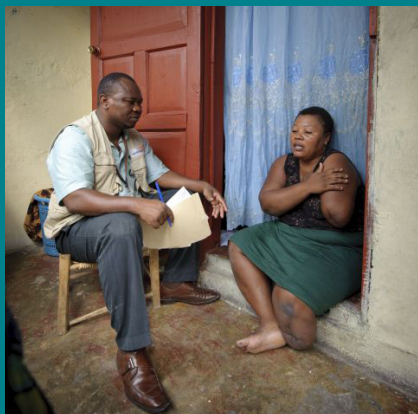**IASC** Inter-Agency
Standing Committee

Review of the Implementation of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

How Are We Doing?

Review of the Implementation of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings
@ Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support, November, 2014

Acknowledgements

Foreword

In 2007, the Inter-Agency Standing Committee (IASC) published the IASC Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings to enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency.

Following the publication of the Guidelines, the IASC MHPSS Reference Group was formed to support global implementation of the guidelines and integration of MHPSS in the Cluster system. The Reference Group has conducted orientations on the guidelines, advocated for the integration of the guidelines into cluster and organizational policies, and for their implementation in emergencies. The Reference Group has also released a series of supplementary implementation tools to accompany the full guidelines. The Guidelines are now available in Arabic, Chinese, English, French, Japanese, Nepali, Spanish and Tajik.

This review looks at the level of implementation of the Guidelines and supplementary tools, and the mainstreaming and integration of the Guidelines across the humanitarian system since the Guidelines were first published. The results are based on key informant interviews, extensive document review, and an on-line survey. In addition, implementation is explored in specific emergency contexts through a combination of in-depth and brief case studies.

Findings of the review indicate that that the impact of the Guidelines has been widespread and significant. Seven years of dissemination, utilization and implementation of the Guidelines in a range of vastly differing contexts has offered an opportunity for reflection, consolidation and mapping of the next steps towards strengthening and improving MHPSS response in emergencies. The review includes in-depth case studies on implementation of the Guidelines in the Central African Republic, Peru, the Philippines, South Sudan and State of Palestine. The report also includes shorter snapshots on MHPSS response in Libya, Sri Lanka and the response to the Syrian refugee crisis in Jordan. I hope that the findings, suggestions and recommendations in this review will further support the practical implementation of the Guidelines and will continue to contribute to reduced suffering and improved mental health and psychosocial well-being of people affected by emergencies.

Kyung-wha Kang,
Chair of the Inter Agency Standing Committee Working Group

Table of Contents

Acronyms

CCCM	Camp Coordination and Camp Management
CFS	Child Friendly Space
CPWG	Child Protection Working Group
ECD	Early Childhood Development
IASC	Inter-Agency Standing Committee
IFRC	International Federation of Red Cross and Red Crescent Societies
IMC	International Medical Corps
IOM	International Organization for Migration
M AND E	monitoring and evaluation
MHGAP	Mental Health Gap Action Programme
MHPSS	mental health and psychosocial support
MOH	Ministry of Health
OCHA	Office for the Coordination of Humanitarian Affairs
PFA	Psychological First Aid
PTSD	Post-traumatic Stress Disorder
RG	MHPSS Reference Group
SGBV	Sexual and Gender Based Violence
UNHCR	UN High Commissioner for Refugees [UN Refugee Agency]
UNICEF	UN Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
4WS	who is where, when and doing what in humanitarian settings (the 4Ws mapping tool).

Executive Summary

In 2007, the IASC released the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings [henceforth referred to as the Guidelines]. One of the factors motivating the development of the Guidelines was recognition of the significant divisions in the field of MPHSS in emergency settings. Key actors were aware that these divisions were negatively impacting quality of services and supports, limiting coordination of activities, and risking that mental health and psychosocial supports were actually doing harm.

The Guidelines, the "first inter-agency consensus about what are the essential first steps to be taken in an emergency," represent a significant achievement in terms of offering conceptual and practical clarity about the role, definition and scope of MHPSS (Wessells and van Ommeren 2008). The Guidelines formally consist of the single document released in 2007, comprised of a set of key principles, dos and don'ts, as well as a matrix of

key interventions spanning emergency preparedness, minimum responses and comprehensive responses. These key interventions are across areas including coordination, human resources, community mobilization and support, health, nutrition and water and sanitation. Since 2007, the Reference Group has also released a series of supplementary implementation tools to accompany the full guidelines, including tools for health, camp management and protection actors.

The emphasis on multisectoral action positions MHPSS as overlapping and linked with all aspects of humanitarian response, and highlights the potential for nutrition, shelter, and water and sanitation interventions to promote MHPSS. The inclusion of the "community mobilization and support" domain, at the same level as other key sectors, health and education, emphasizes the importance of these actions in MHPSS work. This inclusion also reflects that attempts to implement MHPSS interventions without recognition of community strengths, resources and organization, may violate the 'do no harm' principle (Wessells

2009). As the "informative distillation of key practice knowledge from the scores of experts consulted during their development," the Guidelines represent the state of knowledge around MHPSS practices in humanitarian settings at the time of their development. They provide a basis from which to develop mental health and psychosocial support interventions in emergencies (Ager 2008). The Guidelines were released in 2007. Seven years of dissemination, utilization and implementation of the Guidelines in a range of vastly differing contexts offers an opportunity for reflection, consolidation and mapping of next steps towards strengthening and improving MHPSS response in emergencies.

This review aims to provide an overview of the impact of the Guidelines on MHPSS programmes in emergency settings, looking at existing practices and lessons learnt since the release of the Guidelines. The review looks at the level of *implementation* of the Guidelines, exploring institutionalization of the Guidelines within specific agencies, mainstreaming and integration of the Guidelines across the humanitarian system, and perceptions of any gaps or changes in the relevance and utility of the Guidelines.

This review adopts a broad definition of *implementation* as constituting awareness, utilization, and institutionalization of the Guidelines. Key questions of the review are:

1. How and to what extent have agencies in the humanitarian field implemented the Guidelines?

2. What specific measures have agencies taken to implement the Guidelines, including mainstreaming in sectors such as Education, Health, Water, Sanitation and Hygiene and Camp Coordination and Camp Management?

3. What is the impact of the Guidelines on MHPSS coordination in the field?

4. Do the Guidelines adequately address key challenges in the MHPSS field?

5. To what extent do the Guidelines inform existing practices? How have the Guidelines been utilized in different field settings?

6. What is needed to support the practical implementation of the Guidelines in the field and how can the Reference Group [RG] provide more concrete support to their implementation?

These questions were addressed through this review using key informant interviews, extensive document review, and an online survey, in addition to exploring implementation in specific emergency contexts through a combination of in-depth and brief case studies. In addition, a literature review of academic literature that is reflective of the core principles in the Guidelines, directly refers to and discusses the Guidelines, and finally, provides evidence for specific actions and recommendations in the Guidelines, is included. The review represents a consolidation of data generated guided by these key research questions, with findings presented below under the sub-headings of: Overall influence of the Guidelines, Awareness, Utilization and Institutionalization.

Key findings and recommendations:

Overall influence of the Guidelines

- *Interagency consensus and the role of MHPSS in emergencies:*
  The fact that the Guidelines are the product of an interagency process, are endorsed at an agency-level, and are readily identifiable as an IASC product, strengthens the role of MHPSS in emergencies. The activities of the RG are seen as effective and important components of implementation of the Guidelines. The RG is currently leading activities including developing ethical guidelines for research on MHPSS in emergencies, and strengthening of monitoring and evaluation activities, which can lead to improvement of activities and interventions by RG members and across the MHPSS field.

- *MHPSS – a term used for communication and consolidation of the field:*
  The Guidelines introduced the term MHPSS, which has strengthened understanding and made contreate linkages between mental health and psychosocial actors and activities in emergencies. The widespread utilization of the term MHPSS has enabled actors to communicate and coordinate across sectors, often bridging health and protection activities.

- *Influence of core principles:*
  The Intervention Pyramid was commonly described as the most influential of the core principles in the Guidelines. It is easily understood and explained, and is a useful tool for use in training, coordination meetings and discussions at cluster meetings.

Awareness

- *Levels of awareness:*
  Overall, most respondents noted that awareness of the Guidelines at Headquarters level, and particularly within agencies represented at the RG, is high. However, the level

of awareness of the Guidelines varies widely, and awareness often does not translate to knowledge of the content of the Guidelines. In field contexts, presence of strong leadership, usually in the form of coordination groups, is necessary in order for the awareness of the Guidelines to translate into practices and utilization. A significant gap exists in awareness-raising activities with local actors, including faith-based organizations.

- *Methods used to build awareness:*
  Various methods have been used to build awareness of the Guidelines, including wide dissemination, orientation and training. Dissemination of the Guidelines through online platforms could be improved. Brief orientation sessions for all emergency workers have been described as useful, and have been facilitated through coordination groups. Training on the Guidelines has been implemented in various ways since the release of the Guidelines, ranging from agency-specific training programmes to efforts towards building networks of regional advocates.

- *Recommendations:*
  - Develop short, tailored modules to address key content areas in the Guidelines for orientation trainings, especially in Level 3 emergencies;

  - Develop dissemination and awareness-raising activities for local actors, including faith-based organizations and local municipalities in disaster-prone and conflict-affected countries;

- Focus awareness raising within the humanitarian system on key clusters, including child protection, nutrition and health; and

- Improve the web presence of the Guidelines, including increased collaboration with mhpss.net

Utilization

- *Communication between and within agencies:*
  The Guidelines are used to facilitate communication between and within agencies and with donors. MHPSS technical experts use the Guidelines to inform their response to programme proposals, and to engage non-MHPSS sectors.

