SSM - Mental Health 6 (2024) 100354

Contents lists available at ScienceDirect

SSM - Mental Health

journal homepage: www.journals.elsevier.com/ssm-mental-health

Barriers and enablers to a coordinated MHPSS response in Lebanon: A case study of the MHPSS Taskforce

Rozane El Masri [a], Thurayya Zreik [b], Sandy Chaar [a], Rayane Ali [a], Joseph Elias [a], Bassel Meksassi [a], Felicity L. Brown [a], Ibrahim Bou-Orm [a], Martin McKee [c], Michele Asmar [d], Bayard Roberts [c], Michelle Lokot [c,*,1], Rabih El Chammay [e,1]

[a] Research and Development Department, War Child Holland, Beirut, Lebanon
[b] Independent Consultant, Lebanon
[c] Health Services Research and Policy, London School of Hygiene and Tropical Medicine, London, United Kingdom
[d] Higher Institute of Public Health, Saint Joseph University of Beirut, Beirut, Lebanon
[e] National Mental Health Programme, Ministry of Public Health, Beirut, Lebanon

ARTICLE INFO

Handling Editor: B Kohrt

Keywords:
MHPSS
Governance
Lebanon
Refugees
Humanitarian

ABSTRACT

During humanitarian crises, under-resourced and overstretched health systems may not be able to fully meet mental health and psychosocial support (MHPSS) needs of affected populations, including refugees, internally displaced persons and host communities. Health system governance is vital to humanitarian health response, but there has been little research on this, particularly for MHPSS. We present a case study of a national MHPSS coordination mechanism (the MHPSS Taskforce) in Lebanon, a country which has experienced multiple crises and hosts over 2 million refugees. The aim was to explore the barriers and enablers facing the MHPSS Taskforce in responding to the needs of displaced and host populations in Lebanon. Interviews were conducted with 34 key stakeholders, including Taskforce members, representatives from non-governmental organisations, United Nations agencies, and government Ministries. Our findings show that the positioning of MHPSS within the humanitarian cluster system acts as a barrier to mounting an effective response, with the MHPSS Taskforce sometimes siloed rather than integrated across clusters. Coordination within the Taskforce was reported to be effective in some respects, but limited by a lack of clarity about its decision-making processes, affiliation, mandate, and inclusion of regional perspectives and key groups such as mental health services users in Lebanon. While the technical capacity of the Taskforce is strong, limited funding and staffing were seen to impact its capacity to effectively oversee the MHPSS response in Lebanon. Key recommendations include: the need for stronger mechanisms and operating procedures for interagency and inter-sectoral collaboration on MHPSS within the humanitarian cluster system; greater clarity on the role of the Taskforce and key Taskforce actors, streamlined reporting channels and greater inclusion of diverse perspectives, particularly mental health service users; and greater financial and human resources within coordination mechanisms to support the national MHPSS response in Lebanon.

1. Introduction

There are an estimated 35.3 million refugees globally (UNHCR, 2023a). Many refugees experience significant mental health needs, reflecting exposure to traumatic events, poor living conditions, unemployment, limited economic opportunities, discrimination, social isolation and other daily stressors (Charlson et al., 2019; Mesa-Vieira et al., 2022; Miller et al., 2021). Almost three-quarters of refugees live in low- and middle-income countries (LMICs), where under-resourced health systems may struggle to adequately meet their mental health needs (Martineau et al., 2017; UNHCR, 2022). Reasons include lack of financing for mental health services, limited investment in the mental health workforce, lack of an information system that can capture mental health needs, and failure to integrate mental health services within

* Corresponding author.
E-mail address: michelle.lokot@lshtm.ac.uk (M. Lokot).
[1] Joint senior authors.

https://doi.org/10.1016/j.ssmmh.2024.100354
Received 18 March 2024; Received in revised form 31 July 2024; Accepted 2 October 2024
Available online 9 October 2024

primary care and with other sectors such as education and protection (Bruckner et al., 2011; Charlson et al., 2019; Rathod et al., 2017; World Health Organization, 2021). When faced with high levels of displacement, national and international actors often respond with short-term crisis support. While helping to address immediate needs, this commonly results in parallel systems, with policies, financing, and services dominated by international humanitarian actors. This risks uncoordinated, inefficient, and fragmented responses that fail to adequately support health systems, diverting financing and expertise away from national strategies and impeding more sustainable responses (Lupieri, 2020; Olu et al., 2015).

Effective health system governance is critical for an effective humanitarian response, helping to overcome the many challenges associated with multiple actors and their competing mandates and different funding sources (Barnett, 2013; Lokot et al., 2022). Common elements of health system governance include participation, equity and inclusiveness, responsiveness, capacity, transparency, accountability, effectiveness, efficiency, and strategic vision (Barbazza and Tello, 2014; Pyone et al., 2017; Siddiqi et al., 2019). However, research on health system governance in crisis-affected settings remains limited (Lokot et al., 2022), particularly for mental health.

1.1. Global humanitarian architecture and mental health and psychosocial support

The humanitarian cluster approach is the core part of the humanitarian response governance architecture. It was introduced by the United Nations (UN) and key partners in 2005 to improve the quality, coordination, and accountability of humanitarian response (IASC, 2007). The 11 thematic clusters promote a common strategy to encourage good practices, avoid duplication, address gaps, and share information by building national capacity and advocating for more effective and accountable humanitarian action (Humphries, 2013). There are five technical clusters: health, nutrition, protection, education, and camp management. At the global level, each cluster is typically led by one or two UN organisations or international NGOs. At the country level, clusters are usually co-led by a UN organisation and an NGO, occasionally in partnership with the relevant host government Ministry (Humphries, 2013). Organisations who are part of clusters have potential access to funding, specifically pooled funds (UNHCR, 2023b).

Mental Health and Psychosocial Support (MHPSS) is defined as any support that people receive to protect or promote their mental health and psychosocial wellbeing. Current guidelines for humanitarian settings recommend a multi-level intersectoral MHPSS response to respond to mental health and wellbeing needs, including provision of basic and essential services (e.g., integrating key messages about mental health and wellbeing into food and shelter services), strengthening of community and family supports (e.g. safe spaces, supporting community networks), and delivery of non-specialised mental health care (e.g., basic mental health care by generalist doctors and nurses, community workers and trained peers), and more specialised services (e.g., more intensive therapy or provision of medicines by a mental health specialist such as psychiatric nurses, psychologists, and psychiatrists) (IASC MHPSS Reference Group, 2022). This wide range of MHPSS activities extends beyond the health cluster and is recognised as intersectoral (IASC, 2007), requiring that coordination and accountability is shared across clusters. This cross-sectoral nature of MHPSS makes it challenging to ensure that it is prioritised within each cluster while being coordinated among clusters (O' Connell et al., 2012). At the global level, the IASC MHPSS Reference Group is responsible for coordination, operational support, policy advocacy within the humanitarian system, and development of global technical guidance. This Reference Group recommends that national-level MHPSS technical working groups function as the bodies responsible for coordination of MHPSS programming across clusters, uniting approaches, avoiding duplication and gaps, and ensuring the most efficient use of scarce resources (Harrison et al., 2021; IASC MHPSS Reference Group, 2022). The Handbook for MHPSS coordination notes good coordination as activities that "bring together diverse actors, with local humanitarian leadership and knowledge at the centre", and "ensure a coherent, principled, and sustainable response" (IASC MHPSS Reference Group, 2022). It emphasises accountability to affected populations and collaboration to meet their needs equitably and effectively. Other MHPSS guidelines emphasise the need for stronger engagement with, and support to, existing national systems, ensuring respect for governments playing a central role in providing humanitarian services, thereby avoiding creation of parallel humanitarian systems (IASC, 2007; Van Ommeren et al., 2015; World Health Organization, 2013). However, to date, there is very little research to support effective governance of MHPSS responses, including optimal ways of working with national health and protection systems (de Jong et al., 2008; O' Connell et al., 2012).

