Supreme National Child Protection Program was founded by MOH in 2015, with the support and guidance of the National Society for the Protection of Children. The programme operates a child helpline.

National Drug Use Prevention Policy and Management Program

The Ministry of Interior's Drug Control General Department developed a National Drug Use and Prevention Policy and Management Program in collaboration with the United Nations Development Programme (UNDP) and the Kuwait National Development Plan.

NGOs

Table 2: Current MHPSS integrated into PHC facilities: Key informant interviews

	Type of MHPSS service	MHPSS currently integrated in PHC
Responsive care	Early identification, screening and diagnosis of mental health conditions including self-harm or suicidal behaviour (including the standard guideline and training for psychiatrist team)	There is no MHPSS service (including early identification, screening or diagnosis) for children, adolescents or new mothers within the PHC setting.
	Psychological first aid and emergency care	Not established
	Provision of care and management, and psychosocial support (including treatment plans and psychosocial interventions)	Chosen PHC facilities (by PHCI) provide essential mental health medications and manage simple cases; complicated cases are referred to psychiatrists in public hospitals. PHC facilities and private sectors provide treatment in cooperation with many organizations.
	Referral mechanism for specialized services	There is an efficient referral system between PHC and secondary care systems.
	Referral mechanism with other sectors	A referral mechanism is in place to refer children, adolescents and new mothers to secondary care settings for MHPSS care. A referral mechanism is in place to refer children and adolescents within the governmental school sector to MHPSS clinics operated by MOE.
	Multidisciplinary care model	Not established
	Care for parents and care givers	Not established
	Health information system for registering the case and mental health indicators	Several census studies have been conducted on children and adolescents in Kuwait; some are ongoing. The PHC administration collects all patient data on their centralized patient information system. This does not include MHPSS for children, adolescents, pregnant women or new mothers as they are not currently able to seek care within PHC.
Preventive care	Building individual assets and interpersonal skills programmes	Not established
	Positive parenting	This is integrated through NGOs but is missing sustainability.
	Care programmes	Not established
	Addressing the risk factors by identification, screening, intervention and referral especially for substance use, violence	Activities and visits to schools and communities by the Family and Child Protection Office of the Ministry of Interior to raise awareness of risk factors such as substance use, and of rights against violence and abuse.
	Safe and enabling learning environment	Not available

	Type of MHPSS service	MHPSS currently integrated in PHC
Promotion	Stigma reduction campaigns	National programme for MHPSS to promote mental health in the southwest of the country (2012/2013) including MHPSS promotion campaigns.
	Raising awareness programmes to improve community mental health literacy	Through NGO activity
	Family and children and adolescent participation	Through NGO activity
	Linkage and coordination with other sectors	There is a connection between KCMH and MOE, where KCMH participates in providing medical expertise for MOE psychology and psychiatry clinics.
	Policy and legislation	Mostly through NGO activity.

Table 3: Stakeholders' feedback regarding the current MHPSS provision

Type of MHPSS	MHPSS provision	Setting, access and referral coordination regarding MHPSS
Responsive care	There is currently no MHPSS care being provided to children, adolescents, pregnant women and new mothers within the PHC setting.	Children and adolescents are referred to secondary and tertiary care services, usually seeing a paediatrician within the secondary setting first. Pregnant women and new mothers are referred to receive care from their gynaecologist. The gynaecologist is then able to refer the patient to a psychiatrist specialized in women's health within the Kuwait Maternity Hospital.
Preventive care	The MOE employs psychologists and social workers in all governmental schools. They do not provide preventative care, but function as a referral system for MOE psychological clinics. They do not have a link or referral system with MOH or PHC.	Undocumented people and migrant workers have poor access due to a lack of awareness of MHPSS care provided within MOH and a lack of awareness of their rights to seek MHPSS.
Promotion	There are few promotive activities within PHC and MOH regarding MHPSS. Some PHC centres host mental health awareness days and KCMH hosts mental health awareness events. These are not frequent, or impactful.	There is no cross-coordination between government ministries (MOE, MOH, MOSA) to manage and support MHPSS promotion. There are some NGOs operating in Kuwait which focus on MHPSS for children and adolescents. They are active on social media and attempt to conduct their own promotive events.

Table 4: Highest priority gaps in the three tiers of PHC: Workshop feedback

MHPSS care	Highest priority gaps in each tier
Responsive care	• Lack of efficient workforce • Lack in policies, guidelines and care plans • Gaps in prevention in Well Baby clinics • Need for collaboration with Health Cities • Need to emphasize the Importance of adolescent care plans • Lack of collaboration with MOE • Need to highlight the role parents can play • Lack of national programmes • Need to establish home visit programmes for post-partum care
Preventive care	• Need for positive parenting programmes • Need for programmes for newlyweds as currently not designed or applied • Need for pre-birth parenting courses • Need to focus on early detection and diagnosis • Need to educate parents in early detection • Lack of national awareness programmes • Need to use national media to target lack of awareness • Need to develop school programmes related to MHPSS • Need for awareness campaign for new mothers and pregnant women
Promotive care	• Lack of role for national media in mental health promotion • Lack of promotive events • Lack of focus on MHPSS • Need to promote health programmes for adolescents • Need to use national media to raise awareness (Ministry of Information) • Lack of activities on a national level to raise awareness • Lack of outreach on social media • Lack of MHPSS awareness within schools • Need to use social media influencers • Need to have campaign that target stigma • Lack of national programmes • Lack of awareness on MHPSS and addiction • Need to use communities to promote mental health • Lack of awareness on a society level • Lack of group efforts for awareness

Table 5: Highest priority gaps: Core strategic levers

MHPSS care	Highest priority gaps in each core strategic lever
Political commitment and leadership	• Lack of direct governmental scholarships to MHPSS specialties to develop workforce capacity • Need to Role of Disability Authority in lobbying government • Need to define the role of Ministry of Information in raising awareness • Need closer links and with UNICEF and WHO to support development • Need to define the role of the Supreme Council for Development and Planning • Need to involve the Council of Ministers in establishing the importance of MHPSS • Lack of application of child protection law and disability law • Lack of collaboration within governmental ministries • Need to address governmental delays and their impact on MHPSS • Lack of centralized national programmes • Need to establish governmental policies highlighting the importance of MHPSS
Governance and policy frameworks	• Need to have collaboration between MOH and MOE to address MHPSS needs • Lack of laws to protect the MHPSS workforce • Need to develop policy for early detection and diagnosis • Lack of dedicated committees for MHPSS (specifically in MOE) • Need to develop MHPSS plan for children and adolescents • Need to have MOH, MOE and MOSA collaboration • Lack of application of Health Cities concepts • Need to use multisector development • Need to develop national-level MHPSS work plan and monitoring plan • Need to establish what roles sectors play and engage them with a timeline
Funding and allocation of resources	• Need for financial incentive for working within MHPSS • Need for funding for training and recruitment of specialized medical workers
Engagement of communities and other stakeholders	• Need to develop link with MOE to identify those at risk • Lack of training within MOE for MHPSS staff • Need to develop educational programmes in collaboration with MOE and MOH • Need for collaboration with Ministry of Information for promotion and prevention campaigns

Table 6: Highest priority gaps: Operational levers

MHPSS care	The highest priority gaps available in each operational lever
Models of care	• Currently no care plan for children, adolescents, pregnant women and new mothers • Need to establish an early detection plan and ensure parents are able to play a role in it • Need for an early screening plan • Lack of screening for prenatal depression • Lack of prevention of known risk factors (sleep, diet, exercise)
PHC workforce	• Lack of training for psychologist graduates in clinical care • Lack of workforce in PHC and MOH in general (psychiatrists, psychologists, mental health nurses) • Need for training MOE psychologists
Physical infrastructure	• Need to modernize mental health facilities within PHC and governmental hospitals
Medicines and other health products to improve health	• No feedback
Private sector engagement	• Need to engage insurance companies • Need to collaborate with private sector providers, sharing resources and expertise, and referral mechanisms
Purchasing and payment systems	• No feedback
Digital technologies	• No feedback
Systems for improving the quality of care	• Need to develop standards of care for MHPSS workforce within MOH • Need to develop standards of care for psychologists and social workers within MOE
Research	• Need to collect survey data and use it to influence governmental decisions
Monitoring and evaluation	• Need to develop national health care quality monitoring plan

5. Challenges and recommendations for strengthening the integration of MHPSS in PHC

This section includes a narrative summary of the main challenges for each PHC lever, divided into core strategic and operational levers, with specific recommendations to address the challenges.

5.1. Core strategic levers

Political commitment and leadership

There are two standing relevant pieces of legislation: Law 14 of 2019, known as the Mental Health Law; and Law 21 of 2015, known as the Child Rights Act. Law 14 of 2019 addresses the rights of people with mental health conditions to receive adequate mental health care without stigma, and the right to be protected from persecution and prosecution. Law 21 of 2015 covers protective provisions for child health care, child social welfare, child education, child culture, child labour and the rights of working mothers.

Financial allocation is not linked to the standing legislation. There is also an absence of specificity in terms of standards of care within the MHPSS related legislation.