- *Utilization of the Guidelines with donors:*
  Donors interviewed for this review are aware of the Guidelines and seek to use them to inform their funding decisions. The extent to which Guidelines have influenced donors for MHPSS is unclear. The Guidelines have been used to successfully strengthen proposals and obtain support for activities that were formerly difficult to fund, however, there remains a need for further advocacy work with donors.

- *Influence on programmes and activities in the field:*
  The influence of the Guidelines on programmes and activities in the field appears to be positive, however, this influence depends on resources, context and capacity. Improved monitoring and evaluation mechanisms are needed to better assess the impact of MHPSS activities in the field. The Guidelines have been particularly effective in empowering technical ex-

© THE GOOD PRACTICE GROUP
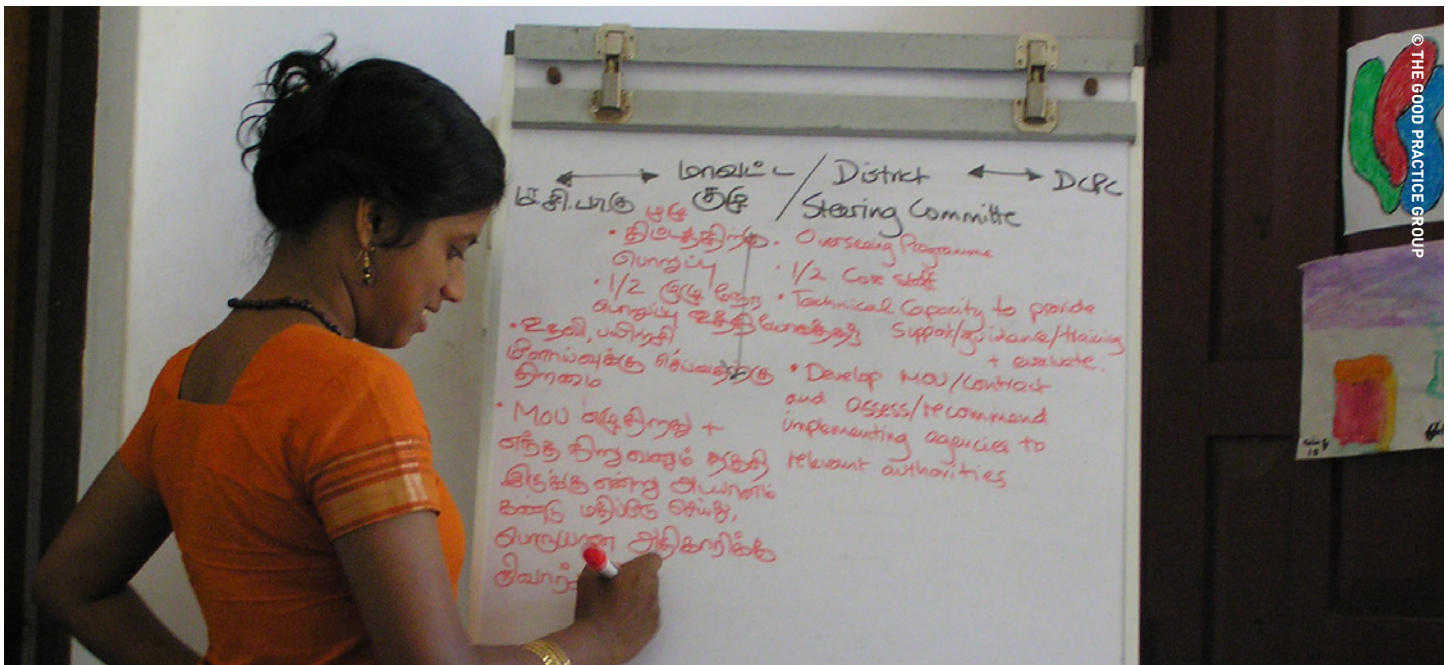
perts to improve quality of programmes, and key informants noted that the Guidelines have therefore reduced the number of inappropriate or harmful interventions. Key informants noted that improvements in interventions have largely been in the area of Level 3 and 4 interventions of the Intervention Pyramid. There appears to be concern about the quality of psychosocial programming. The Guidelines have not been employed to decide who *should* do what, when and where, and implementation of the Guidelines is reliant on coordination, capacity and structure of the humanitarian sector.

- *Coordination:*
  One of the primary ways in which the Guidelines have been used is in coordination in emergency settings. MHPSS working groups have been established in the response to a number of emergencies since the release of the Guidelines. This is a result of the Guidelines' recommendation that an intersectoral MHPSS coordination group be established in emergency settings, including health and protection actors.

- *Utilization and influence in clusters*
  The structure of the humanitarian system was identified as a key challenge to integration of MHPSS activities, recognition of MHPSS activities from the outset of an emergency, and overall implementation of the Guidelines. Respondents noted that integration of MHPSS within clusters has been somewhat limited and challenging. 'Cross-cutting issue' fatigue, and lack of clarity as to the strategy through which cross-cutting issues are integrated into the cluster system, has limited the integration of the Guidelines within the cluster system.

- *Recommendations:*
  - Continue to pursue and strengthen monitoring and evaluation [M and E] frameworks that can demonstrate the impact of common MHPSS activities;

  - Support in-depth case studies that demonstrate implementation of the Guidelines, including field-level data collection, to inform the evidence-base on contextual factors influencing implementation;

  - Develop and implement strategies to enable national and local-level implementation of the Guidelines in selected disaster and conflict-affected countries;

  - Develop toolkit of options for community-based psychosocial interventions, providing examples of best practices;

- Develop off-shoot materials and built products that respond to specific needs for more practical guidance in implementation of the guidelines;

- Encourage and support agencies (RG members and others) to develop practical guidance materials based on the Guidelines for their agency;

- Develop guidance on coordination mechanisms, including examples of how coordination has effectively occurred in recent emergencies;

- Support a focal point for MHPSS, deployed by a RG member, to all L3 emergencies, to ensure coordination mechanisms are established; and

- Prioritize discussion and development of strategy around cross-cutting issues, including issuing a short MHPSS strategy paper on role within the humanitarian system.

Institutionalization

- *Policies and procedures*
  Review of policy documents and procedures, as well as in-depth interviews with RG members, found that many RG members have taken significant efforts within their agencies to develop and disseminate policies, adapting the Guidelines to the specific mandates and activities of their agency.

- *Human resources*
  One of the central challenges to implementation of the Guidelines is availability and quality of relevant human resources in emergency settings, whether within local and national Government systems or international agencies. This review found that institutionalization of the Guidelines requires a stronger level of MHPSS capacity throughout the humanitarian sector.

- *Recommendations*
  - Develop institutionalization checklists for humanitarian agencies, donors, and Governments;

  - Develop a MHPSS roster and fund capacity for deployment of MHPSS experts to support implementation of the Guidelines in emergencies.

I. Background

In 2007, the IASC released the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings [henceforth referred to as the Guidelines]. The stated purpose of the Guidelines is as follows:

to enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency.

The IASC Mental Health and Psychosocial Support [MHPSS] Taskforce, convened in 2005, developed the Guidelines. Following the closure of the Taskforce, the IASC MHPSS Reference Group was formed, to support the implementation of the Guidelines.

One of the factors motivating the development of the Guidelines was recognition of the significant divisions in the field

of MHPSS in emergency settings. Key actors were aware that these divisions were negatively impacting quality of services and supports, limiting coordination of activities, and risking that mental health and psychosocial supports were actually doing harm. Within the field, there had been considerable debate concerning the appropriate theoretical, methodological and contextual approaches to the mental health and well-being of war and disaster-affected individuals and communities. In 2003, Strang and Ager spoke of "fundamentally different theoretical perspectives on the nature of psychosocial issues and the causes of problems" (Strang and Ager 2003). There were multiple approaches across the field. Health sector approaches usually took one of two approaches: a vertical, medicalized approach to mental distress, focusing on trauma-related mental disorders, including post-traumatic stress disorder [PTSD], or a public mental health model, which included all mental disorders and prioritized severe mental disorders, whether they were induced by trauma or not. In contrast, there were two predominant approaches in the protection and social work sector: one focused

on restoration of the social and physical environment, using interventions such as rebuilding livelihoods and strengthening family environments (Betancourt and Khan 2008; Wessells and van Ommeren 2008), while a second, less prevalent approach, focused on trauma and counseling for PTSD.

These conceptual divisions had concrete impacts on the field. For example, the division between a health sector approach and a protection sector approach sometimes resulted in systems of care that divided severely mentally ill individuals from mainstream community-based programmes (van Ommeren, Saxena et al. 2005). Many experts perceived this conceptual divide as holding back development of coordinated responses, agreed-upon guidelines and systematic and effective interventions (Weiss, Saraceno et al. 2003).

The Guidelines, the "first inter-agency consensus about what are the essential first steps to be taken in an emergency," represent a significant achievement in terms of offering conceptual and practical clarity about the role, definition and scope of MHPSS (Wessells and van Ommeren 2008). The emphasis on multisectoral action positions MHPSS as overlapping and linked with all aspects of humanitarian response, and highlights the potential for nutrition, shelter, and water and sanitation interventions to promote MHPSS. The inclusion of the "community mobilization and support" domain, at the same level as other key sectors, such as health and education, emphasizes the importance of these actions in MHPSS work. This inclusion also reflects that attempts to implement MHPSS interventions without recognition of community strengths, resources and organization, may violate the 'do no harm' principle (Wessells 2009).