1.2. MHPSS services in Lebanon

This study focuses on Lebanon, which has faced many internal and external crises in recent decades. Lebanon hosts one of the highest numbers of refugees per capita. The Syrian conflict, which erupted in 2011, created an influx of around one and a half million Syrian refugees into Lebanon (UNHCR, 2024). Lebanon also hosts an estimated 487,000 Palestinian refugees (UNHCR, 2023a). Since 2019, Lebanon has faced a political crisis and one of the most severe economic crises globally (World Bank, 2021). Humanitarian needs have been compounded by the COVID-19 pandemic and the Beirut port explosion on August 4th, 2020. These multiple challenges have exacerbated mental health needs among Lebanese and refugee populations. The Lebanon humanitarian response operates in a complex landscape of international actors with a significant risk of fragmentation, limited capacity, and scarce resources (Noubani et al., 2021).

The National Mental Health Programme (NMHP) was launched informally at the end of 2013 and was formally established in 2014. The NMHP is part of the Ministry of Public Health (MoPH), with a mandate to coordinate national and international MHPSS efforts in Lebanon, set annual action plans, and develop and implement guidelines to support the scale-up of mental health services (Karam et al., 2016; Kik & El Chammay, 2018). In 2015, the NMHP launched its strategy on Mental Health and Substance Use in Lebanon (Ministry of Public Health Lebanon, 2015). In 2017, the MOPH issued a circular to encourage the coordination of MHPSS actors in Lebanon with the NMHP (Ministry of Public Health Lebanon, 2017).

The MHPSS Taskforce in Lebanon was also formally established in 2014, with the mission to ensure an effective, coordinated and focused inter-agency response to the MHPSS needs of persons living in Lebanon, and a special focus on persons affected by the Syrian crisis (Syrian and Palestinian refugees from Syria as well as the most vulnerable within existing Lebanese and Palestinian communities in Lebanon), in line with the national mental health strategy of Lebanon. The Taskforce is chaired by the NMHP and co-chaired by WHO and UNICEF. It is the only nationally-led coordination group within the humanitarian system in Lebanon, and is a good example of a MHPSS group co-led by a national ministry in humanitarian settings. Around 60 members including UN agencies, local and international organisations, and government ministries are part of the Taskforce (Karam et al., 2016). The Taskforce meets regularly to coordinate activities, develop guidelines, and develop and implement a yearly action plan (Ministry of Public Health Lebanon, 2023). The MHPSS Taskforce is positioned within the existing humanitarian structure in Lebanon, which also includes a Psychosocial Support (PSS) committee, which operates under the Child Protection Working Group, chaired by UNICEF. The Taskforce does not receive direct funding for its operational activities from donors or from the government. Funding for MHPSS activities in Lebanon also is not channeled through the Taskforce, but through clusters, usually Health, Protection

and Education clusters.

Since Lebanon represents a protracted and complex crisis with high MHPSS needs among refugee and host communities, it represents a useful case study to explore governance in MHPSS responses. The aim of this study is to explore the barriers and enablers facing the MHPSS Taskforce in responding to the needs of displaced and host populations in Lebanon and thus inform efforts to strengthen MHPSS responses in Lebanon and similar complex crises. This study was part of the GOAL project which brings together academic, government (NMHP) and civil society organisations in Lebanon and the UK to strengthen mental health systems' response to the mental health needs of Syrian refugees and host communities in Lebanon (London School of Hygiene and Tropical Medicine, 2020).

2. Methods

2.1. Design

We conducted a qualitative study using semi-structured interviews, based on the research question: What are the barriers and facilitators to supporting MHPSS responses for displaced Syrians and host populations facing the MHPSS Taskforce in Lebanon?

2.1.1. Sampling and study participants

Interviewees were selected purposively, based on their familiarity with the Taskforce. They represented a range of stakeholders working in the MHPSS field in Lebanon, distributed among members of the Taskforce (including Taskforce leadership), and others who are not members but have worked closely with the Taskforce. An invitation email about the study was sent to all the Taskforce members and others with the support of the Taskforce leadership (as the NMHP were also part of the study). In total, 34 individuals (28 women and 6 men) were interviewed: 21 from NGOs, 8 from UN agencies, 4 from ministries, and 1 independent consultant.

2.2. Data collection

We developed topic guides in consultation with the NMHP and other GOAL partners and focused on the following themes: strengths and weaknesses of the MHPSS Taskforce, coordination with other coordination bodies and the humanitarian system, its influence on coordination of MHPSS in Lebanon, and trust in the Taskforce. The topic guides were piloted to ensure that the questions were appropriate and meaningful.

Interviews were conducted with key stakeholders over Zoom from February to November 2021 in English or Arabic according to the preference of the participant. Interviews were audio recorded, and then transcribed and translated verbatim directly into English by either the research team or external translators. Transcriptions were quality checked and uploaded into Dedoose for analysis, with 10% of transcripts back-translated to ensure accuracy of Arabic-English translations.

The interviews were conducted by a team who were trained in qualitative research and also received training on mental health policies in Lebanon. This data collection team consisted of a female research coordinator (RE), a female consultant (TZ), a female research officer (RE) and two male research officers (JE and BM).

2.3. Data analysis

As described and reflected upon elsewhere (Zreik et al., 2022), the interviews were analysed collaboratively by the analysis team, after training in qualitative data analysis. We used 'Dedoose' software for coding. The development of the codebook was both deductive (using the topic guides for main themes) and inductive (for newly emergent themes). Six team members were involved in coding, meeting monthly to discuss codes. This step was followed by an analysis of codes by several authors (RE, ML, TZ, SC) who arranged them into relevant themes and collated coded content within themes, followed by further refinement. After the initial analysis, we conducted seven feedback sessions in August–September 2022 with small groups of research participants ($n = 16$), including two sessions with Taskforce leadership. Key findings were presented, and participants were given an opportunity to reflect, clarify, and add further information. These responses were incorporated into the analysis and write-up.

2.3.1. Ethics

Ethical approval was obtained from Université Saint-Joseph de Beyrouth (Saint Joseph University of Beirut) (ref: USJ-2020-255, 21/01/2021) and the London School of Hygiene and Tropical Medicine in London (ref: 22793, 13/01/2021). An Information Sheet was shared with participants, and written informed consent was obtained prior to data collection. Confidentiality was ensured by storing data in a secure site accessible only to the research team. To ensure anonymity, participant names, genders, titles, and organisations are not reported.

