Framework Analysis: Potential Repatriation and Mental Health System Recovery in the MENA

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Abstract
During the last decade and a half we have seen the culmination of what is perceived to be the biggest refugee and humanitarian crises the world has witnessed since World War II. The parts of the Middle East and North Africa (MENA) are in turmoil, and we are witnessing an outpouring of people fleeing the violence through precarious means. It is unknown when stability will return to parts of the MENA, but this does not mean the global health community cannot be proactive in planning for post-conflict health system recovery. With the vast number of today’s refugees originating from the MENA, it is possible that future recovering MENA nations will see the return, or repatriation, of refugees. Repatriates undergo a multi-phase exposure period that poses risks for adverse mental health outcomes, but there is extremely limited research about the risk factors and outcomes within this group. Early planning for repatriation and mental health system rehabilitation in the region will help ensure adequate mental health care delivery and coverage to vulnerable groups like repatriates. In this paper, I propose a hybrid framework, called the Repatriation and Mental Health (REPATMENT) Framework, which is built upon the literature review and various UN agency frameworks that address repatriation, health system recovery, and mental health and psychosocial support in post-conflict setting. The REPATMENT Framework acknowledges that 1) cross-system linkages, 2) information sharing, and 3) coordination between recovery actors are key to progressing through mental health system recovery. These essential factors, and the consideration of potential challenges, benefit elements of the REPATMENT Framework and could aid future repatriation and post-conflict recovery efforts.
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Chapter I: Introduction

As we see the twists and turns of the current geopolitical phenomenon impacting the world’s many inhabitants, it is easy to stop short of analyzing the repercussions of these events. During the last decade and a half we have seen the culmination of what is seen to be a forced migration crisis larger than the one witnessed after World War II (Petrou, 2015) (UNHCR, 2016). Parts of the Middle East and North Africa (MENA) are in turmoil, and we have seen an outpouring of people fleeing the violence through precarious means. Some say that the violence and oppression exposed to those fleeing is unimaginable, ranging from shelling, executions, and chemical weapons among other modes (Guha-Sapir et al., 2015). They may be able to leave behind their razed neighborhoods and dead loved ones, but they cannot escape the memories of the horror they experienced. People of all ages are forced to remember the trauma they have fled, but many lack the education, skills, and cultural acceptance to understand the psychological, behavioral, and emotional repercussions (Dimitry, 2012). There is a burgeoning, but limited, analysis of these repercussions within the forcibly displaced MENA population flowing into Europe, but it circumvents a much larger issue. The long term impact of the trauma must not be overlooked, and it is likely that a portion of this population will return to their countries of origin. Moreover, it is unlikely that the countries of origin will be able to meet the mental health needs of the returnees. Much of the MENA lacked robust health care systems, let alone mental health services, before the exodus started. Despite the fact that we are unsure where parts of the MENA are headed developmentally, every year tens of thousands of refugees return to their communities and we must be proactive about preparing for the repatriation process. According to the UN, voluntary repatriation is “the free and voluntary return to one’s country of origin in safety and dignity” (Jallow, Heinbecker, & Malik, 2004). Early
recovery planning and the unique exposures shared by would-be returnees will give countries the opportunity to build effective health care systems that provide comprehensive mental health care to all citizens (UNHCR, 2008b). Adequate attention must be paid to population health recovery and maintaining the continuum of care for refugees who received mental healthcare during resettlement (Jones & Center for Domestic and International Health Security, 2006).

In this paper, I propose a hybrid framework that is built upon the literature and frameworks discussing for repatriation, building health systems, increasing mental health and psychosocial support (MHPSS) (Fig 1). The first framework, the UNHCR 4Rs Framework, focuses on the voluntary repatriation and steps toward social and economic recovery. The second and third frameworks were created by WHO and lay out the components necessary for a well-functioning health system and a formidable MHPSS system. The reason for employing these frameworks is that UN organizations such as the UNHCR and WHO have remained prominent leaders in understanding and addressing global health and humanitarian crises. Each framework was analyzed and merged according overlapping themes shared between them to create the Repatriation and Mental Health Framework. It emphasizes the importance of bridging redevelopment efforts with public health efforts for a more comprehensive approach. Moreover, the
framework can be tailored to varying levels of state recovery and is not inherently dependent on the instability-causing factors. Moreover, it is broad enough to make room for the large variety of mental health services necessary to address trauma-related psychological disorders.

**Chapter II: Literature Review**

Literature was found through various outlets such as EBSCO, Pubmed, and multiple UN groups and agencies. There was an equal amount of primary and secondary literature used to inform this paper, but they differed greatly in the types of publications. A significant amount of the primary literature was publications by international agencies such as the UN and the World Bank. These publications were mainly guides, handbooks, and toolkits that addressed repatriation or mental health promotion and mental healthcare delivery in post-conflict states. Other primary sources were evaluations of post-conflict health sector recovery. Secondary sources were mainly literature reviews about similar topics.

Nothing in the literature could be found that merged voluntary repatriation and mental health system recovery efforts. Most of the countries studied were those that have experienced protracted conflict. The literature about repatriation was lacking in richness because it mostly covered the 4Rs Framework but all touch upon the important dynamics and complexities of repatriation. The work discussing this topic is published sporadically and dates back 37 years. Furthermore, contradictions among works outside of the repatriation were rarely found. They employed different methodologies but agreed upon the fundamental principles surrounding the issues they were discussing. For example, most authors discussing financing health systems in post-conflict countries agreed that due to the burden many people face during post-conflict recovery, the use of user-fees to finance a health system should be
avoided, especially in early recovery. Another example is that literature discussing MHPSS during post-conflict recovery stressed the importance of implementing community-based interventions and training local community health workers in MHPSS at the primary and secondary-care levels. However, there was a contradiction over the benefit of focusing on tertiary-care in early MHPSS development. More articles shared the notion that more attention should be paid to primary and secondary-care, which is understandable in light of the general shift towards the deinstitutionalization of mental healthcare. A recurring theme seen across all topics, including repatriation, is that that regular coordination between recovery actors is extremely vital for the success of any redevelopment effort.