The Guidelines represent a consensus-based agreement, a "synthesis of practice knowledge." Although the Guidelines were informed by existing evidence, due to the lack of comprehensive data available at the time, they are not considered evidence-based. As the "informative distillation of key practice knowledge from the scores of experts consulted during their development," the Guidelines represent the state of knowledge around MHPSS practices in humanitarian settings at the time of their development. They provide a basis from which to develop mental health and psychosocial support interventions in emergencies (Ager 2008). The Guidelines were released in 2007. Seven years of dissemination, utilization and implementation of the Guidelines in a range of vastly differing contexts offers an opportunity for reflection, consolidation and mapping of next steps towards strengthening and improving MHPSS response in emergencies.

Key questions of the review

This review aims to provide an overview of the impact of the Guidelines on MHPSS programmes in emergency settings, looking at existing practices and lessons learnt since the release of the Guidelines. The review looks at the level of *implementation* of the Guidelines, exploring institutionalization of the Guidelines within specific agencies, mainstreaming and integration of the Guidelines across the humanitarian system, and perceptions of any gaps or changes in the relevance and utility of the Guidelines.

Key questions of the review include:

1. How and to what extent have agencies in the humanitarian field implemented the Guidelines?

2. What specific measures have agencies taken to implement the Guidelines, including mainstreaming in sectors such as Education, Health, Water, Sanitation and Hygiene [WASH] and Camp Coordination and Camp Management [CCCM]?

3. What is the impact of the Guidelines on MHPSS coordination in the field?

4. Do the Guidelines adequately address key challenges in the MHPSS field?

5. To what extent do the Guidelines inform existing practices? How have the Guidelines been utilized in different field settings?

6. What is needed to support the practical implementation of the guidelines in the field and how can the Reference Group [RG] provide more concrete support to their implementation?

The methodology of this review includes 57 key informant interviews, conducted by the consultants over the phone. Key informants included RG members and health or MHPSS experts at donor agencies. In addition, the consultants conducted an in-depth review of relevant academic literature, key policy documents, evaluations and assessments. Twenty-four of the key informant interviews focused on specific contexts of implementation of the Guidelines, to inform the case studies and snapshots of implementation in emergencies included in this review. Case studies and snapshots were selected based on input from the Steering Committee, and included a range of regions and different types of emergencies (natural disaster, conflict-related). The case studies were developed by conducting a minimum of three interviews with individuals who had been or are presently involved in provision, design, implementation

or review of MHPSS activities in these contexts. The in-depth case studies are:

- State of Palestine
- Central African Republic [CAR] (early 2013 onwards)
- Taiphoon Haiyan, Phillippines (2013)
- South Sudan (December 2013 onwards)
- Peru (2007)

Summaries of the case studies are included throughout the report as brief snapshots, with the in-depth version of the case study included as an annex (Annex 2). In addition, the report includes shorter snapshots on MHPSS response in Libya, Sri Lanka and the response to Syrian refugee crisis in Jordan. The majority of these case studies and snapshots reflect humanitarian responses a few years after the release of the Guidelines. Previously, case studies were conducted to reflect implementation in emergency settings closer to the release of the Guidelines (Echeverri and Castilla 2008; Horn and Strang 2008; Horn and Strang 2008). The case studies conducted for this report therefore seek to complement the previous documentation of implementation in specific contexts. The review also includes data from an on-line survey of 72 respondents (see Annex 1 for survey questions). Findings from the survey are presented throughout the report, shedding light on the themes that emerged in in-depth interviews, and a full version of the results of the on-line survey is included in Annex 4.

Lack of implementation of some components of the Guidelines in some contexts does not necessarily reflect lack of effort, will or knowledge of the Guidelines, but may in fact reflect political realities and contextual barriers. The consultants therefore employed qualitative methods, which can be more readily and productively used to explore these issues, and did not seek to quantitatively assess implementation in any contexts. Moreover, the question of what constitutes implementation, and the ways in which it differs according to *who* is implementing the Guidelines, and *where* entails that quantitative measurement of what has been the most effective means of implementation, or assessment of the level of implementation through use of a uniform index or checklist, is beyond the scope of this review.

The over-arching aim of this review is to assess the implementation of the Guidelines. However, both "implementation" and "the Guidelines" requires some further definition and delineation, and are therefore discussed below. The following two sections provide conceptual framing and practical boundaries to the scope of this review.

What are the Guidelines?

The Guidelines formally consist of the single document released in 2007, comprised of a set of key principles, dos and don'ts, as well as a matrix of key interventions spanning emergency preparedness, minimum responses and comprehensive responses. These key interventions are across areas including coordination, human resources, community mobilization and support, health, nutrition and water and sanitation. This document is available in 8 languages[1] and forms the core of the Guidelines. The Guidelines were disseminated in hardcopy, softcopy (pdf format), and CD. A poster with the minimum response actions in each area was also disseminated in hardcopy.

Since 2007, the Reference Group has also released a series of supplementary implementation tools to accompany the full guidelines, including:

- The IASC Guidelines on MHPSS in Emergency Settings – Checklist for Field Use
- Mental Health and Psychosocial Support in Emergency Settings: What should Protection Programme Managers Know?
- Mental Health and Psychosocial Support in Emergency Settings: What Should Humanitarian Health Actors Know?
- Mental Health and Psychosocial Support in Emergency Settings: What should Camp Coordination and Camp Management Actors Know?
- Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes
- IASC Reference Group Mental Health and Psychosocial Support Assessment Guide
- Advocacy package
- Advocates training (5 day training)
- 6 one-day orientation seminars

These documents have been utilized in conjunction with the Guidelines, and represent one approach to implementation that is discussed in the body of this review. The on-line survey for this review found that 49% of respondents indicated using the "Checklist for Field Use" and "the 4W's" respectively, followed by 40% for "What Should Humanitarian Health Actors Know," 36% for "What Should Protection Programme Managers Know," 15% for "What Should Camp Coordination and Camp Management Actors Know," while 13% stated they used none of the tools. Given widespread use of these documents throughout the field, this reviews considers these tools as components of the Guidelines.

---

1   The languages are Arabic, Chinese, English, French, Japanese, Nepali, Spanish and Tajik

Several key informants interviewed for this review noted that it is difficult to disentangle the impact of the Guidelines from the impact of related activities of the Reference Group, as well as broader changes in the field in the past seven years – for example, improvements in monitoring and assessment methodologies (WHO/ UNHCR 2012), and an expanded evidence base for specialized interventions (Bass, Neugebauer et al. 2006; Bass, Annan et al. 2013). Moreover, many key informants noted that the process of *developing* the Guidelines was a highly participatory process that brought together a diverse set of actors and widely varying perspectives on MHPSS in emergency settings (see description of the process in Wessells and van Ommeren, 2008). The impact of that *process* can be seen in the field in terms of coordination of activities and understanding of MHPSS needs in emergencies, as well as the relationships built during that process. As such reviewing the Guidelines requires both considering the Guidelines as embedded within the range of other tools, and attempting to discern the specific impact of the Guidelines separate to shifts and movements in the field overall.

What is implementation?

The Guidelines are applicable to actors working at a range of levels, across a range of activities. For example, the 2011 IASC MHPSS Advocacy Package notes that the Guidelines can be used in some of the following ways: as a guide of programme planning and design; as a tool for advocacy for better practice; as a resource for interventions and actions; as a coordinating tool; and, as a checklist to identify gaps in MHPSS response (IASC 2011). Measurement and assessment of implementation of a series of principles, approaches and actions such as the Guidelines is complicated. In the course of this review it became evident that identification of a context in which the Guidelines have been fully "implemented" is not possible. Implementation will necessarily mean something different for a community-based worker, a programme manager, a policy maker, a donor. Therefore, in the course of this review, multiple components of, and perspectives on, implementation were explored.

When the Guidelines were released, some practitioners and experts questioned as to how and by whom the Guidelines would be used (Baingana 2006). In the past seven years, the Guidelines have been used by a wide range of actors, in multiple and various ways, many of which are described in this review. Therefore, a broad definition of implementation was adopted in this review, drawn and adapted from the framework of implementation used by the Inter-Agency Network for Education in Emergencies [INEE] (Sullivan-Owomoyela 2006). This approach focuses on three aspects of implementation:

1. *Awareness:* What is the level of awareness of the Guidelines? Are there specific activities that have influenced this level of awareness?

2. *Utilization:* How are the Guidelines being used, and in what settings? What factors influence their utilization? By whom?

3. *Institutionalization:* Have the Guidelines been institutionalized within organizations, including donors and Governments? What are some of the ways in which institutionalization has occurred?

Outline of the review

Part II of the review identifies academic literature, including articles relevant to the key principles in the Guidelines, as well as research that has directly referred to or utilized the Guidelines as a conceptual framework or basis for research. Part III explores the overall influence of the Guidelines, as described by key informants. Part IV addresses awareness, Part V addresses utilization and Part VI addresses institutionalization. Throughout the review, snapshots of promising practices, key components of implementation through interventions, training or research, or descriptions of aspects of implementation in the field, are highlighted. The snapshots are summaries of the in-depth case studies (Snapshots 1, 2, 4, 9 and 11), and:

- **SNAPSHOT 3:** Capacity-building through skills-building – the case of Psychological First Aid;
- **SNAPSHOT 5:** National level implementation of the Guidelines – key challenges;
- **SNAPSHOT 6:** Efforts to build the evidence-base – review and evaluations of child-friendly spaces through a partnership between Columbia University and World Vision;
- **SNAPSHOT 7:** Contextual aspects of implementation of the Guidelines – the case of Sri Lanka;
- **SNAPSHOT 8:** Use of the Guidelines for coordination – the case of the Syria response in Jordan;
- **SNAPSHOT 10:** Emergency as a catalyst for coordination and consensus – the case of Libya.