3. Results

We present our findings as a case study of the MHPSS Taskforce, according to three identified themes relating to barriers and enablers for its work: (i) coordination of the Taskforce; (ii) affiliation and role of the Taskforce; and (iii) capacity and resources of the Taskforce. Each contains sub-themes that act as enablers and/or barriers. An additional overarching theme is the global structure of the humanitarian system, which impacts each theme, discussed first below. As depicted in Fig. 1, the three themes and the overarching theme of the global humanitarian system are interlinked.

3.1. Global positioning of MHPSS coordinating structures within the humanitarian cluster system

Participants identified the global MHPSS structure as a barrier to the ability of the Taskforce to coordinate MHPSS responses. Participants discussed how the status of MHPSS as a cross-sectoral issue, combined with the problems of siloed working within the cluster system, creates challenges for how MHPSS is positioned and integrated into the cluster system. One participant reflected: "MHPSS is always looking for a home" (NGO actor). Another participant reflected on how MHPSS "doesn't have a fixed place in the humanitarian UN coordination structure … [and it] needs to be given a more defined and systematic place" (Government actor). However, participants highlighted the global nature of this problem, with one participant observing that "it is the same everywhere in all countries in all humanitarian system. It is not a question specific to Lebanon" (Government actor).

Participants, including the Taskforce leadership, described how the cluster system resulted in siloed ways of working, creating "limits" for how effectively cross-sectoral issues can be tackled and requiring additional effort to be integrated. One participant observed, "[T]he fact that these sectors sometimes function very independently is unfortunate because it takes away opportunities to mainstream and properly integrate mental health" (NGO actor).

3.2. Coordination

3.2.1. Effectiveness and process of coordination within the Taskforce

Participants consistently emphasised the importance of robust coordination as a potential enabler for strengthening the MHPSS Taskforce's response. Some participants pointed to examples of good coordination by the Taskforce, praising the Taskforce's ability to adapt to emergency situations and successfully convene different actors and highlighting its strong inter-sectoral presence. The response to the Beirut port explosion was cited as an example of efficient coordination. Participants described the Taskforce leadership as having a clear

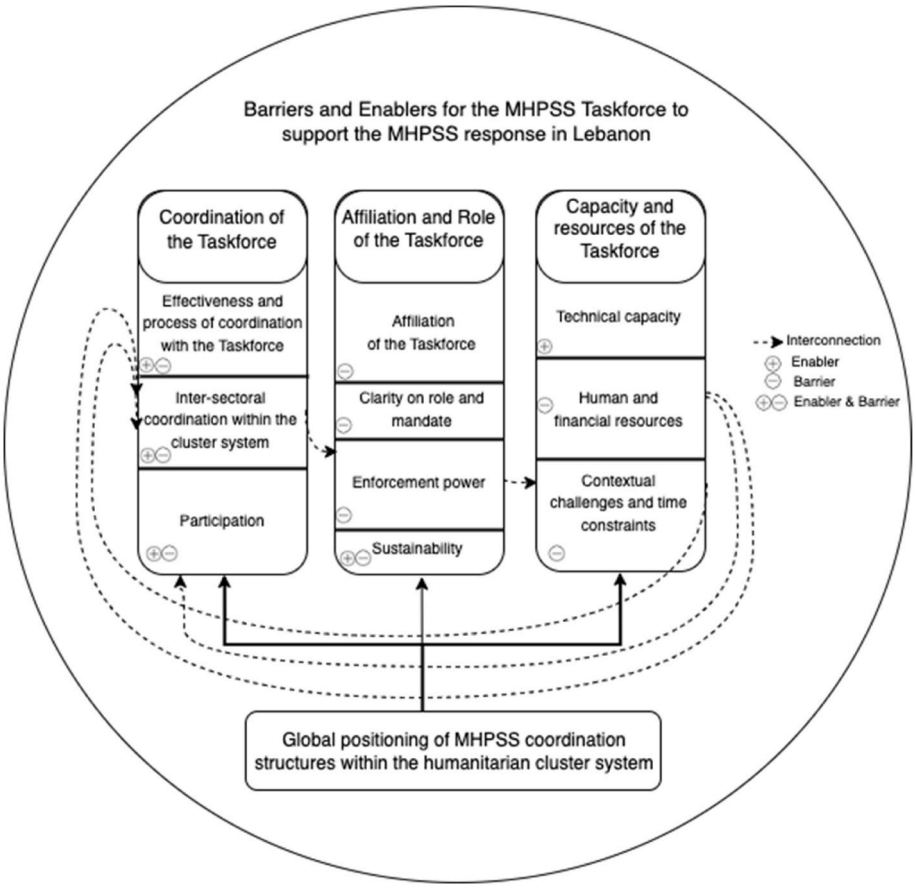

Fig. 1. Barriers and Enablers for the MHPSS Taskforce to support the MHPSS response in Lebanon.

understanding of what coordination entails within the humanitarian sector, emphasising the importance of actively reaching out to partners and colleagues to ensure alignment. Most participants said that the Taskforce leadership fostered coordination by bringing together diverse actors, including medical professionals who weren't directly working in the humanitarian sector.

Participants also described the MHPSS Taskforce's attempts to expand and enhance its coordination efforts among partners by having a clear annual action plan shared regularly with partners, maintaining an online portal for MHPSS inter-agency mapping related to the Cluster's 4Ws (who, what, where, and when), sending routine guidance and emails to all partners, and having shared-decision making (i.e. decisions taken by the majority) on the Taskforce's decisions and processes.

However, other participants identified a lack of clarity on the coordination process by the Taskforce, including the role of Taskforce meetings. Some perceived that the purpose of meetings was to share updates and promote networking but felt this was different to coordination: "[Y]ou spend most of the time listening to updates, but in fact, where is the coordination?. [C]oordination is not just taking updates" (NGO actor). Participants suggested addressing this problem by holding more in-depth Taskforce meetings with clearer objectives. However, during feedback sessions, other participants argued that coordination of activities between humanitarian actors does not typically occur in such meetings, but happens bilaterally and that the Taskforce meetings involve sharing information and updates.

3.2.2. Inter-sectoral coordination within the cluster system

Participants discussed inter-sectoral coordination on MHPSS, noting both exemplary instances and areas for improvement. Factors that facilitated effective intersectoral coordination included: focal points and representatives from different sectors attending Taskforce meetings; collaboration with different sectors to develop the MHPSS annual action plan; and holding joint activities across different sectors. One participant explained how MHPSS is usually listed as an agenda item in the Health Working Group meetings, supporting mainstreaming of MHPSS in the Health sector. The involvement of the Taskforce leadership in, for example, the Health Working Group, was also cited as a positive example. Participants also highlighted the strong ties between the Child Protection Working Group and the MHPSS Taskforce.