**Chapter III: Background**

To understand the mental health status of returnees from the MENA, it is important to look at the culture and policies surrounding mental health in the region prior to the current mass exodus from the MENA. In this section, I will discuss the context of mental health efforts during this time and the considerations to note when addressing refugee mental health during the repatriation process.

**A. How Did They Become Refugees?**

When people uproot themselves under hostile circumstances, they become part of the global community of forcibly displaced persons that is parceled into different groups. The main groups are asylum-seekers (asylees), refugees, and internally displaced persons (IDPs). This categorization is mainly used by international bodies, such as the United Nations Refugee Agency (UNHCR), and government bodies, but do not reflect the respective levels and types of
traumatic exposure. Because this paper’s major scope is mental health, I will disregard the legal differences and use the term “refugee” as a blanket term for these groups in the context of pre-repatriation.

While the political nuances behind the rise of the refugee crisis are vast and complex, it should be reviewed for the sake of the framework. The two major events that catalyzed the massive exodus from the MENA are the Arab Spring and the rise of the Islamic State (ISIS). While they impacted different parts of the MENA respectively, the factors that fueled them were very similar. There was a general disconnect between the political elite and societal groups. As a result of the geopolitical posturing of the West throughout the region, many of the MENA governments were beholden to the interests of Western powers, while letting their citizens’ grievances slip by the wayside (Hazbun, 2015). There was economic growth occurring in the MENA before the Arab Spring, but the uprisings were indicative of the little benefit people felt from the growth. Protesters demanded socioeconomic and political changes including access to food, social justice, freedom, and human dignity, but many regimes responded harshly (Ghanem, 2016). As we have seen in Syria, uprisings from Syrian citizens were met with widespread violence, imprisonment, and torture at the hands of the Assad government and the situation had escalated into a six-year civil war. ISIS, which had already been years in the making, seized the opportunity of societal unrest and disillusionment to violently take control of areas in Syria, Iraq, and Libya whilst carrying out isolated attacks scattered throughout the region (Hazbun, 2015). Distinct situations are found in Iraq and Yemen. While both countries have been tormented by ISIS, Iraq has seen protracted conflict since the 2003 US Invasion of Iraq and Yemen, the poorest country in the region, caused by an
uprising separate from the Arab Spring that lead it to full-out war involving multiple countries (Al-Rashed, 2016).

Subsequent to the start of unrest, the functionality of healthcare systems in countries seriously impacted by unrest has become drastically diminished. The healthcare system in Syria is in collapse and Iraqi doctors reported significant decline in essential drugs, equipment, and overall healthcare services during the height of the US war in Iraq (Burnham et al., 2012) (Pitts-Tucker, 2012). As a result of the compounding effects of the Arab Spring, ISIS, and widespread conflict, many people in MENA sub-regions were forced to flee the increasingly violent situation. These escapees are now part of the millions of refugees vying for limited resources in overwhelmed territories and host countries. Moreover, the literature suggests that between 20%-60% deal with mental health issues (Bartolomei et al., 2016).

Countries where refugees from the MENA have resettled include Germany, Greece, Sweden, Russia, Turkey, Austria, Jordan and Lebanon (Fig 2) (UNHCR, 2016). Major countries of origin for asylum seekers are from Syria and Iraq. IDPs are also a major concern in the MENA as well with 6.6 million in Syria, 4.4 million in Iraq, and 2.5 million in Yemen by the end of 2015 (Fig 3)(UNHCR, 2016). Overall, more than 38% of the world’s forcibly displaced person originate from the MEAN (UNHCR, 2016).

Fig 2. Mena countries with the highest Number of forcibly Displaced Persons

<table>
<thead>
<tr>
<th>Country</th>
<th>Refugees and people in refugee-like situations</th>
<th>Asylum-Seekers</th>
<th>IDPs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iraq</td>
<td>264,107</td>
<td>237,166</td>
<td>4,403,287</td>
<td>4,904,560</td>
</tr>
<tr>
<td>Libya</td>
<td>6,085</td>
<td>6,056</td>
<td>434,869</td>
<td>447,010</td>
</tr>
<tr>
<td>Syria</td>
<td>4,872,585</td>
<td>245,844</td>
<td>6,563,462</td>
<td>11,681,891</td>
</tr>
<tr>
<td>Yemen</td>
<td>15,896</td>
<td>10,075</td>
<td>2,532,032</td>
<td>2,558,003</td>
</tr>
</tbody>
</table>

Source: UN Global Trends Forced Displacement in 2015
B. **Pre-conflict Social, Political, and Economic Factors Influencing Mental Health Efforts in the MENA**

While there has been increasing acknowledgment of and research on mental health in the MENA, more must be done. Between 1994-2005, the MENA generated only 17% of the global output of mental health publications/million population (Jaalouk, Okasha, Salamoun, & Karam, 2012). Moreover, only the three countries, Palestine, Qatar, and Egypt in the entire region have reported figures of mental health care expenditure, and the low figures are far too little to properly assess mental health concerns (Okasha, Karam, & Okasha, 2012). Almost half of the countries in the region lack either mental health legislation or mental health policy and about one-third have less than 0.5 psychiatrists per 100,000 people (Okasha et al., 2012). However it is important to consider that the geopolitics in the region have a significant impact on prioritizing domestic policy. These shortcomings compounded with high rate of uninsured, low coverage, and high out-of-pocket expenses for healthcare services highlight the little planning and few human and economic resources available for mental health care in the MENA (Alami, 2017).

Culture has a strong influence in shaping the regional perception about mental health. Like other societies, widespread stigma toward mental health and mental illness persists in the region. With a majority Muslim population, traditional perceptions in the MENA can account mental illness as “punishment from God” by way of evil spirits, the “evil eye”, and general transference of evil to an individual (Sewilam et al., 2015). The stigma is an amalgam of negative perceptions, such as weakness and tarnished reputation, and is the cause of several social ramifications (Coker, 2005; Sewilam et al., 2015). A study in Egypt observed that stigma
toward mental illness lead to “social disapproval, devaluation of families with mentally ill individuals, and diminished marital prospects” (Coker, 2005). It is common for people to seek out non-professional care such as religious figures that practice non-traditional medicine, but there is very little collaboration between traditional leaders and medical professionals (Okasha et al., 2012). Raising awareness about the importance of mental health in a culturally competent fashion is necessary to combat stigma and quell skepticism about the effectiveness of modern mental health services.