Each section of the report includes a series of recommendations, and Part VII provides a synthesis of findings.

© WORLD VISION

Literature on MHPSS in emergency settings has directly referred to aspects of the Guidelines in a number of ways, including in the course of describing or justifying components of interventions, as a conceptual framework, and as a basis for research.

The Guidelines themselves are not evidence-based in the sense that each recommendation was not based on a systematic review of the literature. However, the guidance was informed by narrative reviews that were available at the time (Batniji, Van Ommeren et al. 2006). Many decisions in the Guidelines text were based on the empirical literature available at the time. In addition, the Guidelines were reviewed by numerous academics to avoid including recommendations that would conflict with existing evidence. Indeed, there is existing and emerging literature that provides evidence for some of the core principles and actions promoted in the Guidelines. A selection of this literature is presented here, including examples of community-based psychosocial, health and nutrition activities that provide evidence for aspects of the Guidelines.

Literature inclusive of core principles in the Guidelines

Most of the core principles in the Guidelines are discussed in literature on MHPSS in emergency settings. The 'do no harm' principle in the Guidelines is discussed in-depth by Mike Wessells in two articles (Wessells 2008; Wessells 2009). These articles outline the types of "unnecessary harm" that can be caused "by the very humanitarian operations that are intended to support affected people," including lack of coordination, limitations of participation of affected persons, duplication of assessment and lack of feedback and dissemination after assessments, and approaches that fail to take into account cultural meanings of distress. These two articles describe instances of MHPSS practices that have violated the 'do no harm' principle, and the ways in which recommendations and actions included in the Guidelines – for example, establishment of a single MHPSS coordination structure – can act to address these issues. These articles emphasize the importance of the 'do no harm' principle,

while also presenting some of the key challenges in the field – including shortage of services and support for the most vulnerable populations, and lack of holistic, integrated community-based activities, as promoted in the Guidelines.

Another core principle in the Guidelines is participation, with the Guidelines noting that as early as possible in an emergency context, "local people should be involved to the greatest extent possible in the assessment, design, implementation, monitoring and evaluation of assistance." A project focusing on empowerment of girl mothers formerly associated with armed forced in Liberia, Sierra Leone and Uganda emphasized the centrality of participation to reintegration and empowerment programmes. The project used participatory action research to encourage girls to define their own needs, design reintegration programmes and develop positive coping skills, resulting in improved relationships and increased economic livelihood activities (McKay, Veale et al. 2011; Worthen, Veale et al. 2012). This project was conducted in post-emergency settings, and required stability and capacity for long-term planning for success. However, it demonstrates the role of participation, a core principle in the Guidelines, and the ways in which active participation by affected individuals and communities can lead to improved programme design and implementation.

Articles on multi-layered approaches to psychosocial and mental health services for children in Sri Lanka, Indonesia, Burundi, Nepal and Sudan describe a series of interventions developed to address a range of psychosocial and mental health needs for conflict-affected children in different contexts. This research notes that this model, "a layered system of care [which] entails provision of complementary supports for sub-populations depending on severity of mental health problems," is a means of translating the Guidelines into "a replicable delivery framework" (Jordans, Komproe et al. 2010). Articles describing the elements of this project, the process of developing the interventions, measurement tools and referral mechanisms, models of implementation, perceived treatment outcomes, treatment satisfaction and estimated cost per user, highlight that this project is notable in its operationalization of the Intervention Pyramid and the core principles of integrated support systems (Jordans, Tol et al. 2010). A number of articles also present results of the impact of the classroom-based psychosocial interventions that were one component of the project, assessing the impact of the intervention on PTSD, depressive and anxiety symptoms, resilience and functioning (Jordans, Komproe et al. 2010; Tol, Komproe et

al. 2010; Tol, Komproe et al. 2012; Tol, Komproe et al. 2014).

The Guidelines reflect conceptual and practical developments that had emerged in the years prior to the release of the Guidelines. The Psychosocial Working Group initiated many of these conceptual developments, developing a conceptual framework that identified the impacts of conflict and displacement on human capacity, social ecology and culture and values (Psychosocial Working Group 2003). A 2004 article on mental health in complex emergencies discussed a number of principles and actions that are present in the Guidelines, including the need for coordination of mental health activities, integrating mental health care into the primary health care system, psychological first aid [PFA], and community participation (Mollica, Cardozo et al. 2004). Hobfoll et al. describe principles that should be used to guide interventions in the immediate and mid-term aftermath of mass trauma – a sense of safety, calming, a sense of self and community-efficacy, connectedness and hope (Hobfoll, Watson et al. 2007). Level 1 interventions – the "(re)establishment of security, adequate governance and services that address basic physical needs," – and a range of other Level 2 and 3 interventions, including PFA, reflect these principles.[2] Promotion of a sense of safety may be achieved through key actions included in Action Sheet 8.1 (Provide information to the affected population on the emergency, relief efforts and their legal rights), and promotion of a sense of self and community-efficacy is reflected specifically in the core principles of participation and building on existing resources and capacities.

Researchers have used elements of the Guidelines as a conceptual framework. For example, in research aiming to "provide recommendations for practice and research by linking practices that are commonly implemented with evidence from intervention evaluations," Tol et al. use the 4Ws mapping tool to identify which MHPSS activities are most commonly implemented, as well as the Intervention Pyramid, in order to categorize evidence from randomized controlled trials or controlled trials of MHPSS interventions (Tol, Barbui et al. 2011). Use of these frameworks allows the authors to compare current practices and evidence-base, identifying the disconnect between research and practice.

---

2   For the purposes of this review, Level 1 interventions are considered to be those interventions in the area of basic services and security (the base of the pyramid); Level 2 are community and family supports; Level 3 are focused, non-specialized supports and Level 4 are specialized supports.

© UNICEF/DENM2014-00073/FEROUZ

Snapshot 1: Implementation of the Guidelines in South Sudan, 2013-2014

Decades of conflict and lack of infrastructure and capacity have presented significant challenges to provision of MHPSS in South Sudan. Availability of clinical and specialized mental health services is very limited, there is extremely low capacity and availability of human resources, and there is a lack of availability of psychotropic drugs (IOM 2014). A 2013 assessment of mental health facilities in South Sudan noted that the mental health system is rudimentary and centralized and there is very limited involvement of international NGOs in mental health or psychosocial programming (IMC 2013).

Interest in and commitment to MHPSS had been emerging in South Sudan. In 2012, a Mental Health Platform was established under the Ministry of Health, with Healthnet TPO coordinating the Platform and implementation of the strategy. A dedicated UNICEF MHPSS specialist had been mapping community support and psychosocial resources. However, in December 2013, political tensions escalated to armed civil conflict, resulting in significant displacement, within South Sudan and to neighboring countries (Humanitarian Country Team - South Sudan 2014). Ongoing conflict has resulted in lack of humanitarian access to a large proportion of displaced persons (OCHA 2014), and a 2014 humanitarian

needs assessment concluded that, due to the conflict, "modest gains on the humanitarian front made in 2013... are likely to be reversed, with a serious impact on people's health and nutritional status" (Humanitarian Country Team - South Sudan 2014). An IOM assessment in February 2014 noted that ongoing insecurity and lack of humanitarian access to individuals and communities affected by the violence has influenced psychosocial and mental health impacts of the conflict (IOM 2014).

Application of the Guidelines in the case of South Sudan is limited, and is primarily reflected in coordination efforts. A MHPSS Working Group, as part of the Child Protection Sub-Cluster, was established in January 2014, and meets weekly in Juba. A child protection 5Ws exercise (who is doing what, where and when, for whom) indicated that the vast majority of MHPSS activities are Child Friendly Spaces (Child Protection Sub-Cluster - South Sudan 2014)

The core challenges to implementation of the Guidelines in the humanitarian response in South Sudan are related to lack of capacity, in terms of health systems and human resources, to support mental health and psychosocial activities (see for example, IMC 2014).

Knowledge about mental health and capacity for identification of mental disorders at a primary health care level is extremely limited. Some PFA training and orientation sessions are planned for these health care providers, which could strengthen the capacity to provide some basic supports.

The case of South Sudan brings to light some of the systemic and structural challenges to implementation of the Guidelines in a Level 3 emergency. One respondent noted, "execution of the Guidelines on the ground" has been quite limited – "not due to lack of willingness by the staff or the lack of understanding but just due to the circumstances can often be quite difficult. We do try to use them and stick to them wherever possible... But in terms of actually ensuring the practical application on the ground, sometimes that is just beyond possibility and you have to do the best that you can." The lack of resources, capacity and awareness of MHPSS within South Sudan poses a significant challenge to provision of a range of MHPSS activities.

Other aspects of the overall humanitarian situation that pose significant challenges to MHPSS activities are the ongoing insecurity and humanitarian lack of

access to affected populations, as well as the fact that proposed activities in the protection cluster are severely underfunded (only 12% of proposed activities are funded), limiting capacity to provide psychosocial activities that fall under the protection cluster (OCHA 2014).