There was, however, a general sense that the Taskforce's coordination role was challenging and that coordination was not being fully achieved, due to the reliance of the Taskforce on the other clusters' continued collaboration efforts and the extent of their prioritisation of MHPSS within their respective clusters. Participants reflected on the need for a structured approach to managing coordination among the diverse actors involved in MHPSS, to not rely solely on individual cluster leads having an interest in MHPSS or MHPSS Taskforce members being present in every sector meeting as the only means to put MHPSS on the agenda. In one feedback session, participants recommended the need for clear Standard Operating Procedures (SOPs) outlining how the different clusters should interact with the Taskforce. In another session, participants suggested SOPs could detail which decisions and processes related to MHPSS service planning and delivery should be coordinated or approved by the Taskforce. The presence of separate structures with overlapping technical capacity and service delivery related to MHPSS, such as the National PSS Committee, and the Sexual and Gender Based Violence and Child Protection sub-cluster working groups, was mentioned frequently as requiring significant resources from the Taskforce leadership and other agencies to ensure effective coordination. For instance, one participant said, "to try to reinforce the importance of coordinating with the MHPSS Taskforce […] establishing channels so that different sectors can re-emphasise the importance of coordination

… this is being done but it takes a lot of effort and time as well" (Government actor). These various coordination structures relating to MHPSS can cause confusion for partners, with many actors reportedly not sufficiently aware of how the MHPSS Taskforce is positioned and its activities. One participant suggested: "I would always recommend having the Taskforce as a big umbrella, with all the organisations representing MHPSS and having the other Taskforces or groups as subgroups under this Taskforce" (Independent). Other participants noted that the MHPSS Taskforce is not always visible to other humanitarian actors. One participant suggested, "more work should be done to ensure that the LCRP [Lebanon Crisis Response Plan], as structured, is supporting the Taskforce to achieve its goals while ensuring that this important issue [MHPSS] is being mainstreamed … within different LCRP sectors" (Government actor). They added, "I think we need to have more visibility for all issues surrounding MHPSS."

3.2.3. Participation

Some participants described the Taskforce as a democratic environment that fosters better coordination. One commented that "decision-making is made by the majority" (NGO actor). Others shared examples of the collaborative development of an annual action plan, and instances where they were consulted and asked for feedback. They reported that the Taskforce chairs and co-chairs were "open to communication" and "always open to receiving ideas and the thoughts of all the organisations" (NGO actor). Participants also cited an example of partnership via the establishment of technical committees led by different partners working on various objectives of the action plan.

However, several participants also expressed the need to include more diverse voices in the Taskforce activities, such as service users and field-level staff. Participants noted that although organisations do regularly present on their activities, this could be strengthened to give greater visibility for the organisations and staff involved. Another participant suggested that more members might participate in technical committees if there were greater incentives such as access to projects grants, noting how this was the case with some other working groups supporting with funds that members can use for implementation. To improve mental health service user involvement, participants in a feedback session recommended giving service users a regular slot in Taskforce meetings to talk about their needs, preferences, and experiences. During feedback sessions, the Taskforce leadership emphasised how the Taskforce meetings are open to anyone to attend, and stated that they are exploring ways to formally engage the newly-established Service User Association in Taskforce coordination efforts. The NMHP has already identified service user participation in mental health policy development as an important gap to address in Lebanon.

Participants emphasised that representation from across all of Lebanon's regions is crucial to achieving effective coordination as it provides a better opportunity to identify and address the diverse MHPSS needs throughout the country. However, participants noted how this did not happen because at the time of data collection, meetings were held only online at the national level, a departure from the regional-face-to-face meetings prior to the COVID-19 pandemic. Despite the Taskforce discussing data from the field through the 4Ws reporting, participants noted how most organisations are managed from Beirut so regional perspectives in Lebanon were poorly represented: "[S]ometimes we notice that there are some things that happen at the regional level that the MHPSS coordination [Taskforce] is not aware of" (UN actor). Finally, participants observed that people participating in the Taskforce meetings are commonly mid-level staff involved in decision-making and coordination, so the views of those directly involved in service delivery may not always be fully reflected. One participant argued that field-level perspectives enable improved engagement with user experiences. However, during other feedback sessions, participants felt that field-level data collected through the 4Ws helped ensure the Taskforce was informed by field perspectives. In addition, it was noted that national Taskforce meetings were open to actors from all regions and the online nature of the meetings helped ensure greater regional participation.

3.3. Affiliation and role of the taskforce

3.3.1. Affiliation of the Taskforce

Many participants from international and local organisations expressed confusion about the relationship between the MHPSS Taskforce, the MoPH, and the NMHP, and raised questions about whether their roles were clearly distinct. During a feedback session, one participant discussed uncertainty about the roles of WHO and UNICEF (who are co-chairs of the Taskforce), observing that the relationship between the Taskforce, the MoPH, the WHO, and UNICEF "is not apparent to the public (…) whether they [the Taskforce] are considered as the Ministry or WHO or a separate program". While the Taskforce is an independent body, it was noted that some confusion may lie in the fact that "the [MHPSS] Taskforce and the program [NMHP] were established at the same time almost. So, the Ministry launched the program and at the same time the Taskforce. And also, the program is the one doing the secretarial work … [doing] the minutes … " In one feedback session, participants felt the differentiation between the Taskforce and NMHP was clear, but acknowledged that newer members of the Taskforce might not fully understand this role. In general, participants suggested it should be clearer to all actors about the exact role of the Taskforce as distinct from the NMHP/MoPH, as this could potentially allow better engagement and support for the Taskforce, clarifying its strategic vision and giving more legitimacy to its work given its affiliation with the MoPH.

3.4. Clarity on role and mandate

The Taskforce's Terms of Reference outlines its mandate to ensure an effective and focused inter-agency response to the MHPSS needs by identifying and addressing gaps and promoting the importance of MHPSS at all levels. However, during interviews and feedback sessions, it was clear that there was a lack of clarity around the Taskforce's mandate. At times, some participants indicated a desire for it to adopt other roles, such as monitoring and quality assurance, outreach, training, and fundraising. One participant commented, "There is a great sense of ambiguity on what the Taskforce does, or did in the past" (NGO actor). In addition, while the Taskforce's Terms of Reference states its focus on the MHPSS needs of persons affected by the Syria Crisis and the host population, participants observed a lack of clarity in practice towards the different groups present in Lebanon (including Palestinians, Syrians, and Lebanese). In a feedback session, one participant said that discussions were mostly centred around specialist services, rather than community-level prevention and promotion activities.

However, action plans from the Taskforce and feedback from its leadership demonstrate that, in addition to coordinating around the specialised services, the Taskforce's plans and coordination address a variety of needs including community-level prevention. Similarly, other participants mentioned that "[T]he focus is also a lot on policies, decision-making, laws, all of these things that go beyond, they're not only focused on interventions, but rather things on a national level."

During interviews and feedback sessions, some participants discussed how high staff turnover in the humanitarian sector meant it took time for new Taskforce members to understand the scope and approach of the Taskforce and to participate: "Sometimes even if there is a proper handover, you feel that it would take time for people to interact … " (NGO actor). Multiple participants in the feedback sessions highlighted the need to have a shared understanding and vision of the Taskforce Terms of Reference. They recommended producing shareable communication material clarifying the Taskforce structure, Terms of Reference, role of chair and co-chair, decision-making related to Taskforce decisions, and achievements.