The Supreme Council for Planning and Development (SCPD) directs national development strategies under the New Kuwait 2035 plan. The SCPD established the Kuwait Public Policy Centre to oversee this development initiative. The Kuwait Public Policy Centre acts as a think tank for policy research and analysis and aims to provide governmental stakeholders and policy makers with evidence-based policy advice to inform governmental decision making. The SCDP and Kuwait Public Policy Centre work closely with United Nations agencies in their development of recommendations.

The SCPD does not, however, dictate required development for governmental ministries and agencies. Their approach is to provide a service to agencies and ministries at their initiation.

The development of MHPSS requires buy-in and motivation from MOH administration. It is important to engage with MOH leaders and highlight the importance of providing MHPSS to children, adolescents and new mothers within PHC. In addition to this, multisector collaboration should be encouraged within the governmental agencies. This endeavour should be a collaborative effort between MOH, MOE (PHC and School Health) and MOSA.

Key recommendations

1. Engage MOH administration and ensure their cooperation and desire to develop the MHPSS systems available to children, adolescents, pregnant women and new mothers.
2. Establish a multisector committee to coordinate the effort between governmental agencies.
3. Integrate specificity within the established legislation regarding care standards and provisions.

Governance and policy frameworks

It is imperative that a multisector effort is established to develop national policies and regulations to determine which health care providers will be providing MHPSS to children and adolescents within PHC. This should involve MOH, MOE, MOSA, SCPD, NGOs and private MHPSS providers.

Currently there is no centralized administrative structure to address MHPSS within MOH. Its management currently falls under the jurisdiction of the Assistant Minister for Technical Services. The development of a dedicated team to oversee the implementation of MHPSS (including national care plans, policies and protocols, and workforce) is imperative.

The PHC administration of MOH has established a Mental Health Committee, which has over recent years established adult mental health clinics in PHC. It is advisable that MOH establish a national MHPSS group which can oversee and guide the development of MHPSS in all levels of care and for all groups.

It is also important that this group addresses the gaps in polices and regulations related to MHPSS for children, adolescents and new mothers within PHC.

The importance of MHPSS should be prioritized by senior MOH administrative management, and its development should be given special consideration.

Key recommendations

1. Develop a high-level multisector group for the development and implementation of MHPSS for children, adolescents, pregnant women and new mothers.
2. Recruit a team of suitable expertise to develop a national care plan, and the required policies and regulations for the implementation of MHPSS for children, adolescents, pregnant women and new mothers.

Funding and resource allocation

MOH of Kuwait is financed adequately through resources from the Ministry of Finance of the Government of Kuwait. There is currently no dedicated allowance for MHPSS within PHC. There is a lack of resources to enable PHC to develop MHPSS to encompass children, adolescents, pregnant women and new mothers. There is also a lack of funding to enable the PHC administration to dedicate resources to the training and capacity building of existing staff (including medical practitioners and MHPSS administration support staff). Training of psychologists to enable them to clinically practice is required, and this also requires financial allocation.

Funding should be allocated to improve MHPSS and to establish dedicated MHPSS care for children, adolescents and new mothers within PHC. This could be achieved by increasing the existing operational budget of the PHC sector to incorporate this initiative. Ultimately, funding the development of MHPSS systems should become a priority of MOH as part of their forward planning. Funding is required for training, capacity building and support staff to ensure the development of the required care plans and policies. This includes manpower allocation of the required staff to develop the theoretical infrastructure of the care plan, as well as the required policies and procedures. This also includes current workforce training and the ability to plan ahead for future workforce requirements.

Key recommendations

1. Engage decision makers within MOH in prioritising budget allocation for MHPSS.
2. Allocate dedicated budget to MOH PHC administration to be able to facilitate the integration of MHPSS for children, adolescents and new mothers within the PHC setting.

Engagement with communities and other stakeholders

NGOs

There is a lack of engagement with NGO communities. The Kuwaiti Association for Learning Differences (KALD) develops and disseminates MHPSS leaflets within PHCs. It is imperative to establish dialogue with community representatives. This will assist in fostering community support for this initiative, as well as enable community expertise to be factored into policy decision-making. The MHPSS NGO community is established, and the governmental health care sector could gain benefit from collaboration.

KALD is active in political advocacy, which is a useful avenue of collaboration as there is an opportunity to use their influence on governmental stakeholders.

Other governmental ministries

MOE administers MHPSS within the governmental school setting. MOH also operates a School Health Department, which is mainly focused on vaccination and dental care for school-age children. This department is in an important position as the bridge between MOH and MOE. However, there is no clear collaborative approach to combine the efforts of MOH, MOE and the School Health Department in the coordination of MHPSS. This gap is imperative to address, specifically within MOE.

Key recommendations

1. Clear collaboration of MOH with MOE to synchronize MHPSS care for school-age children and develop a clear referral system to PHC.
2. MOH and PHC to engage the School Health Department of MOH to coordinated care and develop a plan to address MHPSS for school-age children and adolescents.
3. Establish a cross-sector committee to establish gaps and create plans for development.

5.2. Operational levers

Models of care

Currently there is no platform within the PHC setting of Kuwait that addresses MHPSS for children, adolescents, pregnant women and new mothers. There is a solid referral system in PHC to refer children, adolescents and new mothers to secondary care under paedology and gynaecology departments within governmental hospitals. An encompassing care programme should be developed to design the framework of providing MHPSS to children, adolescents and new mothers.

The development of a robust care plan would benefit from a mhGAP analysis being conducted to uncover the gaps and highlight the tasks needed to be accomplished. This will allow the PHC administration to uncover the required non-specialist MHPSS workforce that will act as support to the facilitate the integration of MHPSS. This overlaps with the PHC MHPSS levers of Governance and Policy Frameworks as well as Political Commitment and Leadership. This endeavour can be modelled on PHC MHPSS integration for adults that was pioneered by the PHC Mental Health Committee under the leadership of current Head of PHC, Dr. Deena Aldhubaib. Members of the existing Committee of Child and Adolescent Health can provide their expertise, and their existing programme may be expanded on to encompass MHPSS for children until the age of 5 years.

The development of a national care plan for MHPSS for children, adolescents, pregnant women and new mothers requires proactive action from the stakeholders of MOH.

Key recommendations

1. Establish an initial plan to provide MHPSS for children, adolescents and new mothers within the PHC setting.
2. Establish postpartum depression screening and integrate into existing Well Baby clinics.
3. Dedicate a multisector team to coordinate a mhGAP analysis.

PHC workforce

The PHC workforce consists of medical doctors, nurses, phlebotomists and medical porters.

The medical doctors working within PHC are either general practitioners or board-certified family medicine doctors.

There is a lack of psychiatrists specialized in children, adolescents, pregnant women and new mothers within the PHC setting, and within MOH as a whole. Health care workers are reluctant to specialize in MHPSS. This is due to the perceived social stigma from working in the field, and the reluctance to work in a disorderly environment. Practitioners currently working in MHPSS are often subjected to violence and abuse. There needs to be improvement in policies that protect health care workers in MHPSS. There is a lack of efficient psychologists within MOH, and a lack of those working within PHC. There is also a lack of mental health nursing staff, efficient administration staff and staff who can provide expertise in the development of care plans, policies and procedures. Currently the members of the PHC MHPSS Committee and the PHC Committee of Child and Adolescent Health specialize in family medicine. It would be advisable to include health policy specialists.

The PHC Mental Health committee has successfully trained FMPs to provide MHPSS care to adults within the PHC setting. Training is an important requirement. Adequately designed accredited training programmes are required to train FM doctors to be able to provide MHPSS care to children, adolescents, pregnant women and new mothers. This includes the development of a care plan and the required accompaniments, such as screening tools, treatment protocols and referral guidelines.

It is important to reach a national-level decision regarding who can provide MHPSS care for children and adolescents within PHC. Once this is established, a capacity building plan should be developed. This will highlight the gaps in workforce and training.

Collaboration with the Public Authority for Applied Education and Training School of Nursing is recommended to develop training curriculums for Mental Health Nurses. Collaboration with the Kuwait University Department of Psychology (under the School of Social Science) is also recommended, to ensure that the psychology graduates are adequately trained to meet MOH workforce requirements.

Key recommendations

1. Prioritize stakeholder engagement in determining who can provide required MHPSS care.
2. Decide on a national programme for training existing medical personnel (psychology graduates from Kuwait University and nursing graduates from the Public Authority for Applied Education and Training).
3. Develop a national workforce capacity-building drive.
4. Expand on existing training of family medicine practitioners in MHPSS to go beyond services for adults only.
5. Expand maternal MHPSS training.

Physical infrastructure

There are no significant challenges in relation to the infrastructure of PHC facilities. Facilities are suitably built clinics dispersed within residential and non-residential areas covering all governates. All PHC facilities have adequate access. PHC centres are frequently placed alongside governmental co-op societies as well as other governmental services such as police stations and civilian service centres. Facilities were not built with privacy provisions, such as spaces to conduct counselling and therapy in private. Facilities are however large enough and designed in a way that would enable structural modifications to facilitate the development of private spaces.

Adult mental health clinics within PHC centres are frequently within the main PHC centre building. The development of dedicated MHPSS areas within PHC centres could be developed to provide privacy for patients and practitioners.