While the MHPSS Working Group within the Child Protection Sub-cluster has acted to bring together child protection actors working on psychosocial activities (the majority on child friendly spaces), there are concerns that the Working Group is comprised primarily of psychosocial actors, and does not have strong links to the Health Cluster or to actors with mental health expertise. The primary focus on psychosocial activities and on children entails that mental health issues, and a focus on adults, is not currently evident. In terms of mental health, there is a Platform for Mental Health, which had been established prior to the crisis in 2013, which has linkages with the Ministry of Health and is currently led by Healthnet TPO. There are some efforts to link the MHPSS Working Group and the Platform for Mental Health. While the gap between the groups is currently a challenge, respondents noted current efforts to improve the linkages and ensure attendance at each others' meetings, and communication between the groups.

Literature that directly refers to and discusses the Guidelines

Some articles and reports have directly referred to and discussed the role of the Guidelines. In a brief discussing the results of the United States Institute for Peace's Peace building and Health Working Group meeting in 2010, Rubenstein and Kohli describe the Guidelines as "a promising approach," that stresses the need for "understanding local context, programming that attends to psychosocial support needs of the entire community, meeting clinical needs of people with more severe conditions, and respecting human rights" (Rubenstein and Kohli 2010). Jones notes that her experiences in the field provide support for the principles in the IASC Guidelines, and in particular, that the Intervention Pyramid shows the strengths of integrated supports (Jones 2008).

A number of these articles are themselves efforts to introduce the Guidelines to various audiences, or describe awareness-raising efforts. For example, Jones et al. describe aspects of the Guidelines, with a focus on the needs of those with severe mental

illness, in the *British Medical Journal* (Jones, Asare et al. 2007). Van Ommeren et al. describe an orientation workshop for psychiatrists on the Guidelines, with the goal of improving psychiatrists' capacities to act as advocates for those with moderate and severe mental disorders in emergencies, as well as undertaking a public health approach to mental health in emergencies (Van Ommeren, Jones et al. 2010). A discussion of the role of disaster psychiatry in preparedness and response to mass catastrophe situations recognizes the importance of the recommendations in the Guidelines in planning from the emergency phase through recovery phase (Raphael and Ma 2011).

The journal, *Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas,* has published a number of articles focused specifically on the Guidelines, starting with a 2008 Special Issue focusing on the development and implementation of the Guidelines, as well as including as critical commentaries and reflections. The journal has played a significant role in promoting the Guidelines. Since then, *Intervention* has also included descriptions of introducing the Guidelines in Nepal (Jordans, Upadhaya et al. 2008), discussion of utilization of PFA

in Haiti (Schafer, Snider et al. 2010), use of the Guidelines in an academic psychology programme (Barrett, Fox et al. 2011), and discussions of integration of mental health care into health systems (Rose, Hughes et al. 2011). *Intervention* has also included a number of field reports including mapping of *who* is *where, when* and doing *what* in humanitarian settings (the 4Ws mapping tool). One article describes the development and piloting of the 4Ws tool (O'Connell, Poudyal et al. 2012), while field reports describe the results of 4Ws processes in Jordan (Baca, Fayyad et al. 2012) and Libya (Fitzgerald, Elkaied et al. 2012).

Literature providing evidence for aspects of the Guidelines

Some research recently published provides evidence for some of the core principles and actions promoted in the Guidelines. This discussion touches on some of the evidence that has emerged in the past seven years, shedding light on some of the recommendations in the Guidelines.

One study examined the impact of a broad-based psychosocial intervention, designed to improve social bonding and social cohesion, on mental health outcomes. Such an intervention is in line with recommendations in the Guidelines, and fit within Level 2 in the Intervention Pyramid. Researchers found, using a quasi-experimental design, that a population-based sociotherapy intervention improved the mental health of participants in the

programme compared to individuals in other communities who did not receive the intervention (Scholte, Verduin et al. 2011). There are very few published research studies on Level 1 and 2 interventions, although recent research provides evidence for the impact of child-friendly spaces in emergency settings [see Snapshot 6].

In the area of focused supports – both specialized and non-specialized (as intervention studies often combine both approaches) – a systematic review of interventions for children highlights the expansion of studies in this area, while noting significant limitations of study design and lack of adherence to principles of community-based and integrated supports (Jordans, Tol et al. 2009). Research provides limited rigorous evidence as to the impact of specialized interventions for survivors of SGBV (Tol, Stavrou et al. 2013). A study of psychological care provided to survivors of rape in Brazzaville, Congo, found that psychological support provided long-term impacts in terms of functioning (Hustache, Moro et al. 2009). A randomized controlled trial of cognitive processing therapy and individual support for female survivors of sexual violence showed reduced depression, anxiety and PTSD symptoms and improved functioning for women who received cognitive processing therapy compared to those who received individual support (Bass, Annan et al. 2013).

Action Sheet 6.1 in the Guidelines, *Include Specific Psychological and Social Considerations in provision of general health care,* includes a number of actions such as orientation of general health and men-

tal health staff in psychological aspects of emergency health care, provision of PFA, and provision of referrals for clinical services outside the primary health care system. It also includes actions to ensure provision of services for those with severe mental illness, such as training and supervising primary health care staff who care for people with severe mental disorders. Some of these actions are described in articles on integration of mental health into primary health care in Uganda (Baingana and Mangen 2011), Lebanon (Hijazi, Weissbecker et al. 2011) and Haiti (Rose, Hughes et al. 2011), and are also closely related to actions in Action Sheet 6.2, *Provision of access to care for people with severe mental disorders.* In Lebanon, training of primary health care providers focused on identification, management and referral of individuals with mental health problems. Qualitative assessment of activities aimed at improving the capacity of health clinics in Uganda to address mental health issues found that capacity of health workers to identify and manage mental health problems increased, community outreach through village health teams provided social support to patients and community mobilization in order to increase utilization of services was effective. The assessment found, however, that attrition of health workers and regular drug supplies proved to be a challenge throughout the project. In Haiti, after the earthquake, mobile clinics were established to provide specialist services for individuals with severe mental illness. While successful in increasing access to such services, the authors note that their experiences bring to light the challenges of implementing the IASC Guidelines in settings with low levels of community services affected by large-scale disasters.

© WORLD VISION

Literature provides support for the integration of psychosocial supports into nutrition programming, providing evidence for the impact of combining psychosocial activities, including early childhood development [ECD] activities and interventions to improve child-caregiver interactions, with nutrition programming to support cognitive, physical and emotional development of children. These activities support the principles of integrated and multi-level supports, as well as recommendations in the Guidelines that note the importance of recognizing the intersection of psychosocial well being and food and nutrition security (Action Sheet 9.1). Some psychosocial and nutrition interventions focus on improving mothers' mood and mental health, given the impact of maternal mood on child well-being and stimulation. For example, a study in Northern Uganda comparing infant stimulation and maternal mood outcomes between a group of mothers who received a psychosocial intervention of mother and baby groups and home visits in addition to an emergency feeding programme for infants compared to a group of mothers receiving only the nutritional support found that the psychosocial intervention "improved maternal involve-

ment, increased the availability of play materials, and decreased sadness and worry in displaced mothers of malnourished children" (Morris, Jones et al. 2012). A systematic review of integration of psychosocial and nutrition programming in low and middle income countries indicated that combining nutrition and child development interventions benefitted young children (Grantham-McGregor, Fernald et al. 2014). This is an area of emerging interest for donors and large agencies. UNICEF West Africa has begun supporting psychosocial support and early childhood development activities in its response to the food and nutrition crisis in the Sahel (McGrath and Schafer 2014), while Action Contre La Faim [ACF] has been actively involved with integration of nutrition programming and psychosocial supports for many years (Action Contre La Faim 2006). The WHO has also released guidance indicating the role of psychosocial supports in addressing child malnutrition in emergencies and integrating ECD into nutrition programming (UNICEF and WHO 2012).

© WORLD VISION

Snapshot 2: Implementation of the Guidelines in response to Typhoon Haiyan, Philippines

Typhoon Haiyan hit the Philippines on November 8, 2013, killing 6,200 people and affected the housing and livelihoods of over 16 million (MSF 2014).
The Guidelines had previously been introduced in the Philippines through a process lead by WHO Philippines, and engaging Government, NGO actors (local and international), UN agencies, academics and faith-based organizations. This resulted in the 2008 Joint Resolution for the adoption of National Disaster Coordination Council [NDCC] member agencies, to guide implementation of the Guidelines.

However, despite this process, many respondents noted the limitations of this adoption and institutionalization by the Government that became evident in the response to Typhoon Haiyan. While the introduction of the Guidelines in the Philippines appeared to have been one of the most successful cases of adopting of the Guidelines by a government at a national level, the influence of this adoption was unclear and limited in the response to Typhoon Haiyan.

Despite some of the challenges noted below, in the month after the initial response to the typhoon, key local and international actors were able to mobilize support for MHPSS, implement PFA trainings across affected areas, conduct a 4Ws mapping of MHPSS activities, and initiate improved institutionalization of the Guidelines within Government ministries.

Respondents noted high levels of cooperation, interest and commitment from local actors. While respondents reported varied levels of awareness of the Guidelines amongst a range of actors, the introduction of the Guidelines earlier, as noted previously, did have some influence on coordination and planning. For example, when a MHPSS Working Group needed a Terms of Reference, the local health coordinator introduced a TOR that had been used in another part of the Philippines response. A respondent noted, "they quoted large bits of the IASC guidelines. Which meant that somewhere in the Philippines, people were using the IASC guidelines as terms of reference for the MHPSS sub-cluster...That to me was evidence in the Philippines, the Guidelines there are accepted as an official way of working; that people are trying to implement them even if not everybody had read them."