3.4.1. Enforcement power

The topic of Taskforce authority was a key theme that reflected participants' uncertainty about its role in enforcing MHPSS practice and guidelines. For one participant, the uncertainty arose because "it is related to a governmental entity, but you do not get a sense that they have this power to actually take the lead in things" (NGO actor). Another participant explained, "part of this is maybe linked to the fact that [there are] no membership requirements to be in the Taskforce (…) There is nothing binding actors or obliging them to do any of the coordination activities or responsibilities" (Government actor). Participants observed that the Taskforce lacks "authority to take matters into their own hands" because "every organisation in the Taskforce already has their own procedures and ways of functioning" (NGO actor), and that "actors on the ground are often very independent and not very keen to adhere to instructions that are coming from central sources" (UN actor). One participant emphasised that the Taskforce cannot "ensure" the quality of MHPSS: "when you say 'ensure', it means that they have a certain authority, so far the MHPSS Taskforce can only have recommendations" (NGO actor). They gave the example of the Taskforce's efforts to standardise national salary scales, which ended up being reduced to "guidelines" because the Taskforce could not enforce that organisations standardise salaries.

During the feedback session with Taskforce leadership, the structure of the humanitarian cluster system was identified as affecting the authority of the Taskforce in decision-making related to MHPSS funding. It was noted, "It's really based on different actors' interests in contributing, there is nothing that obliges them to do anything. And in terms of incentives, because it's not fully integrated [as a separate cluster], it's not within the humanitarian cluster system, the financial incentives that actors may have, in other sectors, coordination mechanisms are not available here."

Other participants provided examples related to the perceived authority of the Taskforce. Speaking on the topic of funding calls, a participant explained how some donors require organisations to demonstrate that they are coordinating within relevant clusters as a condition to receiving funds. The participant explained that even if mental health is the topic being funded, there is no requirement for coordinating with the MHPSS Taskforce when applying for funding, emphasising how it was "easier to incentivise people" via clusters, but is challenging to encourage participation in this cross-cluster working group (Government actor). They recommended encouraging donors to require coordination with the Taskforce. Multiple participants contrasted the lack of authority that the Taskforce has over funding allocations with other working groups such as the Child Protection Working Group and PSS Committee, noting that in those groups members would not miss meetings because they are financially motivated to engage (Government actor). One participant suggested the need to involve the Taskforce in decisions about MHPSS funding allocation "to create a mechanism by which the MHPSS Taskforce and the chairs of the Taskforce are part of how the MHPSS funding is allocated to which activities and on which basis, as we know there is very little money allocated to MHPSS and in most cases not necessarily to the priority because in every cluster there are bits and pieces" (Government actor). This suggests confusion, as in the feedback sessions, the Taskforce leadership clarified the MHPSS Taskforce does not and should not have this authority at the national level. Such enforcements come directly from the MOPH directly or via the NMHP when they are done (e.g. issuing guidelines or circulars or decisions).

3.4.2. Sustainability

There was a consensus among participants that the Taskforce's affiliation with the MoPH through the NMHP is positive and crucial for the sustainability of their role in strengthening the MHPSS response in Lebanon. The Taskforce's link to the government was perceived as an opportunity to bridge the gap between the government-led health sector and other MHPSS actors, thus preventing the creation of a parallel system. When the government issues guidelines, participants felt this supported long-term sustainability: "[J]ust by the fact that the Taskforce is advocating … and working toward integrating mental health services in PHCCs, this is, in itself, something crucial for the sustainability of services" (NGO actor).

Participants from the feedback sessions also confirmed the importance of the Taskforce's link to the government for sustainability:

> "[C]ertainly when we look to sustainability and the ability of countries to sort of come through a humanitarian crisis and transverse into recovery and development, having the Ministry and or national entity having such a strong leadership role is really relevant."

Many participants felt that the link to the government lends more authority to the Taskforce and enables the strengthening of the National Mental Health System: "[B]ecause it's the Ministry taking the lead on coordination, taking a lead on decision making, and making sure that all the activities are aligned with the Ministry's strategy for mental health, and also aligned with other programs that are part of the Ministry" (UN actor).

It was also observed that the humanitarian system is largely based on short-term, annual plans rather than longer-term strategic planning, which "deprives at times the opportunity to pull up and take on a longer view that expands beyond an annual perspective (…) it doesn't afford you all that often moments to really stop, look at the evidence and then have a sort of thoughtful, extended discussion on what have we learned from this? And what do we need to do better?" (UN actor).

3.5. Capacity and resources of the Taskforce

3.5.1. Technical capacity

Participants reflected on the high technical capacity of the Taskforce as facilitating its role in supporting the MHPSS response. The Taskforce co-chairs were described as being "very qualified, well-founded technically, part of a highly functional team, a team of experts, high calibre staff, and professional staff specialised in different areas, knowledgeable and competent" (NGO actor). Participants mentioned that the Taskforce leadership has established itself as a reference point for consultation on technical aspects of MHPSS, resource development, and training. One participant described how the Taskforce is perceived by actors in the field "as one strong standalone Taskforce that has some proactivity and that's following up on the mental health strategy in the country", observing that the Taskforce is "well-positioned and well-perceived" (UN actor). However, participants also discussed how limited human and financial resources, alongside contextual and time constraints, influenced the responsiveness of the Taskforce leadership.

During feedback sessions, participants suggested the Taskforce could demonstrate its alignment with the action plan by releasing a report at the end of each year to update members (and other sectors) on key activities and achievements, and potentially uploading the action plan on the website. Regular and accessible communication to update members about ongoing guideline/tool development was also suggested, including sharing final Taskforce outputs on the Taskforce website. However, it was recognised by participants during feedback sessions that accomplishing this would require additional resources and staff capacity.

3.5.2. Human and financial resources

Despite the existing technical expertise, participants expressed that the Taskforce's efforts are hindered by the lack of financial resources and subsequently a lack of human resources. Participants attributed limited funding to the fact that the Taskforce does not directly receive routine funding for its operational costs. The NMHP obtains funding through advocacy and fundraising, some of which is used for the staffing and other costs required for coordination of the Taskforce. As a result, as discussed in one feedback session, the continuity of the Taskforce is linked to the sustainability of the NMHP and the capacity of the co-

chairs to mobilise human and financial resources as needed. Due to the structure of the humanitarian system, the Taskforce as a coordination body does not receive direct funding from donors nor from the government to operate, and is dependent on external funding which was reported to be increasingly challenging due to donor fatigue in Lebanon.

Several consequences of the limited resources and limited capacity to mobilise resources were reported by participants as impacting the Taskforce's effectiveness. Firstly, challenges were reported around communication and responsiveness. One participant shared: "They really, really need more resources, human resources to answer to email requests because for example when I send feedback on the action plan I never get a reply" (NGO actor). Secondly, the lack of resources also impacts the timeliness of the publication of guidelines and tools, with many participants describing long delays at times, for example, "guidelines come after one year and a half" (NGO actor). To overcome these challenges, participants expressed that strong coordination of the MHPSS Taskforce requires funding for a dedicated focal point to coordinate, ask for, and share regular updates with members of the Taskforce on plans, projects, and to capture and visualise the updates and share them with all members, which would make accessing updates easier for the Taskforce. One participant explained, "coordination is really a full-time job and requires a lot, especially if you're doing coordination on MHPSS as the NMHP across different areas, right?" (UN actor).