The KCMH, the Al-Manara Center (specializing in child psychiatry) and the Kuwait Addiction Treatment Center are dated buildings that need renovation and modernization.

Key recommendations

1. Establish private areas within the present PHC centres dedicated to MHPSS.
2. Renovate and modernize the facilities of KCMH.

Medicines and other health products

All medicines and health related products are provided by MOH to all patients. Clinics are well stocked. There are occasional supply issues, mainly attributed to pharmaceutical manufacturing backlogs.

Practitioners have also described the need for alternative forms of medication, such as pills that can dissolve in water for patients unable to swallow them. This is not currently available.

Key recommendations

1. Establish contingency planning to mitigate any incidences of medicine delays.
2. Provide alternatives to common medications.

Engagement with the private sector

There is no impactful engagement or link between PHC services and the private sector. Patients will frequently access private health care due to lack of awareness of the MHPSS care provided by MOH and due to the perception that health care within the private sector offers more privacy.

There is the opportunity to improve engagement via collaborative efforts such as knowledge sharing and resource development with existing private sector practitioners and services.

Key recommendations

1. Establish connections with MHPSS service providers within the private health care sector.
2. Include private sector health care providers on MOH health committees.

Purchasing and payment systems

All health care needs are provided without a fee to Kuwaiti citizens. The Kuwaiti government levies fees on expatriates seeking health care within MOH system (excluding children of Kuwaiti parents, emergency or critical care, cancer treatment and undocumented persons). Currently, expatriates are obligated to obtain annual health insurance at a fee of KD50 (US$162.8) to access care at governmental hospitals and clinics. Non-Kuwaitis are charged KD2 (US$6.51) per visit at a PHC centre, KD10 (US$32.57) per visit at a governmental hospital. Expats are also required to pay a range of charges between KD0.5 and KD15 (US$1.63 and US$48.85) for other services such as surgery, radiological services, hospital admission, blood transfusions and certain blood tests.

Key recommendations

1. Develop an online payment gateway for patients.

Digital technologies

The PHC sector operates a centralized patient data system. During the COVID-19 pandemic many services were made available online. MOH developed a digital health application system called 'Seha', which translates into 'health'. This system is integrated with the digital governmental ID system. Patients are able to make appointments with MOH services, as well as access their medical test results. Patient referrals are also conducted via this digital system. Patients can obtain adult MHPSS appointments within their designated PHC centre via the 'Seha' application. Patients are also able to access their personal health care information from PHC, secondary and tertiary services (including referrals and medical tests).

Governmental hospitals operate a health information system which houses digital medical records. Medical personnel can input medical notes, as well as access medical records and test results. Currently the system limits access to medical records and tests conducted to one hospital. There is no ability to access records between the PHC sector and secondary and tertiary care.

Key recommendations

1. Expand the ability to obtain MHPSS appointments for children, adolescents and new mothers.
2. Develop sharing of patient medical records within PHC, secondary and tertiary settings.

Systems for improving quality of care

There is a systemic gap in national guidelines for health care practice. Multisector collaboration is needed to conduct a needs assessment, with the findings used to develop a quality assessment programme. The subsequent quality assessment programme should focus on MHPSS being provided within PHC. This will determine the responsibilities of PHC providers and ensure that quality targets are met and maintained.

Medical doctors often follow the practice guidelines of their board-accredited training body. This varies depending on where the medical practitioner received their training. The most common training bodies are the Canadian, British and American boards.

Key recommendations

1. Develop standardized guidelines and protocols for MHPSS needs of children, adolescents and new mothers within PHC.
2. Develop clear national guidelines for MHPSS care.
3. Develop standardized screening tools for common MHPSS conditions of children, adolescents and new mothers within PHC.
4. Develop a clear referral system within MOH, as well as a system for cross-referrals from MOE and MOSA.
5. Develop a national evaluation programme for MHPSS within MOH.

PHC research

There is a significant lack of research conducted on the medical sector, and a lack of dedicated staff with PHC research capabilities. MOH is in possession of a reasonable amount of electronically generated patient data. To mitigate the lack of research expertise, research entities within Kuwait can be engaged to collaborate. This includes both national research bodies and those within the private sector, such as: Kuwait University, private universities, Dasman Diabetes Institute, Kuwait Institute of Scientific Research and the Kuwait Foundation for the Advancement of Sciences.

Key recommendations

1. Funding allocation for research conducted on the PHC sector.
2. Incentivize existing PHC staff members to partake in research endeavours within their own sector.
3. Encourage collaboration and data sharing with research bodies outside of MOH.

Monitoring and evaluation

The PHC administration collects patient data in the form of a centralized digital patient records system. There is no cross-access between PHC centres, and secondary and tertiary health care facilities do not have access to this data. Patients can access certain data such as laboratory and x-ray results on their 'Seha' mobile phone application.

There are some ideas of establishing a national patient health information system, but there is no specific timeline for implementation. This system will improve data collection to survey the usage of facilities and assist in patient care through access to patients' medical history.

Patients can obtain appointments for services within all PHC centres. This includes the diabetology clinic, the ophthalmology clinic, mammogram appointments and the PHC mental health clinic.

Key recommendations

1. Implement a national centralized patient data system which enabled health care providers to access patient data (when applicable) through primary, secondary and tertiary care systems.
2. Use patient data already established in PHC electronic patient health care records to facilitate national MHPSS surveys.

6. Final recommendations and discussion

6.1. Recommendations for core strategic levers and operational levers

Table 7: PHC integration of MHPSS for children, adolescents and new mothers: Core strategic levers

Title	PHC description	Integrating MHPSS for children and adolescents into PHC
Political commitment and leadership	Political commitment and leadership that place PHC at the heart of efforts to attain universal health coverage and that recognize the broad contribution of PHC to the SDGs.	Ensure that the importance of MHPSS is promoted within the government system; specifically, the role PHC should play in prevention, treatment and care as an essential component of MHPSS, and the importance in helping to expand the reach of PHC and strategies for targeting MHPSS.
Governance and policy frameworks	Governance structures, policy frameworks and regulations in support of PHC that build partnerships within and across sectors, and promote community leadership and mutual accountability.	Develop national targets for integrating MHPSS into the PHC setting. This should be conducted with the collaboration of local partners such as NGOs, MOSA, and MOE. Develop linkages with other governmental agencies including MOSA, MOE, the Public Authority of Disability and the Youth Authority, among other professional bodies.
Funding and allocation of resources	Adequate and sustainable financing for PHC that is allocated to maximize financing protection, promote equity and enable access to high-quality care and services.	Dedicate funding to finance the development and implementation of care models within the PHC setting. This funding will ensure the ability to develop adequate care models, as well as the continuation of programmes.
Engagement of communities and other stakeholders	Engagement of communities and other stakeholders from all sectors to define problems and solutions and prioritize actions through policy dialogue.	Use community engagement as an opportunity to promote strategies for MHPSS surveillance, prevention, treatment and care. Develop tangible connections with NGOs and community health care groups, and community-led awareness campaigns.

Table 8: PHC integration of MHPSS for children, adolescents and new mothers: Operational levers

Title	PHC description	Integrating MHPSS for children and adolescents into PHC
Models of care	Models of care that promote high-quality people-centred primary care and essential public health functions as the core of integrated health services throughout the life course.	Conduct mhGAP on existing systems to elucidate the current gaps and assist in the development of a national level action plan in collaboration with MOH and PHC administrations. Incorporate maternal and new mother MHPSS screening into existing Well Baby clinics. Develop guidelines for MHPSS for children and adolescents within the PHC setting.
PHC workforce	Adequate quantity, competency levels and distribution of a committed multidisciplinary PHC workforce that includes facility-, outreach- and community-based health workers supported through effective management, supervision and appropriate compensation.	Expand on the currently established PHC training initiatives. Establish subspecialty training for psychologists, nurses and psychiatrists to expand on the existing workforce. Establish a dedicated system of support staff for the PHC sector which will enable the development of policies and the monitoring of care.
Physical infrastructure	Secure and accessible primary care facilities to provide effective services with reliable water, sanitation and waste disposal/ recycling, telecommunications connectivity and power supply, and with transport systems that can connect patients to other care providers.	Develop existing health facilities to ensure the needs of providers and users are met. This includes dedicating suitable spaces within the existing PHC setting for MHPSS care.
Medicines and other health products to improve health	Availability and affordability of appropriate, safe, effective, quality medicines and other health products, through transparent processes, to improve health.	Increase availability of medication and alternatives to medications (such as non-oral SSRIs for children). Monitor supply chains and supply chain management systems to ensure availability of medication.
Engagement with private-sector providers and NGOs	Sound partnerships between public and private sector providers for the delivery of integrated health services.	Develop connections with the private health care sector, including information sharing enabling the integration and standardization of delivery of care.
Purchasing and payment systems	Purchasing and payment systems that foster a reorientation in models of care towards more prevention and promotion, and towards care delivered closer to where people live and work. Such systems need to provide incentives for the delivery of quality primary care services and facilitate integration and coordination across the continuum of care.	Develop clear and widely accessible guides for payment structures and facilities to pay online.