One key impact of the humanitarian response on the implementation of the Guidelines in the Philippines appears to be improved and renewed engagement from Government departments in MHPSS in general, and in using the Guidelines as a framework for funding and

implementing MHPSS activities. One respondent explained that the Government is now asking her to provide input and review MHPSS proposals, providing an opportunity to introduce and reinforce the Guidelines through this process. This increased engagement from Government actors has also provided concrete opportunities to introduce mhGAP training and mental health training programmes at the primary health care level. Respondents noted that the MHPSS component of the humanitarian response has provided some opportunities for institutionalizing MHPSS within the disaster response framework at a national level, which had not adequately happened despite previous attempts at institutionalization.

As noted below, one of the challenges in the Philippines was the focus on psychosocial processing [PSP], which includes elements of critical incident debriefing, which is recommended against in the Guidelines. Some respondents noted a shift in the focus of the response in the Philippines from PSP to a greater focus on use of PFA. In the humanitarian response, there was widespread use of PFA training, interest from local actors and willingness to learn from consultants and international agencies who advocated for use of PFA, and a process of adaptation of the PFA training for the Philippines context.

Due to support from the WHO and through a UNICEF consultant, effective coordination structures were developed. In the early phase of the response, key actors such as the Department of Social Welfare and Development were not participating in the MHPSS coordination mechanisms. Following efforts, specifically by the UNICEF consultant tasked with this role, the coordination mechanisms were strengthened, with an established TOR and engagement of key actors. The Working Group is co-chaired by the Department of Health and the Department of Social Welfare and Development.

While noting the range of ways the Guidelines were applied in response to Typhoon Haiyan, a number of respondents described some significant challenges that highlight barriers to effective implementation of the Guidelines on the ground. One respondent noted that, as has been the case previously in large-scale emergencies, large numbers of international and local actors mobilized, some of whom did not have previous experience or expertise in MHPSS activities. One respondent noted that many actors had "never heard of or seen the Guidelines." Some of these actors tended to support and implement

MHPSS activities that do not adhere to the principles of the Guidelines.

The use of PSP is an ongoing challenge. One respondent noted that PFA training, while effective, had not adequately addressed the use of PSP, noting that what is needed is "a much bigger cultural shift at the level of universities and psychologists, and with the disaster management communities, and with the church." The IMC found that "[w]hile the Department of Health agreed to stop using PSP and start using PFA after advocacy from the WHO, this message had not filtered down to the local level weeks after the emergency" (IMC 2014).

Another challenge noted in some MHPSS assessments and in key informant interviews is the lack of services for severe mental disorders, and that the "majority of agencies doing MHPSS work are focused on PFA, counseling, supporting children through CFSs and community services" (for example, IMC 2014). The only agencies that were engaged with specialized mental health services were IOM, IMC and CBM, despite assessments that identified a number of significant gaps in provision of these services. As part of this response, IMC has begun a mental health capacity building project, including training in order to support integration of mental health into primary health care.

There were significant initial challenges in the area of coordination. The challenge of MHPSS as a cross-cutting issue emerged from the beginning. An IMC report explained the situation as better than in previous emergencies, "[h]owever MHPSS is not visible anywhere as a sub-cluster in the Cluster list on the home page of the Philippines Humanitarian response, nor is it listed as a cross cutting issue" (IMC 2014). Despite improvements, respondents noted that some key local actors – most notably, faith-based organizations and the Church, which was providing aid directly to survivors – were not adequately engaged by international humanitarian actors. Finally, a UNICEF consultancy report notes a number of significant gaps in coordination at national level, specifically where psychosocial issues are the responsibility of a number of agencies who are not coordinating, noting that "it was evident there was very limited coordination of psychosocial support activities at national level. Whenever there is an emergency, the national response was not coordinated. Each department acted independently" (UNICEF 2014).

Research conducted for this review indicated that beyond the specific components of implementation – awareness, utilization and institutionalization, there are broad and significant impacts of the Guidelines. The following reaction from one respondent highlights some of the key themes in terms of the general influence of the Guidelines:

we actually have a document that we can stand behind there and that we have unified ourselves behind to say: this is our minimum standards and this is the policy that we will stand behind. We never had that before. We never had a document that we could refer to and that we could all universally agree on. So that the whole process of creating a guideline was a peace building process in itself because it brought together the

mental health and psychosocial field for the first time, and then put them together and then actually over a two year process, we managed to get them to agree and then we managed to get the guidelines released as well.

Some of these themes include the influence of the actual *existence* of the Guidelines, beyond their contents. The theme of the impact of interagency consensus in strengthening the role of MHPSS in emergencies was strongly represented in interviews conducted for this review. Moreover, respondents noted that the introduction and spread of the term MHPSS has improved understanding of the linkages between mental health and psychosocial activities, and improved communication and collaboration between various actors. Finally, the key principles of the Guidelines, including the Intervention Pyramid, have been widely used and integrated in various contexts.

Interagency consensus and the role of MHPSS in emergencies

The fact that the Guidelines are the product of an interagency process, are endorsed at an agency-level, and are readily identifiable as an IASC product, strengthens the role of MHPSS in emergencies. An MHPSS practitioner noted that in field settings, she can use the fact that other agencies have endorsed the Guidelines to advocate for certain actions in clusters, noting that in order to advocate for MHPSS in clusters, "I would create a Powerpoint based on their action sheet, and I would say – you have endorsed this. You are in here. Somebody from your agency endorsed it. One of the strengths of the Guidelines is that it's an institutional commitment, not a personal one."

The institutionalization of the principles in the Guidelines, as an IASC product, and as the product of a multi-year, highly participatory process of development, was perceived as one reason why the MHPSS field has seen interest and engagement of new actors in recent years. One practitioner noted, "Many of the ideas and the philosophies that I use now are certainly things I used before the Guidelines, but the most important thing is that they were institutionalized. Before five years ago, it was difficult to get anyone engaged in psychosocial programming. The development of the Guidelines gave us a formal way of introducing the work. And that is and will be and continues to be the most important thing that they do."

The role of the Reference Group

An additional aspect of this interagency consensus is the presence and quality of the RG. The RG's actions were noted by many respondents as effective and important components of improvement in the field of MHPSS. Examples of the role of the RG that were discussed in the course of the review include the provision of a time and space for personal interactions and discussions at the annual meeting, its coordinating role for conference calls in the early stages of emergencies, and its current role leading a number of processes that have been identified as important priorities by RG members – including development of guidelines for ethical research on MHPSS in emergencies and developing a framework for monitoring and evaluation. Members of the RG interviewed for this review noted that it has provided a space and forum for discussion of challenges, opportunities, and improvements in the field of MHPSS. Further investment in the RG – in terms of funding for time for co-chairs and provision of support for improved engagement of co-chairs with importance processes occurring at cluster-level meetings in Geneva

– was identified as an approach that could both strengthen the presence and profile of MHPSS in the IASC system, as well as provide support to RG members in their MHPSS activities. One respondent noted, "all the advocacy work and getting it at the table in Geneva that the various co-chairs have done over the years – that has been really, really important for relationship building with other sectors." This is work that respondents noted is important for the promotion and improvement of MHPSS work and coordination in emergencies, useful for the role of MHPSS within the IASC system, and a step towards improved integration of MHPSS issues within clusters.

Many of the actors who were involved in the development of the Guidelines are still engaged with the RG, which is now seen as a "community of practice." The networks created through participation in the RG were described as positively influencing coordination processes in various field settings. One RG member noted, "[i]t is such a shift in terms of how connected we all are, [and] how easy it is now to get those people connected in a crisis. Now, you have the Haiti Group on MHPSS.net, and we have at the annual meeting, people talking about what are they doing in each region and coordinating with each other. I think it is a combination not just of the IASC guidelines, but all the networks that have been informed that support that, interfaced with that, and these really clear links. It has become valuable through those networks." Another respondent explained, "for me, the Reference Group is one of the main achievements in terms of international coordination and the support for mental health and psychosocial issues in humanitarian work." Ultimately, the achievements of the RG were described as achievements that can be attributed to the Guidelines, as a respondent noted: "the Guidelines have given legitimacy to the RG, and the RG has done a lot for coordination."

MHPSS – a term used for communication and consolidation of the field

Key informants, including RG members, donors, and practitioners, noted that one of the major influences of the Guidelines is the introduction of the composite term, MHPSS. As stated in the Guidelines, the use of the term MHPSS within the Guidelines represents a compromise – an effort to bridge sometimes disparate and divided approaches to mental health and psychosocial needs. However, the term has also acted to concretely reflect the ways in which mental health and psychosocial needs are interrelated, and that services to address the spectrum of these needs should be integrated and holistic. Moreover, various actors have used the term in order to justify the importance of

their work in a range of settings, to increase collaboration and communication between actors, and to ensure the integration of MHPSS concerns within clusters.

One RG member stated, "it was really hard to come to that clarity and those definitions. It slowly evolved over ten years, where people wrestled through those issues of who we are and what we do and realized that it is all a continuum, and that we need both sides of the fence. No matter if you are working on the clinic or the mental health side or treatment of torture survivors or medications just for the seriously mentally ill or epilepsy, or if you are really working on that broad community psychosocial side, you need to be supporting each other and you need to be aware of each other, and you need to be complementing those efforts." Another respondent reflected that the use and spread of the composite term is one of the most significant achievements of the Guidelines, that "it really helps me to define the field within my agency. It's not just health; it's more than health. It helps us to position MHPSS as an intersectoral issue…it has helped me liaise more effectively with the non-health actors, and position MHPSS as something which is not just for health actors. I start by explaining the acronym, and people [from other sectors] see that there is something in it for them as well." Mental health or psychosocial technical experts can use the MHPSS term within agencies to orient, educate and advocate to other sectors within their agency. One respondent noted, the Guidelines have "set certain principles like – yes, MHPSS is part of your job even if you're doing a shelter program." The widespread utilization of

the term MHPSS, developed and institutionalized as part of the Guidelines, has concretely enabled actors to communicate and coordinate across sectors, often bridging health and protection activities.