Chapter IV: Why Repatriation?

The aim of this paper is to discuss the future of mental healthcare in the MENA in the context of repatriation. Currently, we are seeing many refugees resettling in host countries with uncertain futures. During 2015, around 201,400 refugees returned to their countries of origin and 2.3 million IDPS returned to their habitual places of residence (UNHCR, 2016). While it is uncertain how many refugees will return to the MENA if and when stability returns, the decision to return is a part of the recovery process worth dissecting, especially because voluntary repatriation is viewed as the best option for refugees (Stein, 1997; UNHCR, 1980).

The starting-point of the recovery phase is not well defined; oftentimes the brokering of a peace agreement marks the beginning of this phase (Cometto, Fritsche, & Sondorp, 2010). However, the decision to return is an important component of the peace building process as it is an indication that refugees feel strongly enough that safety and security are returning to their countries of origin to be willing to uproot themselves yet again. Once peace talks are held and the stipulations respected, the return of refugees may act as affirmation to the country’s capacity to implement repatriation activities (Stein, 1997). But implementation cannot happen
without thorough planning, and thorough planning cannot be accomplished without understanding the population changes at hand.

Although research is limited about the mental health risks and outcomes particular to repatriates, we know for sure that they endured traumatic exposures that can cause mental duress. von Lersner, Elbert and Neuner studied the mental health of repatriate before and after repatriation and found that psychological disorders significantly increased post-repatriation. The prevalence rate of these disorders increased from 53% prior to repatriating to 88% after repatriation (von Lersner, Elbert, & Neuner, 2008). Therefore, post-conflict health sector recovery efforts should be inclusive of returnees and their mental health needs.

Focusing this paper on establishing mental health services for returnees is an attempt to maximize the effect size of intervention by recognizing the variety of exposures affecting the general population. Program formulation processes and interventions targeting returnees may differ from those targeting other groups, but can also enrich the recovery process as a whole (Jallow et al., 2004). Government officials must recognize the possibility of seeing increased incidence of common mental disorders during repatriation, and efforts to rebuild health systems should include the establishment of comprehensive legislation and policy that target mental health. Placing importance on mental health could facilitate the recovery process as evidence shows that untreated mental health can pose threats to physical health and economic development (Dzator, Dzator, Asante, & Ahiadeke, 2016; Jones & Center for Domestic and International Health Security, 2006). Among these threats are the burden of healthcare costs, violence, physical illness, and premature death (Dzator et al., 2016). Post-conflict recovery poses a multitude of challenges, but might also provide an “opportunity for rapid reforms and
the introduction of new ideas” (Cometto et al., 2010). Therefore, the global health community has a responsibility to aid in the strategic planning of delivering mental health services to trauma-exposed people in the MENA.

Today much of the mental health provisions for refugee depend on the host country or camp. The research indicates that around 30% of refugees suffer from PTSD and major depression and local NGOs are found to provide the bulk of the care for these illnesses (Steel et al., 2009). The reality is that the approach to addressing different mental illnesses are quite varied and many instruments have western origins and as such, might lack the cultural sensitivity necessary to treat an illness (Small, Kim, Praetorius, & Mitschke, 2016). However, research shows that community-based approaches may work better than traditional clinical methods with refugee population including peer-lead support groups meant to empower those suffering from mental illness (Small et al., 2016). Despite the existence of mental health services for refugees, there multiple barriers to accessing these services faced by refugees. These barriers include social stigma, history of political repression and lack of empowerment, as well as shame among other factors (Shannon, Wieling, Simmelink-McCleary, & Becher, 2015). It important to understand these barriers during post-conflict recovery planning as it possible that these same barriers might arise during repatriation. Moreover, countries should strive to maintain the continuum of care for returnees who were able to access mental health services during resettlement. This requires a high-level of coordination between health actors in the host country and country of origin.
A. Returnee Exposures and Outcomes

While returnees and stayees (i.e., those who remained) share the traumatic experiences, or pre-migration experiences, of conflict in their homeland, returnees differ such that they have a unique multi-phase exposure period (Table 1). Evidence indicates traumatic exposure can be a determinant of mental health among refugees, but little is known on outcomes specific to returnees (Bartolomei et al., 2016; de Jong, Komproe, & Van Ommeren, 2003; Fazel, Wheeler, & Danesh, 2005). It is important to consider the correlation between returnee exposures and mental health.

Table 1. Multi-phase exposures and determinant of returnee mental health

<table>
<thead>
<tr>
<th>Phase</th>
<th>Determinants of Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-migration</td>
<td>shelling, executions, shooting, air bombardments, ground level explosives, chemical weapons</td>
</tr>
<tr>
<td></td>
<td>imprisonment, seeing mutilated bodies, social status, education, sociocultural values, religious values, familial values</td>
</tr>
<tr>
<td>Migration</td>
<td>separation experiences, sexual abuse, trafficking</td>
</tr>
<tr>
<td></td>
<td>dangerous routes, dangerous modes of transportation</td>
</tr>
<tr>
<td>Post-migration</td>
<td>poverty, limited access to housing, limited access healthcare</td>
</tr>
<tr>
<td></td>
<td>illness, uncertainty about application process and acculturation challenges, social exclusion from host country, unemployment</td>
</tr>
<tr>
<td>Resettlement</td>
<td>separation experiences</td>
</tr>
<tr>
<td>Repatriation</td>
<td></td>
</tr>
</tbody>
</table>
psychiatric disorders when assessing the risk for mental health.

The returnee exposure period is comprised of four different phases (Kirmayer et al., 2011). At each phase are exposures that have shown to manifest during particular times. There are, however, experiences that appear in more than one phase, which speaks to the complexity of the returnee experience. The multi-phase exposure period includes:

1. Pre-migration: Pre-migration experiences depend on the country of origin, but are usually associated with war and war-like conditions. The traumatic exposures include shelling, executions, shooting, air bombardments, ground level explosives, chemical weapons, imprisonment, and seeing mutilated bodies (Dimitry, 2012; Guha-Sapir et al., 2015; A. A. M. Thabet, Abed, & Vostanis, 2002; A. M. Thabet, Thabet, & Vostanis, 2016; Tourneur et al., 2015). Some refugees may also have been victims of sexual violence, as we have seen with the Yezidi community (Di, 2016; Ensler, 2015). “Education, social status, familial, religious, and sociocultural values” are also pre-migration factors that impact outcome as well as health seeking behavior (Hebebrand et al., 2016).