Title	PHC description	Integrating MHPSS for children and adolescents into PHC
Digital technologies for health	Use of digital technologies for health that facilitate access to care and service delivery, improve effectiveness and efficiency, and promote accountability.	Foster the development of digital technology to monitor, prevent, treat and deliver MHPSS. Technological developments can also lead to more efficient access to care such as promotion of service availability and the ability to make appointments online. Electronic health records can be used for research purposes as well as monitoring and evaluation.
Systems for improving the quality of care	Systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health services.	Develop systems at a local, subnational and national levels to enable the continuous assessment of the delivery of care. This will assist in the improvement of quality.
PHC-oriented research	Research and knowledge management, including dissemination of lessons learned, as well as the use of knowledge to accelerate the scaling up of successful strategies, to strengthen PHC-oriented systems	Promote research to enable knowledge management dissemination and the use of lessons learned to improve health services.
Monitoring and evaluation	Monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors.	Ensure the presence of an evaluation and monitoring system for the treatment and care delivered to address MHPSS within the PHC setting. This can be achieved through the generation of monitoring data. This data may be used to monitor service delivery and assist in decision-making across the governmental health care system. Indicators for monitoring and evaluating MHPSS can be contrasted with the PHC systems of other countries. This will generate a helpful source of reference.

6.2. Key recommendations for ministries, PHC and NGOs

MOH

- Dedicate financial support for MHPSS within PHC and secondary/tertiary services.
- Actively support the integration of MHPSS for children, adolescents, pregnant women and new mothers within PHC.
    - o Investigate the workforce gap and prioritize its development.
    - o Support the PHC administration in the development of the required care plan including the following:
        - – policies and procedures,
        - – screening, diagnosis and treatment, and
        - – required provisions for training of existing PHC medical practitioners.
- Prioritize MHPSS specialized staff capacity building.
- Develop a link with MOSA and MOE to target MHPSS for children, adolescents, pregnant women and new mothers.
- Facilitate collaboration with the MOH School Health Department and PHC.

PHC

- Establish a working group or committee to assess the requirements and capacity for MHPSS integration for children, adolescents, pregnant women and new mothers.
- Study the capacity to integrate maternal MHPSS for new mothers into existing Well Baby clinics.
    - o Develop dedicated policies and procedures for screening, diagnosis and treatment of children, adolescents, pregnant women and new mothers within PHC.
    - o Develop mechanisms of training and job aids to assist existing PHC staff members in providing MHPSS care for children, adolescents, pregnant women and new mothers.
- Petition MOH for dedicated funding to enable integration, including funding for support and administration staff, capacity building, training of existing workforce and dedicated staff to facilitate capacity building.
- Once MHPSS has been established, increase awareness within the community regarding MHPSS care for children, adolescents, pregnant women and new mothers within PHC.

MOE

- Collaboration between the MOE's Department of Social Work and Psychology with the MOH and the greater MOE.
- Develop a clear collaborative effort between MOE and PHC for referral systems.
- Integrate mental health awareness into governmental school curriculum.
- Training existing psychologists employed within MOE in the screening of common mental health conditions in children and adolescents.

MOSA

- Develop long-term strategic plans with MOH and MOE to ensure that the mental health of children, adolescents, pregnant women and new mothers is addressed.
- Collaborate with NGOs and MOH to identify those who are at high risk and establish protocols to protect them.

NGOs

- Champion MHPSS political support, specifically to support the integration of MHPSS for children, adolescents, pregnant women and new mothers within PHC.
- Continue established initiatives to raise awareness and collaborate with MOH to develop initiatives to be more impactful.

6.3. Discussion

There is a significant lack of MHPSS care provided to children, adolescents, pregnant women and new mothers within the PHC service delivery sector of Kuwait. Currently there are no provisions of care targeting these demographics. The PHC system has recently established and integrated MHPSS for adults. This mechanism, along with the committees and stakeholders involved, are a useful starting point for this endeavour.

Integration of MHPSS for children, adolescents, pregnant women and new mothers will require directed cross-sector stakeholder collaboration. Significant sectors to be recruited are the MOE, the School Health Department of MOH and decision-makers within MOH.

It is vital to address workforce capacity-building. There are four registered child psychiatrists and one psychiatrist specialized in women's health working within MOH. There are a suitable number of psychologists in Kuwait as Kuwait University has a dedicated Psychology Department within the College of Social Sciences. Unfortunately, they do not meet the clinical requirements of practice to be suitable to provide care within MOH. While lack of funding is not a major obstacle, there is a need for specific funding allocation to MHPSS care. There is also a significant lack of coordination and collaboration within sectors.

MOH decision-makers must be made aware of the need to address the gaps in services. Their championing of this will ensure adequate financial funding for unmet needs. The most important avenues to target would be policy development (including a national care plan) and workforce capacity building. As a nation, Kuwait has the capacity to meet these objectives. Directed and targeted development is vital to efficient integration of MHPSS into PHC.

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Appendix A

KEY INFORMANT INTERVIEW GUIDE

ESTABLISHING THE FOUNDATIONS FOR INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) IN PRIMARY HEALTH CARE TARGETING CHILDREN AND ADOLESCENTS IN THE MIDDLE EAST AND NORTH AFRICA REGION

Key informant interview

Interviewer ID:	001	Date (dd/mm/yy):	
Start time:		End time:	
Participant ID:		Sector / organization:	
Current designation / role of participant:			
Age of participant		Gender of participant:	
Consent obtained?	YES / NO		

Thank you very much for agreeing to participate in this interview.

Today we will be asking for your views and opinions about how to integrate MHPSS for children, adolescents and pregnant/postpartum women within the primary health care system in [country name]. This will include questions about your thoughts on the mental health needs of children and adolescents and mothers, what role your sector currently plays in delivery of support services and the challenges and opportunities to improve the delivery of MHPSS in primary care.

Mental health and psychosocial well-being' is a positive state in which children, adolescents and adults are able to cope with emotions and normal stresses, have the capacity to build relationships and social skills, are able to learn and have a positive sense of self and identity.

Mental health conditions' is a broad term that encompasses the continuum from mild psychological distress to mental disorders, which may be temporary or chronic, fluctuating or progressive.

During childhood and adolescence, common mental health conditions include: difficulties with behaviour, learning or socialisation; worry, anxiety, unhappiness or loneliness; and disorders such as depression, anxiety, psychosis, bipolar disorder, eating disorders, substance use disorders, conduct disorder, ADHD, intellectual disability, autism and personality disorders.

For women who are pregnant or have recently given birth, maternal mental health conditions include perinatal depression, symptoms of anxiety and anxiety disorders, postnatal psychosis and post-traumatic stress disorder. The perinatal period is also associated with an increased risk of other mental health disorders (such as bipolar disorder or schizophrenia) that may be new diagnoses or relapse of existing mental health disorders.

By MHPSS we mean any services or supports to diagnose and treat mental health conditions, to prevent poor mental health, and to promote mental health and psychosocial well-being.

This could include:

- Services for children, adolescents, pregnant women or mothers who have mental health conditions (screening, clinical care, multi-disciplinary care and support, continuing psychosocial support to support recovery and rehabilitation)
- Preventive interventions to address risk factors for poor mental health or enhance protective factors (supporting social and emotional learning, addressing peer victimisation and positive peer support, building parenting skills, prevention and response to specific risks such as violence or substance use)
- Mental health promotion (efforts to reduce stigma and discrimination, or improve mental health awareness and literacy)

The session today will take approximately 60–90 minutes.

Participating in this project is voluntary. You do not have to answer any question that I ask you, and we can stop the interview at any time. If you don't want to answer a question or would like to stop the interview you do not have to give a reason. If you wish to withdraw from the project after our discussion, please contact the study team and the information that you shared will be destroyed.

With your permission I will be taking notes and recording today's interview, to make sure we gather all your ideas. Everything you say will remain confidential. Your responses will not be shared with your manager or employer, and they will not affect your role or employment.

What we learn from this interview will be compiled with the responses from other interviews. A summary of the key findings will be shared with government representatives, and United Nations agencies both in this country and in the Middle East and North Africa region. They will also be used to develop recommendations to improve the delivery of mental health support services in [country name] and the region. No personal information identifying you or your organization or employer will be included in any reports or other documents.

Please confirm the participant's consent to continue the interview, and consent to have the interview recorded.

Theme	Questions
Mental health needs of children and adolescents	**I would like to start by asking what you think the main mental health needs or problems are of children and adolescents in [YOUR COUNTRY]?** • Children (<10 years) • Adolescents (10–18 years of age) • Pregnant and postpartum women (maternal mental health) • Are there particular groups who have worse mental health than others, or are at increased risk? Why? (e.g., girls vs. boys, pregnant adolescents, refugees, migrants,) • Are they any systems in place to collect and report data on mental health needs (e.g., surveillance systems). Can you describe these?
Current MHPSS provided through primary health care	**I would like to ask you about the different mental health and psychosocial support services that are currently provided through primary health care.** • What types of services are provided and what mental health needs do they address? o Children o Adolescents (10–18 years of age) o Maternal mental health • Who provides these services (which types of health care providers)? • How are they provided? Are they standalone mental health services such as community mental health clinics, or integrated with other services, such as general outpatient clinics, maternal and child health, nutrition programmes, outreach services and school-based services? • Who uses these services? • Who funds the services? Are fees charged? Are any services subsidized? • Are there any services that are specifically for children and adolescents? • Are there any population groups that face additional barriers to access (rural families, refugees or displaced populations, migrant families)? • How is data about mental health services collected and reported, and who is this reported to?