3.6. Contextual challenges and time constraints

Taskforce members reported workload challenges, which are exacerbated by the cross-sectoral nature of MHPSS, and have the potential to limit member participation in the Taskforce. These challenges include multiple reporting platforms to manage, and numerous coordination meetings to attend: "I think maybe each NGO is struggling with a lot of workload within the NGO itself of reporting and documenting" (NGO actor). For instance, participants expressed frustration at being required to report 4Ws data on multiple cluster/sector-specific platforms for humanitarian coordination. One participant suggested, "why not have them in place all with one access [referring to reporting platforms] and then make the lives of everyone easier" (NGO actor). This idea of streamlining with other platforms was echoed in feedback sessions. Participants suggested that actors could be encouraged through providing feedback on how data is used, as well as incentives for coordination and reporting. Additionally, participants suggested a unifying platform with all tools and references created by all MHPSS actors.

4. Discussion

We have identified barriers and enablers in MHPSS responses to the needs of displaced and host populations in protracted crisis settings, using a case study of the MHPSS Taskforce in Lebanon. Governance of humanitarian response is characterised by a diverse landscape of international and national actors often driven by different agendas and priorities (Pyone et al., 2017). Despite MHPSS guidelines emphasising the importance of establishing cross-sectoral coordination mechanisms and working with national governments (IASC, 2007), there appears limited research on this topic. Our study is among the first empirical explorations of country-level experiences and it contributes to work on health system governance in humanitarian crises (Barbazza and Tello, 2014; Lokot et al., 2022; Siddiqi et al., 2019). It also draws attention to the need for critical reflection on key governance principles in MHPSS responses. We identified four key themes, which are now discussed in turn below.

First, was the positioning of MHPSS within the humanitarian cluster system. Our findings are consistent with other literature on how the siloed nature of the cluster system risks MHPSS becoming marginalised if mitigation measures are not taken (Tol et al., 2011; Ventevogel et al., 2015). Connections between the relevant clusters and the MHPSS Taskforce should be clearly defined and strengthened. One recommended mechanism to achieve this is by establishing Taskforce focal points for each cluster, which may reduce burden on co-chairs and promote collaborative leadership (IASC MHPSS Reference Group, 2022). The Taskforce could also benefit from developing an intentional, harmonised strategy for engaging and embedding MHPSS across and within different clusters. This might include MHPSS orientation sessions, shared advocacy messages, joint briefs on referral pathways and procedures, clear interagency and intersectoral monitoring, and evaluation strategies with a common set of indicators and means of verification, while promoting a central information management platform for the 4Ws. Creating a shared strategic vision among members of the Taskforce could also strengthen the MHPSS Taskforce's governance capacity (Siddiqi et al., 2019). Finding ways to strengthen the power of enforcement by the Taskforce may also enhance its positioning and coordination. Evidence from elsewhere shows that a lack of enforcement can impede implementation of plans and limit the ability to convene organisations in crises (Fortnam et al., 2021). Our findings point to the potential benefit of a mechanism through which agencies receiving funding for MHPSS are systematically required to coordinate with the MHPSS Taskforce, to ensure the optimal use of scarce and scattered resources for MHPSS nationally, rather than fragmented approaches within each cluster and for the MHPSS action plan to be formally endorsed by the Humanitarian System. Additionally, while active participation in other Technical Working Groups within the cluster system is encouraged through perceived financial incentives (such as competitiveness for funds distributed through the cluster), no such incentives are available for the MHPSS Taskforce members. The creation and enforcement of clear SOPs to formalise the importance of engaging the MHPSS Taskforce in all issues related to MHPSS in the humanitarian cluster system is vital for effective response and MHPSS coordination. Our study highlights that future research should be conducted to explore the positioning of MHPSS coordinating structures within the global humanitarian cluster system.

Second, the importance of having the government involved in co-leading MHPSS responses where this is possible. The MHPSS Taskforce in Lebanon is co-led by a government-affiliated actor which supported coordination and strengthening the agency of local actors in humanitarian responses. This helps to address key recommendations in MHPSS responses of preventing duplication, supporting existing structures, and utilising existing resources and expertise (IASC MHPSS Reference Group, 2022; World Health Organization, 2013). However, a challenge was the lack of understanding among some agencies on how the Taskforce is affiliated to the MoPH and its role and mandate. Our findings highlight the need for a strong communication plan, including MHPSS orientation sessions and terms of references to help promote a better understanding of the strategic and technical mandate of the Taskforce, prevent unmet expectations, and promote transparency.

Third, there were positive examples of intersectoral coordination, but at times individual agency agendas took priority over the shared response. In addition, the roles and responsibilities within the Taskforce, and its mechanisms of accountability, were not always clear. Expectations among members about what the Taskforce should do (e.g. enforce quality of MHPSS) were not always realistic for a coordination group. Finding ways to strengthen group cohesiveness, clarify roles and responsibilities, and create shared, transparent accountability may enhance the quality of coordination. This reflects findings from studies elsewhere where MHPSS coordination in the field has been important in strengthening communication and cooperation (Bou-Orm et al., 2023; Elshazly et al., 2019; Gooding et al., 2022). Additionally, the characteristics of staff attending coordination meetings are important, and participants highlighted the need for inclusion of frontline perspectives, and regional perspectives. The Taskforce leadership provided feedback that information from field and program activities is typically channeled to central program and technical personnel within each organisation, who are usually the ones attending coordination meetings. We recognise that in 2023, Taskforce meetings have been reintroduced at the regional

level and anticipate this will improve coordination and promote equity, inclusiveness, and participation. Mental health service user perspectives appeared lacking, despite attempts to incorporate their perspectives in the Taskforce's work. This reflects a wider need for greater involvement of mental health service users in decision making in protracted crises (Douedari and Howard, 2019; Semrau et al., 2016). The recently established Service User Association in Lebanon offers a mechanism for greater mental service user involvement in the Taskforce, and this is a priority of the NMHP.

Fourth, while it was highlighted that the Taskforce had strong technical capacity, which is essential for coordination bodies (IASC MHPSS Reference Group, 2022), a key barrier was insufficient human and financial resources to support the technical capacity and coordination tasks of the MHPSS Taskforce and participating agencies. This underpinned many of the challenges to the MHPSS response. Despite guidelines emphasising the importance of supporting existing structures (IASC MHPSS Reference Group, 2022), no direct funding support is available to MHPSS coordination structures. The lack of sufficient financial human resources may hinder the effectiveness of the coordination efforts, as shown in other studies in different humanitarian settings (Gooding et al., 2022). Guidance recommends that co-chair roles of MHPSS technical working groups are full-time roles (IASC MHPSS Reference Group, 2022), and the reliance on NMHP resources for coordination and support means there needs to be a commitments from other MHPSS actors, including, having other actors equally involved and committed to support the costs associated with coordinating MHPSS activities. The scarcity of resources available to local actors, relative to UN and international agencies, and the resulting power imbalances, should also be recognised (Martins, 2020; Roepstorff, 2020). Limited, short-term, and project-based donor funding for local actors further constrains active participation in MHPSS coordination as local actors prioritise project implementation over coordination and information sharing, despite open information sharing and reporting being key to coordination (Gooding et al., 2022). A unified and coordinated reporting system between clusters on MHPSS indicators through a central platform would also help reduce reporting burden for actors (IASC MHPSS Reference Group, 2022). Finally, a streamlined processes for contributing to the MHPSS Action Plan and an easily accessible resource centre may also reduce perceived burden.