2. Migration: Trauma can be compounded along the journey through exposures such as separation experiences, sexual abuse, and trafficking such as forced labor and sexual exploitations (Hebebrand et al., 2016). Dangerous routes and modes of transportation can lead to injury, illness, death, and near death experiences whether it is traveling via boat across the Mediterranean or traveling on land through zones of conflict (Tourneur et al., 2015). Common acute health problems seen among refugees arriving from the MENA include diarrhea, acute respiratory infections,
scabies, and head lice (Hebebrand et al., 2016; Tourneur et al., 2015). Strenuous travel exacerbates the health ailments of refugees with pre-existing conditions (Tourneur et al., 2015). Pregnant women, children, elderly, and immunosuppressed individuals are especially vulnerable to health threats (Tourneur et al., 2015).

3. Post-migration Resettlement: Arriving in the host country or resettlement camp does not remove the insecurities that many refugees face. Among these insecurities for refugees are poverty, limited access to housing and healthcare, unemployment, illness, uncertainty about application process and status, acculturation challenges, and social exclusion from the host country (Hebebrand et al., 2016; Horyniak, Melo, Farrell, Ojeda, & Strathdee, 2016; Tourneur et al., 2015). The internally displaced experience similar insecurities within camps in addition to small-scale violence (Dimitry, 2012; Hutson, Shannon, & Long, 2014).

4. Repatriation (LESNERVE): Research on experiences during the journey back to the country of origin and habitual places of residence was not found. However a possible exposure could be separation experiences for those who had adapted to life in a host country.

Strong evidence shows that traumatic exposures increase the risk of mental disorders among refugees. Refugees exhibit high rates of depression, post-traumatic stress disorder (PTSD), chronic pain, and other somatic complaints (Fazel et al., 2005; Hebebrand et al., 2016; Kirmayer et al., 2011; Lindert, Ehrenstein, Priebe, Mielck, & Brähler, 2009; A. M. Thabet et al., 2016). Lindert et al. conducted a meta-analysis and observed the combined prevalence rates of depression, anxiety, and PTSD. They found that the combined prevalence rates for studies on
refugee mental health were 44% for depression, 40% for anxiety, and 36% for PTSD. The level of risk of mental illness is related to the severity of traumatic exposure with violence, war, and forced migration associated with elevated risk (Kirmayer et al., 2011; A. A. M. Thabet et al., 2002).

Further research is necessary to study the potential difference in mental health outcomes across age, socioeconomic status, and gender for refugees. However, some studies suggest that females exposed to violence are more frequently affected by mental illness and that socioeconomic factors are not associated with prevalence of psychiatric disorders (Dimitry, 2012; Lindert et al., 2009; Russell, Vasilenko, & Lanza, 2016; A. A. M. Thabet et al., 2002). Alcohol and substance abuse are worth mentioning due to the association between trauma and avoidant coping (Zang et al., 2017). One study on alcohol use among Arab Americans showed that 13.4% of Iraqi refugees, the majority of whom were men, reported ever drinking alcohol (Arfken, Arnetz, Fakhouri, Ventimiglia, & Jamil, 2011). However, evidence shows that cultural beliefs found in the MENA have protective effects against alcohol and substance abuse, so the level of focus on these outcomes should be based on community needs (UNHCR, 2008a, 2008b).

**Chapter V: The Repatriation and Mental Health (REPATMENT) Framework**

The redevelopment of a country’s health system is ambitious, requires, thorough planning, and should be guided by a comprehensive framework. The Framework proposed in this paper is a hybrid of several preexisting UN system frameworks and was adapted around the common challenges that arise during the repatriation.
A. Shaping the Framework

When thinking about post-conflict recovery, it is important to remember that development efforts and humanitarian efforts are tightly linked. This is especially important for health sector recovery because the aim is to save lives while improving overall health by fostering government stewardship and service delivery apparatus (Cometto et al., 2010). The Framework
of this paper aims to incorporate mental health care development with future repatriation activities in the MENA (Fig 1, Fig 3). It emphasizes the importance of cross-system linkages that supplement one another and facilitate effective mental health service delivery. It also mentions various economic and social action necessary for mental health promotion but will focus on health system components, or building blocks, crucial for building a network of mental health services for repatriates.

The REPATMENT Framework is a combination of elements from the literature review, the UN Refugee Agency’s 4Rs Framework (Appendix 1), the World Health Organization’s (WHO) Health Systems Building Blocks Framework (Appendix 2), and WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health (Appendix 3). The creation of the 4Rs Framework was a collaborative effort spearheaded by the UN Refugee Agency, or UNHCR, that is based on consultations with UN agencies and partner governments, donors, and NGOs. It was included in UN efforts aimed at creating durable solutions for refugees and other groups of concern. It is comprised of 4 stages: Voluntary Repatriation, Reintegration, Rehabilitation, and Reconstruction. The boundaries between the stages are blurred as post-conflict recovery activities rarely occur linearly (Jallow et al., 2004). However, it gives structure to what is often a chaotic process that involves a substantial amount of time and actors. The 4Rs Framework delineates recommended sector activities to take place at each stage, but implementation is dependent on the capacity of a post-conflict country. This integrated approach is useful, but its reach extends far beyond the health-focused scope of this research.
In order to sharpen the focus and timeline of the 4Rs Framework, I grouped the 4Rs into “short-term repatriation responses” for repatriation and reintegration activities, and “medium and long-term repatriation responses” for rehabilitation and reconstruction activities (Fig 4).