Theme	Questions
Current MHPSS provided through primary health care	Some **examples** could include: • Screening, early identification and diagnosis • Triaging and assessment • Treatment and management of mental health conditions (including developmental disorders) • Continuity of care/multi-disciplinary case management • Mental health facilities / residential care • Screening and management of risk factors (exposure to violence, abuse, neglect, bullying, substance use, etc) • Parenting support • Linkages with schools or communities for mental health promotion **What are the existing linkages and referral mechanisms with secondary and tertiary level care, including specialist mental health services? How could these be strengthened?**
Current barriers and enablers	**I would like to ask you about the current challenges delivering or integrating MHPSS into primary health care.** • What is **currently being done well** to address the mental health of children, adolescents and mothers through primary health care? • What do you think could be improved or strengthened? • What specific areas of mental health and well-being or services aren't being addressed? • What are the main challenges delivering MHPSS through primary health care? Some **prompts** could include: • Access to clinical guidelines, protocols, tools, job aids • Workforce (availability, training, skills, supervision) • Referral mechanisms • Workload pressure/integration into other services • Financial and other resources • Lack of medical supplies for mental health • Low care-seeking/stigma • Lack of data/health information systems • Can you explain the social norms or attitudes towards mental health, stigma, care seeking behaviour? o How do these norms impact on service providers and quality of care? o How do these norms impact on the community and care-seeking behaviour?

Theme	Questions
How could MHPSS be strengthened	**I would like to ask you about what additional mental health and psychosocial supports or services could be integrated into primary health care.** **Are there any mental health and psychosocial supports or services that you think could be provided through primary health care that are not currently being provided? Can you describe these? (i.e., what services could be integrated into primary health care?)** Some **prompts** could include: • Additional services to identify or screen for mental health conditions • Management (including multi-disciplinary support and case-management) • Services to identify and address risk factors (violence, bullying, substance use) • Parenting programmes and support • Outreach, community-based, school-based services Which of these would be the highest priority in your opinion? How could these be delivered? • Integrated with existing services (if so, which ones)? • Establishing new services/programmes specifically for mental health? • Community-outreach or school-based? • Linkages with communities and community-based organizations • Who (which providers) should be engaged in delivering these?
Considerations for implementation	**Reflecting on the challenges you have already described, and some of the gaps and priorities, what would be needed to support MHPSS through primary health care?** Some **prompts** could include: • What policy or legislative changes are needed (e.g., parental consent for adolescents)? • What is needed to support planning and coordination (between government departments, different levels of health care, between health services)? • What additional guidelines, protocols, standards, job aids are needed? • What infrastructure or facility environment changes are needed? • What workforce supports are required (numbers, training and capacity building, skills mix, supervision)? • Financial resources? • Data and information (e.g., health information systems, surveillance, further research)? • What service delivery approaches are needed to reach children, adolescents, pregnant women and new mothers? • Improved community engagement/care-seeking

Theme	Questions
Linkages with other sectors	**What are the existing linkages and referral mechanisms between primary health care and other supports/sectors (schools, social welfare, NGOs)?** • How are mental health referrals to primary health care from schools, child protection, NGO or other services currently managed? What are the challenges? • What referrals are made by primary health care to other MHPSS supports (e.g., child protection, special education, social protection)? What are the challenges? • Are there any examples of coordinated programmes or services provided by primary health care and other sectors to address mental health and well-being? For example: o School-based screening, counselling, support o Multi-disciplinary case management of those with mental health conditions o Multi-disciplinary case management for children or families at increased risk **What role could other sectors (social welfare, social protection, child protection education) have in supporting community-based mental health for children, adolescents and their families?** **What would be needed to strengthen these linkages and coordination?**
Any other issues?	**Are there any other comments or suggestions you would like to raise that we have not yet covered today?** I will go over a summary of what we have discussed; if you would like to add or change anything you have said please let me know.

Appendix B

CONSENT FORM - ENGLISH

ESTABLISHING THE FOUNDATIONS FOR INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) IN PRIMARY HEALTH CARE TARGETING CHILDREN AND ADOLESCENTS IN THE MIDDLE EAST AND NORTH AFRICA REGION

Participant information and consent form

You are being invited to participate in a project that is aiming to understand how mental health and psychosocial support (MHPSS) for children, adolescents and maternal mental health can be effectively integrated and delivered through primary health care in the Middle East and North Africa (MENA) region. The project is being conducted in collaboration of the Ministry of Health (MOH) in Kuwait and UNICEF.

This Participant Information and Consent Form tells you about the research project and explains what is involved. Knowing what is involved will help you to decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or trusted professional.

Participation in this research is voluntary. If you don't wish to take part, you don't have to. There will be no negative consequences for you if you choose not to take part.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read,
- Consent to take part in the research project,
- Consent to research activities that are described, and
- Consent to the use of your information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

What is the project about?

The aim of this project is to understand how MHPSS for children, adolescents and pregnant/postpartum women can be effectively integrated and delivered through primary health care in the MENA region. The project is being conducted in six countries in the region: Egypt, Jordan, Libya, Lebanon, Saudi Arabia and Kuwait.

The **specific objectives** of this project are to:

1. Identify the current (or potential) roles and responsibilities for primary health care in delivering MHPSS for children, adolescents and maternal mental health (mapped against global and regional MHPSS frameworks).
2. Explore current challenges and opportunities to strengthen delivery of MHPSS through primary health care.
3. Identify the supports and capacity building steps required for implementation of MHPSS through primary health care through a systems-strengthening lens.
4. Explore linkages between primary health care and other key sectors (including child protection and education) needed to support MHPSS.

The findings of this study will inform the development of country-specific and regional recommendations, defining what MHPSS could be integrated through primary health care and through which services/platforms, and considerations to support effective implementation. These recommendations will be targeted and presented to governments, non-government organizations (including service-delivery agencies), United Nations agencies, youth-focused organizations and donors in the region. The study is being funded by UNICEF MENA Regional Office.

What are we collecting information about?

We are interviewing representatives from government ministries, United Nations agencies, private sector organizations, professional associations and youth organizations. We are aiming to interview around 15 people in each country to gain their perspectives on the mental health needs of children, adolescents and pregnant/postpartum women, current approaches to provide MHPSS, current or potential role of key sectors in supporting MHPSS and challenges and opportunities to strengthen MHPSS.

Do I have to take part?

Participation is voluntary. We would like you to take part in the interview, but it is up to you to decide whether or not you do so. Your decision will not be shared with anyone, including your colleagues, managers, or the government. Even if someone referred you, we will not tell them whether or not you decide to take part. You can change your mind and leave the interview at any time without having to give a reason. Please let us know if you have any questions or worries about the interview. You are also free to withdraw from the project at any time before, during or after the interview, even if we have already recorded your responses. If you wish to withdraw from the project please contact sarah.alkandari@dasmaninstitute.org. If you withdraw, all the notes, recordings or transcripts from this interview will be destroyed immediately and we will not include any of your responses in any reports or recommendations. If you decide to withdraw this decision will not be shared with your manager or employer, and will not affect your role or employment.

What happens if I agree to take part?

You will be asked to participate in an interview. Where possible this will be done in person, but where COVID-19 restrictions do not allow this will be conducted via videoconferencing (Zoom or Skype). If through videoconferencing, you will need a stable internet connection, a web browser and a comfortable, private space to complete the interview. A trained interviewer will ask you some questions about your opinions and experiences. There are no right or wrong answers. The interview will take approximately 60–90 minutes to complete. We will record some notes during the interview and will also record the interview on an audiotape so that we can accurately write down your responses. If we record the interview in Zoom, a video file and an audio file are automatically created. As soon as the interview is finished, we will delete the video file, we will not use this file at all. The audio recording of the interview will be transcribed (written down word for word) by a trained member of the research team. Once we have written down all your responses, we will destroy the audiotape within four weeks of your interview. There are no costs associated with participating in this research project, nor will you be paid. If you decide to withdraw from the project at any time any notes, recordings or transcripts from this interview will be destroyed immediately.

What if I am concerned about anything discussed in the interview?

You can speak to us today if you have any concerns or questions before, during or after the interview is complete. You don't have to answer any questions you don't want to, and there will be time at the end of the interview to raise any problems, concerns, or make amendments to your responses.

Will anyone know what I talk about?

Everything that we discuss will be kept confidential. We will not record your name, or the name of your organization or workplace, on any of the notes or on the recordings. Your views, opinions and responses will be kept confidential: your responses will not be shared with your manager or employer and will not affect your role or employment. All the information recorded in hardcopy will be securely stored in a locked filing cabinet. Electronic information will be stored on a secure computer server accessible only to members of the research team. Audio recordings will be transferred to a secure computer by the end of the day, and then deleted from the recording device. The digital audio file of the interview will be deleted within four weeks, once we have written down all your responses. The written record of the interview will not include any details that identify you or your organization, and will be stored on a secure computer server by Burnet Institute. The only people who will have access to this information will be the research team.