The use of the composite term has served to decrease conflicts between mental health and psychosocial approaches, noted some respondents; the field has less "mental health vs. psychosocial thinking," and more recognition that "we need the overlap, and some people do more clinical, and some do less, and that's OK." Some respondents noted that the combination of both mental health and psychosocial support into one term has lent legitimacy to the field of psychosocial support. It has enabled other actors to recognize that psychosocial support is not just "running around with a football and making everyone draw pictures." One practitioner stated, "[i]t's given legitimacy to an approach that, let's be honest, everyone thinks they can do. Everyone thinks they can set up a tent and stick children in it. The mental health element has made it seem to be a little bit more valid intervention."

In terms of communication between agencies, RG members noted that the Guidelines and the common language created by the Guidelines can be used to educate and orient new actors without MHPSS expertise. Ultimately, the achievements of the RG can be attributed to the Guidelines, as one respondent noted, the Guidelines "provide a common language for us internally, which…helps then unify our projects around the world in a set

of common ideas." One respondent explained that the added value of the Guidelines has been "a common language, common vocabulary, common way of organizing ideas that allow people working on this field and people not working on this field to speak a common language."

Recent introduction of the term into agencies includes the use of the term in UNHCR's Operational Guidance for MHPSS Programming for Refugee Operations. The journal *Intervention* recently changed its subtitle from "*the International Journal of Mental Health, Psychosocial Work and Counseling in Areas of Armed Conflict,*" to "*Journal for Mental Health and Psychosocial Support in Conflict Affected Areas.*" This change reflects that the term mental health and psychosocial support has become a "household term in the field." The previous sub-title, which had been designed to ensure that "all schools" from a divided field would become involved, was deemed to be no longer necessary given that the field is now more cohesive and coherent (Tankink and Ventevogel 2014).

Influence of core principles

The core principles of the Guidelines – human rights and equity, participation, do no harm, building on available resources and capacities, integrated support systems and multi-layered systems of support (which includes the Intervention Pyramid) – are a reflection of practices and concepts that had been emerging and around which consensus was coalescing prior to the development of the Guidelines (see, for example, conceptual frameworks proposed by the Psychosocial Working Group). The extent to which these principles have influenced the design and implementation of specific activities, as well as the selection of particular approaches in the field, is in essence the core question of this review. However, the strong emphasis of respondents on the impact of the Intervention Pyramid, specifically, necessitates further discussion of this core principle separately here.

As one respondent stated, "the most visible contribution [of the Guidelines] is the multi-layered system of supports, the pyramid…using] the visualization in the pyramid, you can just give some examples, and people get it…They can easily position their own activities within that framework, which helps. It helps to make MHPSS inclusive." The visual nature of the Intervention Pyramid, and the way in which it allows actors from a range of perspectives to position their own activities, and understand the role of other activities, both within the MHPSS field and more broadly, has made it a particularly effective component of the Guidelines, and one that has had significant influence through-

out the field. As one respondent reflected, "The pyramid is what people remember, it's what people use the most. The pyramid has made the biggest difference." The Intervention Pyramid was commonly described as easily understood and easily explained, and as a useful tool for training, coordination meetings and discussions at cluster meetings. The content of the Pyramid, particularly Level 1 components, have also been useful as a tool to advocate for inclusion of social considerations in shelter and camp management, water and sanitation and information dissemination.

The Intervention Pyramid was discussed as the most widely known aspect of the Guidelines, the component that most effectively communicates key principles of the Guidelines, and a tool that can serve to improve communication and coordination. However, the degree to which the Intervention Pyramid has actually impacted selection and spread of activities in a given emergency may be limited. The Intervention Pyramid was not developed with the aim to guide funding and allocation of efforts, but rather to communicate that the entirety of the components of the Intervention Pyramid should be covered. Given how widespread the knowledge of the Pyramid is, therefore, there are potentially opportunities to increase its use in advocacy with donors and to use it to guide funding and allocation of efforts.

In addition, some respondents discussed the principle of do no harm. In the Guidelines, this principle is strongly linked to the need to coordinate, in order to "learn from others and to minimize duplication and gaps in response." This is discussed further in *Part V, Utilization.* Moreover, do no harm was cited in reference to the ways in which the Guidelines have improved the quality of programmes, and enabled potentially harmful programmes to be excluded from emergency response. One respondent noted, "I really believe the Guidelines have enabled us to do less harm. If nothing else, they have enabled us to do less harm. When people from the North come to me and say I want to do music therapy with refugees but only stay for a week, I can go back to the Guidelines and say – this is not an internationally recognized approach. The fly-in, fly-out model is not recommended…It has enabled us to have a basis for saying – this is within the Guidelines, this is not within the Guidelines. This has allowed an informal accountability for our work." Another respondent noted that the Guidelines "empower us to implement good practice. The Guidelines say – do not do stand alone trauma programmes. It's got the 'do not's'. The human rights basis and the dos and do not's are the most helpful bits. And they empower us to educate people in the best practices."

Further discussion of the impact of the Guidelines on programmes in the field is included in *Part V, Utilization.*

IV. Awareness

Awareness of the existence of the Guidelines, their key principles, and their key recommendations is a central aspect of implementation of the Guidelines. Efforts towards ensuring and increasing awareness have been central to the activities of the Taskforce, and subsequently, the RG, from the outset. The process of developing the Guidelines included efforts to reach out to various constituencies in a range of contexts, to ensure a multiplicity of perspectives was reflected in the final product. The process of developing the Guidelines included efforts to reach out to various constituencies in a range of contexts, to ensure a multiplicity of perspectives was reflected in the final product. This meant when the Guidelines were disseminated after the launch in 2007, there were already a number of agencies and key actors who were highly involved and engaged.

Views on awareness of the Guidelines

Objective data on the level of awareness of the Guidelines in emergencies since their launch is not available. Survey data collected for this review indicates that respondents learned about the Guidelines from a variety of sources, including orientation within their agencies (30.9%), training/education (26.5%), and website/internet (22.1%). Several indicated other sources (20.6%), including being part of planning and development of the guidelines, and learning about the guidelines from colleagues.

According to in-depth interviews, perspectives on awareness of the Guidelines vary throughout the field. Overall, most respondents noted that awareness of the Guidelines at Headquarters level, and particularly within agencies represented at the RG, is high. This awareness generally includes high levels of knowledge

of key aspects of the contents of the Guidelines and capacity to translate this knowledge into technical advice and support to field settings.

However, at the field level, most respondents acknowledged that the level of awareness of the Guidelines varies widely. One respondent noted that within her agency, at the field level, "in some countries, they've been actively using them in terms of trying to build them into trainings, for example, or making others aware of it or making their own team aware of it…some will be very aware that they exist or know the content of it, because they are working on psychosocial support projects or they have attending cluster meetings or coordination groups… for others, they have heard of it, but it's just another booklet. It's not really on the level where they can really use it." Some respondents noted that awareness of the Guidelines, previous experience using the Guidelines, and capacity to discuss components of the Guidelines are listed in job descriptions and are key expectations of new staff who are hired to MHPSS positions. Within the methodology of this review, it was not possible to assess whether differences in levels of awareness of the Guidelines and utilization of the Guidelines amongst field staff are linked to the different levels of institutionalization of the Guidelines between different agencies, for example, through training, hiring requirements or policy guidelines. However, it appears that agencies that have initiated concerted efforts to incorporate the Guidelines into various aspects of agency policy and practice are able to ensure that staff members have a basic level of awareness of the Guidelines. Agencies with a dedicated MHPSS specialist, technical advisor or unit at Headquarters level were also able to describe and discuss awareness-raising efforts that were an integral part of their position within the agency. Variations in knowledge of the Guidelines between regions were also discussed, with awareness of the Guidelines in the Middle East described as particularly high, and facilitated by active and effective MHPSS Working Groups in Jordan and Lebanon, for example.

Respondents noted that there is often a key set of actors in emergency settings who have little or no knowledge of the Guidelines – local community-based organizations, including faith-based organizations. For example, in the recent response to Typhoon Haiyan in the Philippines, there were a number of groups at the local level who were heavily involved in providing psychosocial support activities who were not oriented to the Guidelines and were not engaged in coordination groups. As one respondent noted, "you have to geared to do a rapid induction with them … our failure is with the wider humanitarian community, particularly faith-based groups, to educate them in advance of

emergencies." Awareness raising activities have largely focused on international humanitarian organizations, and have failed to engage with local actors who may be best placed to provide MHPSS activities.