### Fig 4. The 4Rs

<table>
<thead>
<tr>
<th>Short-term Repatriation Response Period</th>
<th>Long-term Repatriation Response Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voluntary Repatriation</strong></td>
<td><strong>Reintegration</strong></td>
</tr>
<tr>
<td>&quot;The free and voluntary return of refugees to their country of origin in safety and dignity&quot; (Jallow et al., 2004)</td>
<td>&quot;The ability of returning refugees (as well as IDPs and others) to secure the necessary political, economic, legal and social conditions to maintain their life, livelihood and dignity&quot; (Jallow et al., 2004)</td>
</tr>
<tr>
<td><strong>Rehabilitation</strong></td>
<td><strong>Reconstruction</strong></td>
</tr>
<tr>
<td>&quot;The restoration of social and economic infrastructure (e.g. schools, clinics, water points, public facilities and houses) destroyed during conflict in areas of return to enable communities to pursue sustainable livelihoods&quot; (Jallow et al., 2004)</td>
<td>&quot;The (re)establishment of political order, institutions and productive capacity to create a base for sustainable development&quot; (Jallow et al., 2004)</td>
</tr>
</tbody>
</table>

Furthermore, it was combined with the WHO Health Systems Building Blocks Framework in order to express health sector recovery within the voluntary repatriation context. This WHO framework focuses on the factors critical to functioning health systems, including service delivery, health workforce, information, medical products, financing, and leadership (Appendix 2). Incorporating these building blocks through coverage, access, quality, and safety can a robust mental health network be woven into health systems in the MENA. To make the framework address mental health efforts in fragile settings, the frameworks were further
compounded with the WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health (Appendix 3) to align the health systems building blocks with MHPSS a post-conflict setting, which in this case, is repatriation and reintegration.

At each building block, REPATMENT points to major actions necessary to (re)establish a functioning and inclusive mental health system. Some actions lean more towards rapid response while others are more long-term solutions. However as indicated in the Framework (Fig. 3), steps are not completely linear and can overlap the two time periods. This speaks to the complexity of mental health redevelopment and general repatriation process. The REPATMENT Framework attempts to address repatriation, health system recovery, and MHPSS effort all at once. The following sections will discuss each building block its various activities over the course of repatriation

B. Overview of REPATMENT Framework

1. Service Delivery

Service delivery during repatriation should be methodical and strategic. Because newly post-conflict countries have extremely weakened sectors and little resources, it is common for them to contract out the delivery of health services -usually to NGOs- until they are able to take over stewardship of these services. Studies show that contracted service delivery during recovery can reduce inequities, expand coverage, and increase access (Newbrander, Waldman, & Shepherd-Banigan, 2011; Witter, 2012). The service delivery actions the framework are concerned with meeting the basic needs of repatriates, maximizing access and coverage, and raising awareness about mental health issues and ways that are culturally appropriate.
a. **Short-term activities**

Services provided in the early stages of the 4Rs should be broad and have the largest impact but also be an optimal mix of services, including mental health services, that address all levels of need (WHO, 2009). Providing basic necessities such as food, shelter, water, and basic healthcare is a critical step to providing MHPSS. For example, repatriation packages are one way to help returnees rebuild their lives by giving them temporary access to essential resources. Not all packages are the same in every case of repatriation, but can include a combination of monetary aid, basic health care, shelter, and food (George, Vaillancourt, & Rajan, 2016; Jallow et al., 2004). Basic healthcare can include informal mental health services such as disseminating self-help information and providing Psychological First-Aid (PFA) on the community care level. PFA is a common practice used to address the emotional burdens felt by those who have been through a crisis. Those giving PFA can support repatriates by providing practical care and support, assessing needs and concerns, connecting people to critical resources, and providing comfort to those in distress (Snider, Van Ommeren, & Schafer, 2011; Subedi et al., 2015). While it is not necessary for those who delivery PFA to have a background in psychology, it is recommended that they work through an organization or community group and understand the culture of those they are helping (Snider et al., 2011).

b. **Medium and Long-term Activities**

As the country progresses through recovery, physical and mental health service delivery can be refined by offering repatriates a Basic Package of Health Services (BPHS). Experts in the global health community, such as USAID and WHO, can aid countries in creating, financing, and delivering BPHS (Newbrander, Ickx, Feroz, & Stanekzai, 2014). A BPHS aims to provide basic
evidence-based interventions at the different levels of the health care system (Frost, Wilkinson, Boyle, Patel, & Sullivan, 2016; Ventevogel et al., 2012). The most viable way to deliver professional mental health treatment in fragile states is by integrating mental health care with community-based primary care (Ventevogel et al., 2012; WHO, 2013a). This is achieved by training community health workers in MHPSS and increasing their mental health literacy. Primary health care professional can then properly detect, screen, treat or give referrals for mental health problems. Moreover, the community-based approach of the BPHS facilitates the community outreach that is necessary to increase demand for mental health services (WHO, 2007). Activating social networks and promoting help-seeking behavior among returnees involves culturally-sensitive activities such as community psycho-education in public and frequented settings (i.e schools, health facilities, mosques), workshops, support groups, and supportive counseling (Ventevogel et al., 2012; WHO, 2013a). Efforts to raise mental health awareness can be expanded to include social marketing campaigns via social media and other modes of mass communication such as newspapers, billboards, and TV (Sampogna et al., 2017). Media sources can help mitigate the stigma associated with mental health through positive change, and may be able to challenge the stigma that persists within communities throughout the MENA (Sampogna et al., 2017). However, in order for this to happen, leadership must enforce transparency of information and freedom of the press (Jones & Center for Domestic and International Health Security, 2006; WHO, 2007).

Another important component of mental health service delivery is health infrastructure. A majority of health facilities found in areas of post-conflict recovery are run by NGOs (Newbrander et al., 2011). Part of state capacity-building is ensuring the ability of the local and
national health ministries are able to take over full-time stewardship of service delivery. After a health infrastructure assessment is conducted, development of primary-care and secondary-care infrastructure can take full effect. Facilities should be strategically placed as to increase access and reduce utilization disparities between facilities. Planning for health infrastructure rehabilitation would encompass steps to creating spaces specifically for mental health services. This can range from integrating a community health center into a larger primary-care facility or a psychiatric in-patient wing in secondary-care facilities such as hospitals (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010; Inter-Agency Standing Committee, 2007). Deinstitutionalization efforts States should avoid developing tertiary-care mental facilities in the early stages of the 4Rs because from tertiary care to primary and secondary care makes it easier to scale up comprehensive treatment coverage (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010; Saymah, Tait, & Michail, 2015). Identifying areas of heavy repatriation will help ensure that they are well equipped to serve returnees with mental health disorders.