What will happen to the information collected?

Everyone's responses from the interviews will be compiled, and we will use the anonymous, compiled responses to summarize the perceptions of mental health needs among children, adolescents and pregnant/postpartum women, current or potential role of key sectors, challenges and opportunities to strengthen MHPSS. A summary of the main findings will be included in a report to the UNICEF MENA Regional Office, that will also outline some important recommendations based on your opinions. A paper to be published in a medical journal, summarising the key findings and recommendations, will also be prepared. No names or any other identifying information will be included in these reports or summaries. This includes no details about you or your organization. The anonymous information will be securely stored for a period of seven years and then all the records will be destroyed. You will be provided with a copy of the final document that summarizes all the key findings of the study, as well as a summary of the findings from your country at the completion of the project.

What are the possible benefits of taking part?

There are no direct benefits of participating in the interview, and you will not be paid for participating. However, your involvement in the study may improve your own understanding of important mental health needs amongst children, adolescents and mothers, relevant policies and services in your country, and may give you an insight into potential opportunities to engage in government and non-government initiatives. However, we cannot guarantee that there will be any benefits to you or your organization from participating. It is hoped that the findings from this study will be used to advocate for a minimum-services package of mental health for children, adolescents and maternal mental health in your country, and increased supports to implement this.

What are the possible risks of taking part?

The risks of participating in this interview are minimal. The interview will take approximately 60 minutes of your time, which may be inconvenient. There is a small risk of a breach of confidentiality, however we will not be collecting any personal or sensitive information from you and procedures will be in place to protect your privacy at all times. You will be reminded not to use your own name, the name of your organization or other third parties at the start of the interview. There is a potential that you could be identified by your voice on the audio recording. To protect your privacy the recording we make today will be kept by the senior researcher and transferred to a secure computer at the end of the day. The recording will then be immediately deleted from the recording device. All audio files will be deleted within four weeks once a written record of the interview has been made. This written record will not include any details that could identify you or your organization.

You do not have to answer any questions you do not want to, and you can leave the interview at any time without needing to give a reason. At the end of the interview there will be an opportunity for you to review some of the key topics discussed and add to or change any of your responses.

The ethical aspects of this research project have been approved by the Office of Regulatory Affairs at the Dasman Diabetes Institute. This statement has been developed to protect the interests of people who agree to participate in human research studies.

Questions?

You are free to ask any questions before agreeing to participate. Do you have any questions at this time?

If you have more questions later, or if you have any complaints about this project, you may contact:

[Sarah Alkandari at sarah.alkandari@dasmaninstitute.org
[Dasman Diabetes Institute] [Kuwait]

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Complaints Officer
Office of Regulatory Affairs
Alfred Health, Melbourne, Australia

Email: Rashmi.shiju@dasmaninstitute.org

Appendix C

CONSENT FORM - ARABIC

أنشاء مؤسسة لدمج الصحة النفسية والدعم النفسي الاجتماعي في نظام الرعاية الصحية الأولية تستهدف الأطفال و المراهقين في منطقة الشرق الأوسط وشمال أفريقيا

معلومات المشارك واستمارة الموافقة

أنت مدعو للمشاركة في مشروع يهدف إلى فهم كيف يمكن دمج خدمات الصحة العقلية والدعم النفسي الاجتماعي للأطفال والمراهقين والصحة النفسية للأمهات بشكل فعال وتقديمها من خلال الرعاية الصحية الأولية في منطقة الشرق الأوسط وشمال إفريقيا MENA). يتم تنفيذ المشروع من قبل معهد بيرنت بالشراكة مع مكتب اليونيسف الإقليمي في منطقة الشرق الأوسط وشمال إفريقيا MENA).

يخبرك نموذج الموافقة ومعلومات المشارك هذا عن مشروع البحث ويشرح ما يتضمنه. سيساعدك معرفة ما ينطوي عليه الأمر على تحديد ما إذا كنت تريد المشاركة في البحث.

ارجوك اقرأ هذه المعلومات بدقة. اطرح أسئلة حول أي شيء لا تفهمه أو تريد معرفة المزيد عنه. قبل أن تقرر ما إذا كنت ستشارك أم لا ، قد ترغب في التحدث عن ذلك مع قريب أو صديق أو محترف موثوق به.

المشاركة في هذا البحث تطوعي. إذا كنت لا ترغب في المشاركة ، فلا داعي لذلك. لن تكون هناك اي عواقب سلبية عليك إذا اخترت عدم المشاركة.

إذا قررت أنك تريد المشاركة في مشروع البحث ، فسيُطلب منك التوقيع على قسم الموافقة. بتوقيعك عليه فإنك تخبرنا أنك:

- فهم ما قرأته
- الموافقة على المشاركة في مشروع البحث
- الموافقة على أنشطة البحث الموصوفة
- الموافقة على استخدام المعلومات الخاصة بك كما هو موضح.

سيتم إعطاؤك نسخة من معلومات المشارك واستمارة الموافقة للاحتفاظ بها.

ما الهدف من المشروع؟

الهدف من هذا المشروع هو فهم كيف يمكن دمج الصحة النفسية والدعم النفسي الاجتماعي للأطفال والمراهقين والنساء الحوامل / بعد الولادة بشكل فعال من خلال الرعاية الصحية الأولية في منطقة الشرق الأوسط وشمال إفريقيا. يتم تنفيذ المشروع في ست دول في المنطقة: مصر والأردن وليبيا ولبنان والمملكة العربية السعودية والكويت.

الأهداف المحددة لهذا المشروع هي كالتالي:

1. تحديد الأدوار والمسؤوليات الحالية (أو المحتملة) للرعاية الصحية الأولية في تقديم الصحة النفسية والدعم النفسي الاجتماعي للأطفال والمراهقين والأمهات (تم تحديدها مقابل أطر الصحة النفسية والدعم النفسي الاجتماعي العالمية والإقليمية).
2. استكشاف التحديات والفرص الحالية لتعزيز تقديم الصحة النفسية والدعم النفسي الاجتماعي من خلال الرعاية الصحية الأولية.
3. تحديد خطوات الدعم وبناء القدرات المطلوبة لتنفيذ الصحة النفسية والدعم النفسي الاجتماعي من خلال الرعاية الصحية الأولية من خلال عدسة تعزيز النظم.
4. استكشاف الروابط بين الرعاية الصحية الأولية والقطاعات الرئيسية الأخرى (بما في ذلك حماية الطفل والتعليم) اللازمة لدعم الصحة النفسية والدعم النفسي والاجتماعي.

ستفيد نتائج هذه الدراسة في تطوير التوصيات الخاصة بالبلد والإقليمية ، وتحديد ما يمكن أن يتم دمجه من خلال الصحة النفسية والدعم النفسي الاجتماعي من خلال الرعاية الصحية الأولية ومن خلالها الخدمات / المنصات ، والاعتبارات اللازمة لدعم التنفيذ الفعال. سيتم استهداف هذه التوصيات وتقديمها إلى المنظمات الحكومية وغير الحكومية (بما في ذلك وكالات تقديم الخدمات) ووكالات الأمم المتحدة والمنظمات التي تركز على الشباب والجهات المانحة في المنطقة. سوف يتم تمويل هذه الدراسة من قبل المكتب الإقليمي لليونيسف في الشرق الأوسط وشمال إفريقيا.

ما هي المعلومات التي نجمعها؟

نجري مقابلات مع ممثلين من الوزارات الحكومية ووكالات الأمم المتحدة ومنظمات القطاع الخاص والجمعيات المهنية والمنظمات الشبابية. نهدف إلى مقابلة حوالي 15 شخصًا في كل بلد للتعرف على وجهات نظرهم حول احتياجات الصحة العقلية للأطفال والمراهقين والنساء الحوامل / بعد الولادة ، والنهج الحالية لتقديم خدمات الصحة النفسية والدعم النفسي الاجتماعي ، والدور الحالي أو المحتمل للقطاعات الرئيسية في دعم خدمات الصحة النفسية والدعم النفسي الاجتماعي ، و التحديات والفرص لتعزيز الصحة النفسية والدعم النفسي الاجتماعي.

