Earlier this year, a woman named Dorothy witnessed the unspeakable: the murder of her husband and two of her children. Like many others, the family was caught in the ongoing conflict in the English-speaking parts of Cameroon.

Dorothy had to muster every molecule of her inner strength to gather up her other children and run for safety.

I meet people like Dorothy everywhere I go. Women in the east of the Democratic Republic of the Congo, in South Sudan, women and girls from the Rohingya community in Bangladesh, a woman I met three weeks ago in southern Ethiopia, people in displacement camps in northern Yemen and others on the border between Nigeria and Niger who have fled from the Boko Haram terrorists.

I have heard so many heartbreaking stories of people witnessing atrocities, of losing loved ones, of being forced by fighting to flee homes and livelihoods, of seeing a child die from hunger because of drought or war.

People weep and shake as they tell their stories. Their trauma is etched in their eyes and written in their faces.

Your Majesty, Your Royal Highness, my dear friend and colleague Minister [for Foreign Trade and Development Cooperation] Sigrid Kaag, my good friend and colleague [Director-General of the World Health Organization] Dr. Tedros, thank you for gathering today for this, thank you for bringing us together to talk about and find solutions to this huge set of problems. It is an honour and a privilege to join you.

Too often we overlook one of the most important aspects of what helps us as humans to survive. And that is our state of mind.

People caught in crisis do need water, food and shelter and other material things – but they also need help to cope and recover from calamity. They need help to restore their mental wellbeing.

According to the World Health Organization (WHO), one person in five living in a conflict zone has some form of mental disorder. I suspect from my own - now too extensive - personal experience in talking to people in war zones that the real number is a lot higher.
Unimaginable loss, years of displacement, violence, families torn apart, hunger, thirst, discrimination, fear – all those things take not only a physical toll, they impact on a person’s mental health.

We know that our state of mind impacts everything we do. Yet in many humanitarian responses, while medicine is brought to heal physical wounds, often the necessary care has not been there to help mend mental health.

Practically all our assessments during emergencies highlight the need for mental health and psychosocial support – from the very young to the very old.

Take Syria, one of the world’s longest and most brutal crises.

WHO estimates that the majority of Syrians – more than half the people of the country – now need mental health and psychosocial support services. One child in four is at risk of developing a mental health disorder.

Yet, in many cases, these conditions are ignored or trivialized despite the fact that they risk leading to serious long-term consequences.

According to a Syrian community health worker with a local NGO, Syria Bright Future, 90 per cent of the depression cases now in Idlib are caused by the conflict.

Yesterday and today, you talked about how children and adolescents can get help to maintain and improve their mental and psychosocial wellbeing, and I’m pleased to hear that that will be reflected in the Declaration from our meeting today. It is also important to recognize that women and men have different experiences, and they have different needs.

The message that I want to highlight today is that activities on mental health and psychosocial support have to be a stronger part of our overall aid efforts.

Because our mental wellbeing affects every aspect of our lives, so our mental health and psychosocial support needs have to be factored in to all humanitarian aid responses.

That helps everyone cope and recover better.

Involving the affected people will restore a sense of dignity and safety and help to improve basic services.

The United Nations and the organizations we work with have started providing support for mental health in many emergencies including in Syria and Yemen.

When the conflict began in Syria, mental health care services were available in just two cities. Only 70 psychiatrists and a limited number of psychologists were available.
With WHO’s support, mental health services have now more than doubled, with provision in more than 150 primary and secondary health centres in 11 governorates across the country, including those most affected by the crisis. And they involve not just doctors, but also other health professionals and support workers who can reach much larger numbers of people than the tiny number of doctors available.

Again, when the cyclone struck, and I saw its impact in the Bahamas just three weeks ago, support to coordinate mental health and psychosocial support services were provided from the outset. But we can do better. We do have the knowledge, and we do have the tools.

The Guidelines on Mental Health and Psychosocial Support in Emergency Settings which has been developed by the Inter-Agency Standing Committee are a strong start.

They are available in 16 languages and they are the gold standard reference. They can be used to build minimum service packages, the essential, affordable packages of health which will enable us to deal with this problem better.

We need to be mindful too of the mental wellbeing of aid workers, who are often the first responders in a crisis. Working for months and in some cases years in emergencies can be traumatic.

The aid community has to ensure staff have access to mental health and psychosocial support when they need it.

At the end of August this year, nearly 150 million people – that is one person in 50 across the whole planet - in 58 countries were estimated to be in need of humanitarian assistance.

We also need to look at the long-term recovery of people affected by crises. We are examining how our programmes can restore social capital for communities in crisis; the links, the shared values and understandings in society that enable individuals and groups to trust each other and collaborate.

Research has shown that social capital determines individuals’ mental health, and their recovery from mental ill health.

More research is needed into social capital in crisis settings. OCHA, my office, is leading an expert academic group convened on this topic, with members from the Clingendael Institute, Utrecht University, and Stichting Centrum ’45 as well as from Harvard, the World Bank and others.

This group is setting out a research agenda to test how social capital affects humanitarian outcomes like mental health and how our programmes can better support that.
But a lot more remains to be done as this conference has shown us. So how do we ensure that support on these issues becomes a mandatory part of our response?

By 2020, next year, we hope that the Common Monitoring and Evaluation Framework for Mental Health and Psychological Support services will be launched in 6 languages. This Framework will ensure that the support being provided changes lives forever.

For that to happen we have to be able to count on dedicated funding lines for mental health and psychosocial support.

In the meantime, all of us in our organizations must ensure that we do not ignore this silent crisis, because we know it can have devastating impacts not only in the recovery of people like Dorothy but for entire communities and countries for generations.

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