4.1. Limitations

First, given our co-production approach, staff from the NMHP, who co-chair the Taskforce, participated in various aspects of the study (e.g., reviewing interview topic guides, being interview participants, providing inputs during feedback sessions, providing commentary on findings during feedback sessions and co-authoring this article). This could have influenced the findings. However, these staff members did not conduct the interviews or feedback sessions and they were not involved in the data analysis. Their participation is concurrently viewed as a strength as it ensured that the findings account for the complexities of the context in Lebanon. Second, we encountered challenges recruiting interviewees due to the severe economic and political crises in Lebanon, the COVID-19 pandemic, the Beirut Blast, and significant electricity shortages. This might have omitted the voices of participants who were more severely impacted by these crises. Third, not all interview participants were able to attend the feedback sessions due to staff turnover and the contextual challenges mentioned in the second limitation.

5. Conclusion

This study is among the first empirical exploration of the enablers and barriers to supporting MHPSS responses through a coordination body in a humanitarian setting. We provide insights to help improve the MHPSS response in Lebanon, with implications for other protracted crises. Our findings highlight challenges for MHPSS responses linked to the inter-sectoral positioning of MHPSS within the humanitarian system. While technical capacity of the MHPSS Taskforce leadership was high, the Taskforce was weakened by limited resources, particularly financial resources. The co-leadership from the MoPH was considered valuable, providing legitimacy and supporting the sustainability of the response. However, greater clarity was needed on the positioning of the Taskforce. Greater inclusion of diverse groups, particularly service users, would further strengthen the Taskforce. Our findings suggest that the Taskforce could begin by developing a strategy to clarify mechanisms for engaging with the different clusters and identifying key actions for communicating its scope and role to both members and those outside the Taskforce to help strengthen an effective and equitable MHPSS response in Lebanon.

CRediT authorship contribution statement

Rozane El Masri: Writing – review & editing, Writing – original draft, Validation, Project administration, Methodology, Formal analysis, Data curation. **Thurayya Zreik:** Writing – review & editing, Writing – original draft, Validation, Methodology, Formal analysis, Conceptualization. **Sandy Chaar:** Writing – review & editing, Writing – original draft, Validation, Formal analysis. **Rayane Ali:** Writing – review & editing, Formal analysis. **Joseph Elias:** Writing – review & editing, Formal analysis. **Bassel Meksassi:** Writing – review & editing, Formal analysis. **Felicity L. Brown:** Writing – review & editing, Supervision, Project administration, Methodology, Funding acquisition, Conceptualization. **Ibrahim Bou-Orm:** Writing – review & editing, Methodology. **Martin McKee:** Writing – review & editing. **Michele Asmar:** Writing – review & editing, Funding acquisition, Conceptualization. **Bayard Roberts:** Writing – review & editing, Methodology, Funding acquisition, Conceptualization. **Michelle Lokot:** Writing – review & editing, Writing – original draft, Validation, Supervision, Project administration, Methodology, Formal analysis, Conceptualization. **Rabih El Chammay:** Writing – review & editing, Supervision, Funding acquisition.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

This research was part of the GOAL project, funded by the UK Research and Innovation as part of UKRI Collective Fund Award UKRI GCRF Development-based approaches to protracted displacement [grant number ES/T00424X/1].

References

Barbazza, E., Tello, J.E., 2014. A review of health governance: definitions, dimensions and tools to govern. Health Pol. 116 (1), 1–11.

Barnett, M., 2013. Humanitarian governance. Annu. Rev. Polit. Sci. 16 (1), 379–398.

Bou-Orm, I.R., Moussallem, M., Karam, J., deLara, M., Varma, V., Diaconu, K., Apaydin, M.C.B., Van den Bergh, R., Ager, A., Witter, S., 2023. Provision of mental health and psychosocial support services to health workers and community members in conflict-affected Northwest Syria: a mixed-methods study. Conflict Health 17 (1), 46. https://doi.org/10.1186/s13031-023-00547-4.

Bruckner, T.A., Scheffler, R.M., Shen, G., Yoon, J., Chisholm, D., Morris, J., Fulton, B.D., Dal Poz, M.R., Saxena, S., 2011. The mental health workforce gap in low- and middle-income countries: a needs-based approach. Bull. World Health Organ. 89 (3), 184–194. https://doi.org/10.2471/BLT.10.082784.

Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., Saxena, S., 2019. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. Lancet 394 (10194), 240–248. https://doi.org/10.1016/S0140-6736(19)30934-1.

de Jong, K., Mills, C., Mackintosh, K., 2008. Humanitarian issues beyond the technical tools: the IASC guidelines on mental health and psychosocial support in emergency settings. Intervention 6 (3), 334–337. https://doi.org/10.1097/wtf.0b013e3283200260.

Douedari, Y., Howard, N., 2019. Perspectives on rebuilding health system governance in opposition-controlled Syria: a qualitative study. Int. J. Health Pol. Manag. 8 (4), 233–244. https://doi.org/10.15171/ijhpm.2018.132.

Elshazly, M., Alam, A.N.M.M., Ventevogel, P., 2019. Field-level coordination of mental health and psychosocial support (MHPSS) services for Rohingya refugees in Cox's Bazar. Intervention 17 (2), 212. https://doi.org/10.4103/INTV.INTV_38_19.

Fortnam, M., Hailey, P., Balfour, N., Sheen, K., Lea, R., 2021. Innovation history of the CMAM Surge approach: towards a shock-responsive health system in Kenya. https://www.opml.co.uk/files/Publications/A2241-maintains/cmam-surge-final-draft-2106.pdf?noredirect=1.

Gooding, K., Bertone, M.P., Loffreda, G., Witter, S., 2022. How can we strengthen partnership and coordination for health system emergency preparedness and response? Findings from a synthesis of experience across countries facing shocks. BMC Health Serv. Res. 22 (1), 1441. https://doi.org/10.1186/s12913-022-08859-6.

Harrison, S., Chemaly, W.S., Hanna, F., Polutan-Teulières, N., Ventevogel, P., 2021. Engagement of protection actors in MHPSS: the need for cross-sectoral cooperation. Forced Migr. Rev. 66, 8–11.

Humphries, V., 2013. Improving humanitarian coordination: common challenges and lessons learned from the cluster approach. Journal of Humanitarian Assistance. https://reliefweb.int/report/world/improving-humanitarian-coordination-common-challenges-and-lessons-learned-cluster.

IASC, 2007. Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

IASC MHPSS Reference Group, 2022. Handbook: Mental Health and Psychosocial Support Coordination.

Karam, E., El Chammay, R., Richa, S., Naja, W., Fayyad, J., Ammar, W., 2016. Lebanon: mental health system reform and the Syrian crisis. BJPsych Int. 13 (4), 87–89. https://doi.org/10.1192/S2056474000001409.