هل يجب علي المشاركة؟

المشاركة طوعية. نود منك أن تشارك في المقابلة ، ولكن الأمر متروك لك لتقرير ما إذا كنت ستفعل ذلك أم لا. لن يتم مشاركة قرارك مع أي شخص اخر ، بما في ذلك زملائك أو مديرك أو الحكومة. حتى إذا أحالك شخص ما ، فلن نخبره بما إذا كنت قد قررت المشاركة أم لا. يمكنك تغيير رأيك ومغادرة المقابلة في أي وقت ودون الحاجة إلى إبداء الأسباب. يرجى إعلامنا إذا كان لديك أي أسئلة أو مخاوف بشأن المقابلة. أنت أيضًا حر في الانسحاب من المشروع في أي وقت قبل المقابلة أو أثناءها أو بعدها ، حتى لو كنا قد سجلنا ردودك بالفعل. إذا كنت ترغب في الانسحاب من المشروع ، يرجى الاتصال بـ سارة الكندري (sarah.alkandari@dasmaninstitute.org) في حالة الانسحاب ، سيتم إتلاف جميع الملاحظات أو التسجيلات أو النصوص من هذه المقابلة على الفور ولن نقوم بتضمين أي من ردودك في أي تقارير أو توصيات. إذا قررت التراجع عن هذا القرار ، فلن تتم مشاركته مع مديرك أو صاحب العمل ، ولن يؤثر على دورك أو وظيفتك ،

ماذا يحدث إذا وافقت على المشاركة؟

سيُطلب منك المشاركة في مقابلة. وحيثما أمكن ، سيتم إجراء ذلك شخصيًا ، ولكن في الحالات قيود COVID-19 التي لا تسمح فيها ، سيتم إجراء ذلك عبر مؤتمرات الفيديو Zoom أو Skype. إذا كانت المقابلة من خلال مؤتمرات الفيديو ، فستحتاج إلى اتصال إنترنت ثابت ، ومتصفح ويب، ومساحة مريحة وخصوصية لإكمال المقابلة. سيطرح عليك المحاور المدرب بعض الأسئلة حول آرائك وخبراتك. لا توجد اجابات صحيحة أو خاطئة. ستستغرق المقابلة حوالي 60–90 دقيقة لإكمالها. سنقوم بتسجيل بعض الملاحظات أثناء المقابلة وسنقوم أيضًا بتسجيل المقابلة علي شريط صوتي حتى نتمكن من تدوين ردودك بدقة. إذا سجلنا المقابلة عن طريق Zoom ، سوف يتم انشاء فيديو وملف صوتي تلقائيًا. و بمجرد انتهاء المقابلة سنقوم بحذف ملف الفيديو ولن نستخدم هذا الملف إطلاقا. سيتم نسخ التسجيل الصوتي للمقابلة (مكتوب كلمة بكلمة) من قبل عضو مدرب من فريق البحث. بمجرد قيامنا بتدوين جميع ردودك ، سنقوم بتدمير الشريط الصوتي في غضون أربعة أسابيع من مقابلتك. لا توجد تكاليف مرتبطة بالمشاركة في هذا المشروع البحثي ، ولن يتم الدفع لك. إذا ما قررت الانسحاب من المشروع في أي وقت ، فسيتم على الفور إتلاف أي ملاحظات أو تسجيلات أو نصوص من هذه المقابلة.

ماذا لو كنت قلقًا بشأن أي شيء تمت مناقشته في المقابلة؟

يمكنك التحدث إلينا اليوم إذا كانت لديك أية مخاوف أو أسئلة قبل أو أثناء أو بعد انتهاء المقابلة. انت لست مضطرًا للإجابة على أي أسئلة لا تريدها ، وسيكون هناك وقت في نهاية المقابلة لإثارة أي مشاكل أو مخاوف أو إجراء تعديلات على ردودك.

هل سيعرف أي شخص ما تحدثت عنه؟

كل ما نناقشه سيبقى طي الكتمان. لن نسجل اسمك أو اسم مؤسستك أو مكان عملك في أي من الملاحظات أو على التسجيلات. ستبقى آرائك وآرائك وردودك سرية: لن تتم مشاركة ردودك مع مديرك أو صاحب العمل ولن تؤثر كذلك على دورك أو وظيفتك. سيتم تخزين جميع المعلومات المسجلة في النسخة المطبوعة بشكل آمن في خزانة ملفات مقفلة. سيتم تخزين المعلومات الإلكترونية على خادم كمبيوتر آمن يمكن الوصول إليه فقط أعضاء فريق البحث. سيتم نقل التسجيلات الصوتية إلى جهاز كمبيوتر آمن بحلول نهاية اليوم ، ثم يتم حذفها من جهاز التسجيل. سيتم حذف الملف الصوتي الرقمي للمقابلة في غضون أربعة أسابيع ، بمجرد كتابة جميع ردودك. لن يتضمن السجل المكتوب للمقابلة أي تفاصيل تحدد هويتك أو مؤسستك ، وسيتم تخزينه على خادم كمبيوتر آمن بواسطة .Burnet Institute سيكون الأشخاص الوحيدون الذين يمكنهم الوصول إلى هذه المعلومات هم فريق البحث.

ماذا سيحدث للمعلومات التي تم جمعها؟

سيتم تجميع ردود الجميع من المقابلات ، وسنستخدم الردود المجمعة مجهولة المصدر لتلخيص تصورات احتياجات الصحة النفسية بين الأطفال والمراهقين والنساء الحوامل / بعد الولادة ، والدور الحالي أو المحتمل للقطاعات الرئيسية ، والتحديات والفرص لتعزيز خدمات الصحة النفسية والدعم النفسي الاجتماعي. سيتم تضمين ملخص للنتائج الرئيسية في تقرير إلى مكتب اليونيسف الإقليمي في الشرق الأوسط وشمال إفريقيا ، والذي سيحدد أيضًا بعض التوصيات المهمة بناءً على آرائك. كما سيتم إعداد ورقة تنشر في مجلة طبية تلخص النتائج والتوصيات الرئيسية. لن يتم تضمين أي أسماء أو أي معلومات تعريفية أخرى في هذه التقارير أو الملخصات. هذا لا يتضمن أي تفاصيل عنك أو عن مؤسستك. سيتم تخزين المعلومات مجهولة الهوسة بشكل آمن لمدة سبع سنوات وبعد ذلك سيتم إتلاف جميع السجلات. سيتم تزويدك بنسخة من المستند النهائي الذي يلخص جميع النتائج الرئيسية للدراسة ، بالإضافة إلى ملخص النتائج من بلدك عند الانتهاء من المشروع.

ما هي الفوائد الممكنة من المشاركة؟

لا توجد فوائد مباشرة للمشاركة في المقابلة ، ولن يتم الدفع لك مقابل المشاركة. ومع ذلك ، قد تؤدي مشاركتك في الدراسة إلى تحسين فهمك لاحتياجات الصحة العقلية الهامة بين الأطفال والمراهقين وصحة الأم العقلية والسياسات والخدمات ذات الصلة في بلدك ، وقد تعطيك نظرة ثاقبة على الفرص المحتملة للانخراط في المبادرات الحكومة والغير الحكومية. ومع ذلك ، لا يمكننا ضمان أنه ستكون هناك أي فوائد لك أو لمنظمتك من المشاركة. من المأمول أن يتم استخدام نتائج هذه الدراسة للدعوة إلى حزمة خدمات الحد الأدنى للصحة العقلية للأطفال والمراهقين والصحة العقلية للأم في بلدك ، وزيادة الدعم لتنفيذ ذلك.

ما هي المخاطر المحتملة للمشاركة؟

مخاطر المشاركة في هذه المقابلة ضئيلة. ستستغرق المقابلة حوالي 60 دقيقة من وقتك ، وهو ما قد يكون غير مريح. هناك خطر ضئيل لحدوث خرق للسرية ، لكننا لن نجمع أي معلومات شخصية أو حساسة منك ، وستكون الإجراءات المعمول بها لحماية خصوصيتك مطبقة في جميع الأوقات. سيتم تذكيرك بعدم استخدام اسمك أو اسم مؤسستك أو أطراف ثالثة أخرى في بداية المقابلة. هناك احتمال أن يتم التعرف عليك من خلال صوتك في التسجيل الصوتي. لحماية خصوصيتك ، سيحتفظ كبير الباحثين بالتسجيل الذي نجريه اليوم وننقله إلى جهاز كمبيوتر آمن في نهاية اليوم. سيتم بعد ذلك حذف التسجيل على الفور من جهاز التسجيل. سيتم حذف جميع الملفات الصوتية في غضون أربعة أسابيع بمجرد عمل سجل مكتوب للمقابلة. لن يتضمن هذا السجل المكتوب أي تفاصيل يمكن أن تحدد هويتك أو مؤسستك.

لست مضطرًا للإجابة على أي أسئلة لا تريدها ، ويمكنك مغادرة المقابلة في أي وقت دون الحاجة إلى إبداء الأسباب. في نهاية المقابلة ستكون هناك فرصة لك لمراجعة بعض الموضوعات الرئيسية التي تمت مناقشتها وإضافة أو تغيير أي من ردودك.

تمت الموافقة على الجوانب الأخلاقية لهذا المشروع البحثي من قبل لجنة أخلاقيات مستشفى ألفريد ، أستراليا. سيتم تنفيذ هذا المشروع وفقًا للبيان الوطني للسلوك الأخلاقي في البحث البشري (2007). تم تطوير هذا البيان لحماية مصالح الأشخاص الذين يوافقون على المشاركة في الدراسات البحثية البشرية.

أسئلة؟

أنت حر في طرح أي أسئلة قبل الموافقة على المشاركة. هل لديك أي أسئلة في هذا الوقت؟

إذا كان لديك المزيد من الأسئلة لاحقًا ، أو إذا كان لديك أي شكاوى حول هذا المشروع ، فيمكنك الاتصال بـ:

سارة الكندري

[معهد دسمان للسكري] [الكويت]

إذا كانت لديك أي شكاوى حول أي جانب من جوانب المشروع ، أو الطريقة التي يتم إجراؤها أو أي أسئلة حول كونك مشاركًا في البحث بشكل عام ، فيمكنك الاتصال بـ:

دمج الصحة النفسية والدعم النفسي الاجتماعي في نظام الرعاية الصحية الأولية في منطقة الشرق الأوسط وشمال أفريقيا

نموذج الموافقة

لقد قرأت نموذج معلومات المشارك أو قرأه لي أحدهم بلغة أفهمها.