2. **Health Workforce**

As the majority of mental health services are contracted out to international organizations early on in the 4Rs, much of the health workforce is contracted as well. However, as recovery advances through the repatriation response periods, it is necessary to mobilize community health workers (CHWs) to revitalize the health sector. Mobilization methods include MHPSS training and incentives that will aid in the retention and recruitment of health workers. These activities are sustainable ways improve MHPSS during repatriation.
a. **Short-term activities**

To ensure that mental health remains a focal point of health system recovery, workers in all sectors, including health, education, and government, can be oriented or trained in MHPSS. These educational fora can cover a range of interventions from PFA to specialized psychosocial treatment. Orientation sessions can provide “immediate, basic, essential, functional knowledge and skills” pertaining to mental health needs and resources (Baines, Boetig, Waller, & Jindal, 2017; IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010; Tribe, Weerasinghe, & Parameswaran, 2014). These sessions can be provided to those working in education, government, faith-based initiatives, and other community members interested in learning about MHPSS.

b. **Medium and long-term Activities**

During rehabilitation and reconstruction, training should involve more exhaustive education about MHPSS and may target CHWs in primary and secondary-care facilities (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010). With in-services training, CHWs obtain the knowledge and skills needed to identify and manage mental illness. Training may also encompass short and intensive recruitment and certification programs that will quickly supply the health sector with a range of health workers, including mental health specialists (Tribe et al., 2014). Over time, these programs will allow local health workers to provide the majority of clinical and other face-to-face MHPSS to their communities (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010). Around 2010, WHO lead the development of the Mental Health Gap Action Program
(mhGAP) with intervention guides that have been widely used for orientation or training for MHPSS at different levels of recovery and development (Siriwardhana, Adikari, Jayaweera, Abeyrathna, & Sumathipala, 2016; WHO, 2010; WHO & Office of the United Nations High Commissioner for Refugees, 2015). However the guides do not include mental health interventions that target repatriates, and it would be beneficial if they could be adapted to cover information about mental health risks and outcomes pertaining to that sub-group.

Attention should also be paid to retaining the health workforce. Being aware of health workers’ financial and non-financial concerns will facilitate long-term service delivery necessary to maintain momentum in health system recovery (Consultation on AIDS and Human Resources for Health & World Health Organization, 2006). The creation of health worker associations that empower the workforce can stimulate national dialogue surrounding worker rights, safety, and health, as well as impact national policy (Consultation on AIDS and Human Resources for Health & World Health Organization, 2006).

3. Information

National information systems are critical for monitoring and observing trends within a population. The goal is for governments to have the capacity to identify public mental health trends and understand their implications.

a. Short-term activities

Creating a repatriation registry that can be generated during repatriation package distribution would be good way to monitor the progression of returnee capacity to rebuild their lives post-conflict. It would keep record of the time of repatriation, host country, mode of
return (i.e. through organization), types of resources and provisions given, and the end date of repatriation packages.

b. Medium and long-term activities

Thorpe et al. explain that it is essential to have “electronic information exchange infrastructure that supports sharing patient health information across the healthcare delivery system and, increasingly, outside the healthcare delivery system” (Thorpe, Gray, & Cartwright-Smith, 2016). Physical and mental health surveillance can only be achieved with the generation of population and facility-based data (WHO, 2007). Censuses, surveys, medical records, and data on health system capacity are all methods of generating population and facility-based health information (WHO, 2007). Developing a system of standardized reporting to recovery actors and, eventually, national health leadership will facilitate the surveillance of mental health determinants, health system performance, and health status (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010). Surveillance should also cover data collection of physical and mental health status of returnees.

Once the proper metrics and other mechanism for surveillance are in place, effective analysis and synthesis of health data can be conducted routinely and made readily available, particularly to national health leadership. With this health information, the leadership can make informed decisions while reviewing mental health policies about service delivery, promotion, and prevention (WHO, 2013b). Health information given to leadership should include trends observed among the repatriated.
4. Medical Products

The leadership should ensure that there is an availability of essential drugs, medical products, and technology throughout the REPMEN time-frame. A national standardized list of essential drugs should be created and consistent with the WHO Model List of essential drugs, which includes a list of minimum provision of psychotropic drugs (WHO, 2016b). Guidelines for primary healthcare drug administration and prescription of psychotropic drugs should be delineated in mental health policy to maintain safety and reliability. It is advised that post-conflict states use “locally available and generic off-patent medicine” as they tend to be cheaper (Inter-Agency Standing Committee, 2007). The main goal for this building block is for states to work towards fortifying procurement, storage, and distribution capacity of pharmaceuticals and medical products (Cometto et al., 2010).

5. Financing

Financing post-conflict health recovery is a dynamic and, similar to the other health system building block activities, requires multi-level cooperation. It often takes years for post-conflict states to be financially independent from donors but that would occur outside of the Framework’s timeframe. Therefore, mental health system financing would comprised of donor grants required throughout repatriation with the eventual adoption of fund pooling mechanisms in the latter period.

a. Short-term activities

During early stages, most health system financing is supported by donors that allocate funds to NGOs as they are delivering the majority of health services at this time (Newbrander et al., 2011). Major international donors include the European Commission, USAID, and the World
Bank, but many other countries and agencies pledge millions of dollars to international aid every year (Fig. 5) (Cometto et al., 2010; Financial Tracking Service, 2017).

**Fig 5. Largest sources of response plan and appeals funding**

According to the Financial Tracking Service, which tracks the flow of global humanitarian aid, a significant portion of today’s global aid is allocated to almost every country in the MENA in 2016 and 2017 (Financial Tracking Service, 2017). Donors are distributing funds among battleground nations such as Yemen, Syria, and Iraq, but also to countries that have been indirectly impacted by conflict through the refugee crisis including Jordan and Lebanon. This means that the funding pathways necessary for repatriation strategies have already been tapped and can be continued to be used during post-conflict. International donors should be prepared for long-term financial commitment during recovery, especially in countries that have experienced protracted war and conflict like we have seen in the MENA.