Kik, N., El Chammay, R., 2018. Improving Humanitarian Crisis Response Policy and Practice: Mental Health and Psychosocial Support Coordination in Lebanon.

Lokot, M., Bou-Orm, I., Zreik, T., Kik, N., Fuhr, D.C., El Masri, R., Meagher, K., Smith, J., Asmar, M.K., McKee, M., Roberts, B., 2022. Health system governance in settings with conflict-affected populations: a systematic review. Health Pol. Plann. 37 (5), 655–674. https://doi.org/10.1093/heapol/czac027.

London School of Hygiene and Tropical Medicine, 2020. Goal. https://www.lshtm.ac.uk/research/centres-projects-groups/goal.

Lupieri, S., 2020. When 'brothers and sisters' become 'foreigners': Syrian refugees and the politics of healthcare in Jordan. Third World Q. 41 (6), 958–975. https://doi.org/10.1080/01436597.2020.1723414.

Martineau, T., McPake, B., Theobald, S., Raven, J., Ensor, T., Fustukian, S., Ssengooba, F., Chirwa, Y., Vong, S., Wurie, H., Hooton, N., Witter, S., 2017. Leaving no one behind: lessons on rebuilding health systems in conflict- and crisis-affected states. BMJ Glob. Health 2 (2), e000327. https://doi.org/10.1136/bmjgh-2017-000327.

Martins, A., 2020. Reimagining equity: redressing power imbalances between the global North and the global South. Gend. Dev. 28 (1), 135–153. https://doi.org/10.1080/13552074.2020.1717172.

Mesa-Vieira, C., Haas, A.D., Buitrago-Garcia, D., Roa-Diaz, Z.M., Minder, B., Gamba, M., Salvador, D., Gomez, D., Lewis, M., Gonzalez-Jaramillo, W.C., Pahud de Mortanges, A., Buttia, C., Muka, T., Trujillo, N., Franco, O.H., 2022. Mental health of migrants with pre-migration exposure to armed conflict: a systematic review and meta-analysis. Lancet Public Health 7 (5), e469–e481. https://doi.org/10.1016/S2468-2667(22)00061-5.

Miller, K.E., Jordans, M.J.D., Tol, W.A., Galappatti, A., 2021. A call for greater conceptual clarity in the field of mental health and psychosocial support in humanitarian settings. Epidemiol. Psychiatr. Sci. 30. https://doi.org/10.1017/S2045796020001110.

Ministry of Public Health Lebanon, 2015. Mental health and substance use - prevention, promotion, and treatment. Situation analysis and strategy for Lebanon 2015-2020. https://www.moph.gov.lb/userfiles/files/MentalHealthandSubstanceUseStrategyforLebanon2015-2020-V1_1-English.pdf.

Ministry of Public Health Lebanon, 2017. Circular Number 64: Related to Projects Around Mental Health and Psychosocial Support and Substance Use Response in Lebanon.

Ministry of Public Health Lebanon, 2023. Mental health and psychosocial support task force. https://www.moph.gov.lb/en/Pages/0/9895/mental-health-and-psychosocial-support-task-force.

Noubani, A., Diaconu, K., Loffreda, G., Saleh, S., 2021. Readiness to deliver person-focused care in a fragile situation: the case of Mental Health Services in Lebanon. Int. J. Ment. Health Syst. 15 (1), 21. https://doi.org/10.1186/s13033-021-00446-2.

O Connell, R., Poudyal, B., Streel, E., Bahgat, F., Tol, W., Ventevogel, P., 2012. Who is Where, When, doing What: mapping services for mental health and psychosocial support in emergencies. Intervention 10 (2), 171–176. https://doi.org/10.1097/WTF.0b013e3283561e64.

Olu, O., Usman, A., Woldetsadik, S., Chamla, D., Walker, O., 2015. Lessons learnt from coordinating emergency health response during humanitarian crises: a case study of implementation of the health cluster in northern Uganda. Conflict Health 9 (1), 1. https://doi.org/10.1186/1752-1505-9-1.

Pyone, T., Smith, H., van den broek, N., 2017. Frameworks to assess health systems governance: a systematic review. Health Pol. Plann. 32 (5), 710–722.

Rathod, S., Pinninti, N., Irfan, M., Gorczynski, P., Rathod, P., Gega, L., Naeem, F., 2017. Mental health service provision in low- and middle-income countries. Health Serv. Insights 10, 117863291769435. https://doi.org/10.1177/1178632917694350.

Roepstorff, K., 2020. A call for critical reflection on the localisation agenda in humanitarian action. Third World Q. 41 (2), 284–301.

Semrau, M., Lempp, H., Keynejad, R., Evans-Lacko, S., Mugisha, J., Raja, S., Lamichhane, J., Alem, A., Thornicroft, G., Hanlon, C., 2016. Service user and caregiver involvement in mental health system strengthening in low- and middle-income countries: systematic review. BMC Health Serv. Res. 16 (1). https://doi.org/10.1186/s12913-016-1323-8.

Siddiqi, S., Masud, T.I., Nishtar, S., Peters, D.H., Sabri, B., Bile, K.M., Jama, M.A., 2019. Framework for assessing governance of the health system in developing countries: gateway to good governance. Health Pol. 90 (1), 13–25.

Tol, W.A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T.S., Souza, R., Golaz, A., Van Ommeren, M., 2011. Mental health and psychosocial support in humanitarian settings: linking practice and research. Lancet 378 (9802), 1581–1591. https://doi.org/10.1016/S0140-6736(11)61094-5.

UNHCR, 2022. Global trends: forced displacement in 2021. https://reliefweb.int/report/world/global-trends-forced-displacement-2021-enar.

UNHCR, 2023a. Global trends: forced displacement in 2022. https://www.unhcr.org/global-trends-report-2022.

UNHCR, 2023b. *Cluster system*. UNHCR emergency handbook. https://reliefweb.int/report/world/global-trends-forced-displacement-2022.

UNHCR, 2024. Lebanon factsheet, april 2024. https://reporting.unhcr.org/lebanon-factsheet-8385.

Van Ommeren, M., Hanna, F., Weissbecker, I., Ventevogel, P., 2015. Mental health and psychosocial support in humanitarian emergencies, 21 (7).

Ventevogel, P., van Ommeren, M., Schilperoord, M., Saxena, S., 2015. Improving mental health care in humanitarian emergencies. Bull. World Health Organ. 93 (10), 666. https://doi.org/10.2471/BLT.15.156919, 666A.

World Bank, 2021. Lebanon economic monitor: Lebanon sinking (to the top 3). https://documents1.worldbank.org/curated/en/394741622469174252/pdf/Lebanon-Economic-Monitor-Lebanon-Sinking-to-the-Top-3.pdf.

World Health Organization, 2013. Building Back Better: Sustainable Mental Health Care after Emergencies.

World Health Organization, 2021. Mental health atlas 2020. https://www.who.int/publications/i/item/9789240036703/.

Zreik, T., El Masri, R., Chaar, S., Ali, R., Meksassi, B., Elias, J., Lokot, M., 2022. Collaborative coding in multi-national teams: benefits, challenges and experiences promoting equitable research. Int. J. Qual. Methods 21.