أفهم الأغراض والإجراءات والمخاطر للبحث الموصوف في المشروع.

لقد أتيحت لي الفرصة لطرح الأسئلة وأنا راضٍ عن الإجابات التي تلقيتها.

أوافق بحرية على المشاركة في هذا المشروع البحثي كما هو موضح ، وأتفهم أنني حر في الانسحاب في أي وقت أثناء المشروع دون التأثير على دوري أو وظيفتي.

أوافق على تسجيل المقابلة بالصوت والفيديو كما هو موضح في ورقة معلومات المشارك.

أفهم أنه سيتم إعطائي نسخة موقعة من هذا المستند للاحتفاظ بها

اسم المشارك _____

توقيع المشارك _____

اسم الباحث _____

توقيع الباحث _____

التاريخ: _____

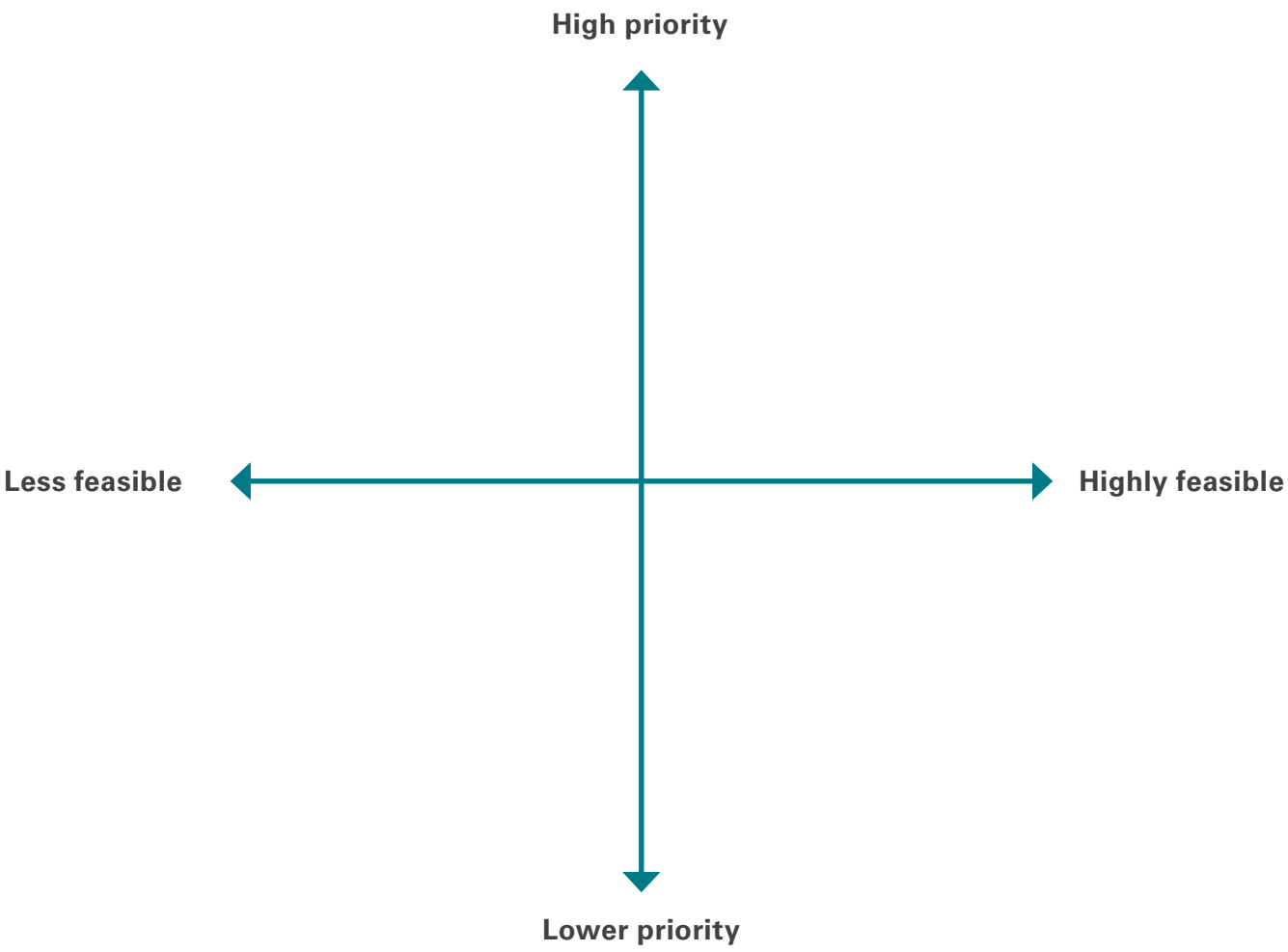
سبب عدم تقديم الموافقة (إن وجد): _____

Appendix D

WORKSHOP TOOLS AND AGENDAS

WORKSHEET 1.

GROUP NAME: _____



WORKSHEET 2.

GROUP NAME: _____

WHAT What specifically needs to change	**WHO** Who is responsible for leading this, and who else needs to be engaged	**HOW** What are the next steps	**WHEN** Achievable in the short (<2 years), medium (2–5 years) or longer term (5+ years)

Establishing the foundation for integration of mental health and psychosocial support in primary health care for children, adolescents, and pregnant/postpartum women in Kuwait

Consultation Workshop

Location: Dasman Diabetes Center **Time:** 9am–12pm **Date:** July 27th 2023

Aims

- Provide an overview of the research project objectives and approach.
- Present key findings from the desk-based review
- Explore existing mechanisms for delivery of MHPSS through primary health care, including challenges, linkages, and opportunities.

Participation

Ministry of Health
Ministry of Education
Ministry of Social Affairs
Supreme Council for Planning
Youth Authority
Public Authority for Disability
NGOs

Programme Schedule

Time	Activity
Session 1	
9:00 – 9:30	Welcome remarks Introduction on MHPSS and its relationship with primary health care Project overview and desk report findings Key findings are recommendations
Session 2	
9:30 – 10:00	**Group Activity 1: Prioritizing gaps or challenges** (15 minutes) Each group to discuss and classify each 'gap' or 'implementation challenge' by *priority* (very high/critical to address, to lower priority/less critical) and *feasibility* (highly feasible to achieve in short term, to unlikely to be feasible within short term). Each 'gap' can be written on a sticky note and added onto a flip chart diagram. **Group Activity 2:**
10:00 – 10:30	Feedback and Discussion
Break (20 minutes)	
Session 3	
10:50 – 11:30	**Group Activity 3: Action plan** Group to work through each of the gaps or challenges identified in Session 2, beginning with the highest priority and working through to the lowest priority *(note that not every gap may be able to be addressed in the time, so the group should focus on their top three priorities).* For each priority gap, group to discuss and develop an action plan. Worksheets will be provided.
11:30 – 11:45	Feedback and discussion
11:45 – 12:00	Questions

إرساء أسس إدماج الصحة النفسية و الدعم النفسي الإجتماعي على مستوى الرعاية الصحية الأولية للأطفال و اليافعين و النساء الحوامل و ما بعد الولادة في الكويت

اجتماع استشاري

المكان معهد دسمان للسكري **الوقت** ٩.٠٠ ص – ١٢.٠٠ م **التريخ** ٢٧ يوليو ٢٠٢٣

أهداف

- تقديم لمحة عامة عن أهداف المشروع البحثي ومنهجيته
- تقديم النتائج الرئيسية من البحث المكتبي
- استكشاف الآليات الحالية لتقديم خدمات الصحة النفسية والدعم النفسي الاجتماعي من خلال الرعاية الصحية الأولية، بما في ذلك التحديات والقيود والفرص

الجهات المشاركة

وزارة التربية
وزارة الشؤون الاجتماعية
الأمانة العامة للمجلس الأعلى للتخطيط والتنمية
الهيئة العامة للشباب
الهيئة العامة لشئون ذوي الإعاقة

مسودة برنامج

TIME	نشاط
الجلسة ١ – مقدمة	
9:30 – 9:00	كلمة ترحيب وأهداف ورشة العمل مقدمة عن الصحة النفسية والدعم النفسي الاجتماعي والرعاية الصحية الأولية نظرة عامة على أهداف المشروع والنهج والمخرجات المتوقعة النتيجة الرئيسية من الاستعراض المكتبي
الجلسة ٣ – رسم خرائط المناهج الحالية لتقديم الصحة النفسية للأطفال والمراهقين والأمهات	
10:00 – 9:30	نشاط جماعي ١
10:30 – 10:00	ردود الفعل الجماعية والمناقشة
	استراحة (20 دقيقة)
الجلسة ٤ – التحديات والفرص لتعزيز الصحة النفسية والدعم النفسي الاجتماعي	
11:30 – 10:50	نشاط جماعي ٢
11:45 – 11:30	ردود الفعل الجماعية والمناقشة
12:00 – 11:45	الأسئلة والخطوات التالية

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