**b. Medium and long-term activities**

Later in recovery, resource-pooling can be expanded to include contribution from the country and its people once it has the fiscal capacity to do so. One method of this form of resource pooling is the use of user fees, but the research cautions heavy dependence on this
system as a short-term recovery action (Bornemisza, Ranson, Poletti, & Sondorp, 2010; Witter, 2012). In the context of voluntary repatriation, conflict, escape, and repatriation have significant financial impacts on returnees and user fees increase their financial burden (Witter, 2012). Therefore, establishing user-fee programs may be better suited as a long-term recovery financing mechanism. Evidence shows that effective allocation of revenue generated from user fees, such as allocation towards facility quality improvement, can have positive effects on patient utilization and satisfaction (Akashi, Yamada, Huot, Kanal, & Sugimoto, 2004). In turn, these effects generate even more revenue for facilities that can go toward furthering quality enhancement efforts. However, if user fees are showing to place serious strain on certain groups, waiver programs and health equity funds (HEFs) could be put in place to mitigate this strain (Ir, Bigdeli, Meessen, & Van Damme, 2010; Steinhardt & Peters, 2010). Results from community needs assessments can inform leadership about how to distribute financial assistance funds to those in need. Demand-side financing (DSF) has also been shown to increase healthcare utilization and improve health-seeking behavior through financial incentives (Gopalan, Das, & Mutasa, 2014). DSF programs have commonly used healthcare vouchers to target population that would benefit from the under-utilized services they promote, including mental healthcare (Gupta, Joe, & Rudra, 2010). Further research is needed to know if repatriates are likely to be targeted and benefit from voucher schemes promoting mental healthcare utilization, but it is worth looking into. Overall, successful user fee, waiver, HEF, and DSF program implementation requires relatively sound health sectors with adequate human, medical, and infrastructural resources.
6. Stewardship

Stewardship, which involves leadership and governance, is the glue that keeps repatriation and reintegration activities from falling apart. Across the time periods of the REPMEN Framework, the international community must be consistently involved with overseeing activities as the country rebuilds the capacity to do so on its own. Stewardship is likely the most involved building block because it has a hand in all other activities in the framework. The leadership must provide support for the planning, implementation, and monitoring of all framework elements while having the ability to calculate next steps based population characteristics and the progress of each move toward recovery.

a. Short-term activities

A health authority should be established early on to ensure that health sector recovery activities as well as service delivery are going accordingly. If mandated, the UN may intervene early on in the repatriation process to act as a transitional health authority while the state works on capacity-building (Bornemisza et al., 2010). However, this does not mean that the state is not involved in health sector oversight during early recovery. It is important to establish coordination platforms and groups involving NGOs, international organizations, and local government representatives that regularly convene to discuss the plans and actions towards fortifying the health system and establishing a robust mental health network (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010). These actions involve ensuring health equity across the population and understanding that some groups, such as returnees, may be more vulnerable than others. Within the health authority, it is recommended that an intersectoral MHPSS coordination group be established if enough MHPSS
actors are present. This coordination group would be tasked with coordinating MHPSS activities across all sectors to comprehensively secure psychosocial well-being (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010).

Leadership should also be heavily involved with early rapid mental health and health sector assessments. It is likely that organizations with a protracted presence in the region have conducted their own assessments and may be used and supplemented with other assessments conducted during post conflict recovery (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010). Logistical factors to be assessed include but are not limited to infrastructural damage, pharmaceuticals, medical disposal, patient information systems, communication, transportation, and human resources (Daw, El-Bouzedi, & Dau, 2016). The Global Health Cluster’s Health Resource Availability Mapping System, or HeRAMs, is an instrument that can be used to gauge early levels of health resources and services and includes a mental health checklist for each level of care. HeRAMS has been used in several MENA countries including Syria and Yemen (Mehchy, Nasser, & Saba, 2017; WHO, 2016c, 2016a). Moreover, it is very important to conduct mental health needs assessments among returnees and stayees to ensure informed decision making during planning, as well as medium and long-terms actions such as monitoring and evaluation (Adaku et al., 2016). Helpful methods of data collection for needs assessments may include “literature review, group activities (e.g. focus group discussions), key informant interviews, observations and site visits” (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010).
b. Medium and long-term activities

The majority of medium and long-term activities build upon the short term activities. Leadership should continue to facilitate the coordination within collaborative groups in addition to creating sustainable solutions. Ideally, the government’s health authority would have the capacity to lead the creation of social welfare policies which would include BPHS; these policies intend to increase access to basic needs for vulnerable populations. In addition, mental health policies should be formulated with clear aims and objectives based on population mental health needs and leadership capacity. They should be established upon a comprehensive framework that identifies (Raphael, 2004):

1) Population mental health needs across all groups and demographics indicated in needs assessments

2) Standardized evidence-based strategies and interventions that will be employed to address those needs. These strategies should be expressed in the form of policies, legislation, and government-run programs.

3) The actors that will manage and sustain the mental health network, including NGOs, clinical professionals, international agencies, and intersectoral partnerships that will aid in advancing the mental health agenda.

4) Regulation and incentives that are put in place to ensure quality care as well as the bodies that enforce them.

5) Mental health care financing schemes

6) The overarching aims and objectives of the established policies
The creation of mental health policies in the context of the 4Rs is better suited as a long-term solution because a certain level of development must be achieved before able to collect, analyze, and distribute national mental health data. Moreover, a sufficient number of mental healthcare specialists is paramount to inform and implement policies (Raphael, 2004).

Another major leadership responsibility is the monitoring and evaluation of all of the activities of the Framework. This is a major task that requires proper health information and surveillance systems in conjunction with a capable and informed health authority. An evaluation of mental health information, trends, resources, and services must be conducted as a springboard for mental health policy reform. Post-conflict countries that lack the resources to design their own mental health system evaluation tool may use instrument that have already been created by other entities (Hamid H, Abanilla K, Bauta B, & Huang KY, 2008). For example, the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) is an instrument that was developed in the mid-2000s to be used by countries to collect vital information on their mental health resources and services (WHO, 2005). Saymah et al. employed WHO-AIMS to evaluate the mental health resources in Gaza during 2010 and were able to identify major strengths and weaknesses that lie within the system. However, other research suggests that while WHO-AIMS may be useful for developing countries, its limitations include “the neglect of the politics of mental health policy development, underestimation of the role of culture in mental healthcare utilization, and questionable measurement validity” (Hamid et al., 2008).

C. Goals and Outcomes

The REPATMENT Framework is not a guide for how to become a fully functioning state and countries do not have to follow the activities in the order they appear. It will likely require
many years for MENA countries receiving repatriates to achieve fully functioning status, with a
time period extending well beyond the scope of our framework. Therefore, countries can be
flexible in how they use REP MEN and tailor activities to what works best for their needs. The
major goals and outcomes of REPATMENT include:

1. Creation of sustainable coordinating platforms and collaborative groups for MHPSS
2. Access to basic quality mental health care and coverage to returnees and stayees.
3. Decreased stigma in the MENA surrounding MHPSS and health-seeking behavior
4. Increased mental health awareness and community-based mental health outreach
5. A health workforce that is well-trained in MHPSS at the primary and secondary level of
care.
6. Protecting repatriates and stayees from the financial burdens health cares.
7. Increased government capacity to create, implement, and evaluate mental health policy
   and evidence-based strategies meant to improve MHPSS

D. Considerations and Potential Barriers to REPATMENT’s Success

There are, however, several factors that will hinder progression through the Framework.
The objective is to make repatriation activities sustainable, but this cannot happen if the state
cannot facilitate the recovery process. States should assess their capacity to move forward with
recovery activities and accept returnees before the elements of the Framework come into play.
With the help of the international community, post-conflict nations must focus on building the
capacity to create a robust mental health network. This collaborative effort involves multiple
actors including donor agencies, such as USAID and the World Bank, Non-governmental
organizations (NGOs), and international organizations such as the World Health Organization
and other United Nations agencies. The UN, which has laid the groundwork for our Framework, has long acted as a key player in global conflict and post-conflict relief and has developed an extensive field presence and rapport with developing nations and NGOs. The involvement of the UN and its agencies in repatriation effort in the MENA would supplant the activities with resources and expertise. However, without highly coordinated steps and a focus on capacity-building, problems such as differing organizational cultures and planning, inadequate management systems, diminished human resources, and weak infrastructure will continue to act as barriers to health sector recovery despite aid from foreign entities (Cometto et al., 2010; UNHCR, 2008b). Other barriers to REPMEN’s success are lack of political freedoms and overall safety of returnees (Jallow et al., 2004; Jones & Center for Domestic and International Health Security, 2006). The Framework attempts to mitigate these issues by including collaborative activities within each stage of the repatriation process.

Chapter VI: Conclusion

As we see a large amount of people from the Middle East and North Africa part of greatest level of forced migration ever recorded, it is likely that we will see repatriation among the migrants who fled the MENA (UNHCR, 2016). This paper attempts to start the early planning process necessary to improving health among returnees, as well as pose questions surrounding this topic. What are the mental health status and needs of returnees? How do we address mental health issues in an area that lacked the resources and political will to nurture and mental health care network prior to migration? How do we stop mental health care revitalization from being underrepresented in post-conflict recovery? The REPMEN Framework
partially answers these questions, but more research on repatriation and returnee mental health is needed to answer them comprehensively.

The REPMEN framework is a presentation of the critical components necessary for mental health care and health sector recovery, but remains flexible. It represents the ideal approach to mental healthcare recovery but users are not expected to accomplish every activity, but the framework would be able to tailor the framework in ways that best meets the needs of the leadership and population. However, the instrument emphasizes of cross-system linkages, coordination platforms, and information sharing during and this emphasis should be transferred to future repatriation strategies in the MENA. It is also important that countries understand the importance of elements involving coordinating platforms, delivery of basic social and health services, and the need to reach out to communities and raise awareness about mental illness. With a third of today’s refugee population originating from the region, the global health community must act now for the sake of health equity, access to healthcare, and adequate coverage for populations of concern.
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Appendix

Appendix 1. Example of Repatriation Framework

<table>
<thead>
<tr>
<th>Stage</th>
<th>Emergency Stage</th>
<th>Transition Stage</th>
<th>Development Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Humanitarian emergency assistance (reintegration packages, non-food items, cash grants, agricultural tools)</td>
<td>Initial support to returnees</td>
<td>Repatriation of refugees</td>
<td>Initial support to IDPs and other displaced groups</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>relief to countries in post-conflict situations</td>
</tr>
<tr>
<td>2 Reconciliation and peace building</td>
<td>Fostering reconciliation and co-existence QIPs</td>
<td>Development of areas left behind for political/ethnic reasons</td>
<td>Peace building activities</td>
</tr>
<tr>
<td>3 Infrastructure (schools, clinics, water points, shelter, feeder roads)</td>
<td>Rehabilitation of basic infrastructure (roads, markets, electricity, etc.)</td>
<td>Assistance to health, water supply and sanitation and education</td>
<td>Assistance for shelter</td>
</tr>
<tr>
<td>4 Governance (national protection, documentation, property rights)</td>
<td>Fostering civil society</td>
<td>(Interim government) coalition assistance</td>
<td>Support to free media</td>
</tr>
<tr>
<td>5 Assistance to particular social groups (female-headed households, key policy priorities)</td>
<td>Returnee protection and monitoring</td>
<td>Development of government administration/rule of law and judiciary systems/human rights promotion</td>
<td>Reintegration of child soldiers and assistance to street children</td>
</tr>
<tr>
<td>6 Security (mine awareness, demining)</td>
<td></td>
<td></td>
<td>Assistance to widows and war orphans</td>
</tr>
<tr>
<td>7 Economic recovery (livelihoods, sectoral linkages, markets and trade, private sector)</td>
<td></td>
<td></td>
<td>Psycho-social rehabilitation</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Assistance to people with disabilities caused by landmines and armed conflict</td>
</tr>
<tr>
<td>8 Cross-cutting issues</td>
<td></td>
<td></td>
<td>Demining and mine awareness campaigns</td>
</tr>
</tbody>
</table>

UNHCR's role should peak during the early transition stage and diminish significantly afterwards.

Source: Jallow et al., 2004
Appendix 2. WHO Health System Building Blocks

Appendix 3. Optimal Mix of Mental Health Services in Emergency Situations