Another key theme that emerged was the distinction between *awareness* and *knowledge* of the Guidelines. One respondent explained, "it is rare to encounter someone who ought to know about the Guidelines who does not know about the Guidelines. The awareness that they are there is high. That awareness is not always matched by knowledge." A donor noted that awareness of the Guidelines across the humanitarian sector is "large, but shallow. Everyone knows that they exist, but nobody knows them." Multiple interviews indicated that in field contexts, presence of strong leadership, usually in the form of coordination groups, is necessary in order for awareness of the Guidelines to translate into practices and utilization. One of the key challenges to improving levels of awareness of the Guidelines in the field is that, especially with the current context of a large number of Level 3 emergencies, many staff in emergency settings do not have extensive experience in previous emergencies. Respondents discussed that this context influences the level of awareness of the Guidelines in these current emergencies, noting, for example, that public health or child protection officers in some emergency settings may not have experience or expertise using the Guidelines in previous work. The high turnover and continual introduction of new staff into the field of humanitarian work creates a challenge for spreading awareness about the Guidelines. RG members discussed the need to develop new forms of dissemination that can rapidly and effectively orient new fieldworkers to the Guidelines and ensure integration of key principles into MHPSS work and clusters in emergency settings.

This review cannot draw conclusions as to the levels of awareness of the Guidelines in clusters. In the Child Protection Working Group [CPWG], there is widespread knowledge of the Guidelines, and considerable overlap between active members of the RG and active members of the CPWG. When the child protection minimum standards were developed in 2012, the psychosocial support standards were based on the Guidelines. One practitioner noted, "right from the beginning there was no question that the standard that was going to be developed on psychosocial support would have the Guidelines as their primary foundation. Everyone in the room took it for granted." The Camp Coordination and Camp Management cluster has been supportive of the Guidelines, and engaged in the process of developing the specialized product, *Mental Health and Psychosocial Support in Emergency Settings: What should Camp Coordination and Camp Management Actors Know?* However, as discussed further below,

this review was largely unable to access key actors in the other clusters, and therefore cannot conclude whether awareness of the Guidelines is throughout the cluster system.

Methods used to build awareness

RG members and other agencies have used various methods, including dissemination, orientation and training, to build awareness. A 2009 review of Orientation and Training Materials provides a comprehensive compilation and in-depth analysis of the various tools and approaches to orientation and training (Baron 2009). The review indicated that training and orientation does not adequately reach the full set of relevant actors, including all emergency workers, and have generally been conducted many months after emergencies occur, while only some have been conducted in preparation for emergencies.

DISSEMINATION: Translation of the Guidelines into eight languages has helped to facilitate dissemination. The level of demand for the Guidelines is reflected in the fact that the IASC Secretariat receives the most requests from the field for the Guidelines, compared to other IASC Guidelines and products. However, dissemination could be further supported by improved web presence. The website, mhpss.net, serves as a useful resource for disseminating orientation and training materials throughout the MHPSS field. The current IASC MHPSS website (http://www.humanitarian-info.org/iasc/pageloader.aspx?page=content-subsidi-tf_mhps-default) does not provide adequate up-to-date information – for example, the most up-to-date RG workplan posted on the website is from 2008. There is an opportunity to use the website as a mode of dissemination of key products, including and beyond the Guidelines themselves, which is largely missed at the moment.

ORIENTATION: One method of awareness-raising is through orientation of staff and agencies on the Guidelines, for example, orienting new actors in emergency settings. One respondent noted, "the Guidelines are really useful in having a common language and structure, so if new actors are joining the [MHPSS Working] group, we say – by the way, this is our foundation and this is how we commit to designing programming, so we have a common foundation and common language that we can refer back to, and use those coordination groups as a platform to educate about MHPSS about what should be done and what shouldn't be done." One example of how this has been done effectively is the MHPSS Working Group in Jordan. IMC and UNICEF produced a four-page document on "social considerations for displaced Syrians in Za'atri Camp," which addresses components of Level 1 interventions and suggests appropriate

measures to address risks to mental health and psychosocial wellbeing due to camp safety, information dissemination and access, dignity and privacy, and water and sanitation, which are all risks that can be addressed by non-MHPSS actors (IMC and UNICEF 2012). The Guidelines were used to effectively orient non-MHPSS actors, and new actors involved in MHPSS who were not aware of the Guidelines (for example, medical teams who were providing psychotropic medication), on key principles, to ensure coordination and referral mechanisms, and to avoid duplication and gaps in services.

TRAINING AND CAPACITY BUILDING: Training on the Guidelines has been implemented in various ways since the release of the Guidelines, ranging from agency-specific training programmes to efforts towards building networks of regional advocates. Some respondents noted that limited follow-up after trainings, including limited time for trainees to dedicate to integration of the Guidelines into their everyday work, and limited support for trainees to continue to develop and strengthen skills and knowledge they gained in training seminars, has been a challenge. This challenge was also noted in the 2009 review of orientation and training (Baron 2009). One respondent explained that within her agency, "training has been given, but there's no ways of following up on "Okay, so how effective was that?" six months later; or "What else would you like to know?"; or "How is it being used?" Then it kind of falls through the cracks quite, it drifts off the radar and it's gone."

It should be noted that orientation and training in itself constitutes a component of implementation of the Guidelines, given that Action Sheet 4.3 is Organise orientation and training of aid workers in mental health and psychosocial support. Training appears to be a large component of utilization of the Guidelines. In response to the on-line survey conducted for this review, 62% of respondents reported using the Guidelines to prepare workshops or trainings. Of those who had used the Guidelines to prepare trainings, 46% reported training partner agency staff, followed by 42% of respondents' agency staff, 33% for government agency partners, 24% for students and interns, and 10% for other, including cluster members, donors, non-specialized workers, and school instruction.

One recent example of training and capacity-building was the South Asia Regional Advocates Training, supported by The Good Practice Group, War Trauma Foundation, and World Vision Australia, a five-day training held in South East Asia with participants from India, Pakistan, Sri Lanka, Nepal, Bangladesh, Myanmar and Afghanistan. The goal of the training was to engage influential practitioners and policy-makers who can influence the MHPSS response in emergencies in their home countries. Facilitators

© UNICEF/RWAA2011-00625/NOORANI

Snapshot 3: PFA training – skills-building as capacity-building

Psychological First Aid [PFA] is mentioned in the Guidelines as one of the recommended "dos" ("Organise access to a range of supports, including psychological first aid, to people in acute distress after exposure to an extreme stressor"), as part of emergency preparedness for health services ("Orient health staff in psychological first aid"), and as part of Action Sheet 5.2, *Facilitate community self-help and social support,"* ("Providing basic support, i.e. psychological first aid, for those acutely distressed after exposure to extreme stressors"). Action Sheet 6.1, *Include specific psychological and social considerations in provision of general health care,* provides the most in-depth description of PFA in the Guidelines. PFA is described as encompassing:

- "Protecting from further harm (in rare situations, very distressed persons may take decisions that put them at further risk of harm). Where appropriate, inform distressed survivors of their right to refuse to discuss the events with (other) aid workers or with journalists;
- Providing the opportunity for survivors to talk about the events, but without pressure. Respect the wish not to talk and avoid pushing for more information than the person may be ready to give;
- Listening patiently in an accepting and non-judgmental manner;
- Conveying genuine compassion;
- Identifying basic practical needs and ensuring that these are met;
- Asking for people's concerns and trying to address these;
- Discouraging negative ways of coping (specifically discouraging coping through use of alcohol and other substances, explaining that people in severe distress are at much higher risk of developing substance use problems);
- Encouraging participation in normal daily routines (if possible) and use of positive means of coping (e.g. culturally appropriate relaxation methods, accessing helpful cultural and spiritual supports);
- Encouraging, but not forcing, company from one or more family member or friends;
- As appropriate, offering the possibility to return for further support;
- As appropriate, referring to locally available support mechanisms or to trained clinicians.

Following the release of the Guidelines, there was considerable interest in PFA, and requests from organizations for further guidance on PFA. The existing guidance was primarily oriented towards mental health professionals or specific to disasters and emergencies in high-income settings. A review of existing resources by World Vision and the War Trauma Foundation in 2008 identified gaps in existing resources that could be addressed by development of specific guidance on PFA for non-specialists in emergency settings (World Vision International and War Trauma Foundation 2010). World Vision, the War Trauma Foundation and the WHO collaborated to produce a Guide for Fieldworkers. The Guide is endorsed by 24 UN and NGO agencies. As one respondent interviewed for this review noted, it was a "big consensus process." The guide served to respond to the widespread interest of many organizations and individuals in using PFA in emergencies (WHO 2011). The guide was "informed by practices and principles drawn from an extensive review of the literature and existing PFA resources from around the world" (Schafer, Snider et al. 2010). The Haiti earthquake occurred during the process of development of the guide, and the guide was pilot tested during the Haiti response. Lessons learned from those orientation sessions were incorporated into the guide and the subsequent facilitator's manual (Schafer, Snider et al. 2010).

In 2013, a PFA training facilitator's manual was released, with modules for half and full-day orientation sessions, and accompanying slides. There is a group for PFA Training and Adaptation on mhpss.net, with information on PFA webinars held in Sri Lanka, the Philippines and Mongolia. The Guide for Fieldworkers has been translated into Spanish, Arabic, Tamil, Sinhala, Japanese and Chinese. Save the Children developed a guide for PFA specifically for children (Save the Children 2013). PFA orientation sessions and trainings have been used in a number of recent emergencies, including in the humanitarian response in the Philippines, Libya, Mali and Japan (Semlitz, Ogiwara et al. 2013). The use of PFA alongside other mental health and psychosocial

interventions has also been documented, for example, in the case of Medicins Sans Frontiere's interventions for displaced populations affected by violence in the Philippines (Mueller, Cristofani et al. 2011).

PFA is perceived by many in the humanitarian field as an important set of skills, and is increasingly an "entry point" that has been used to introduce a wide range of actors to the importance of MHPSS. One respondent noted that PFA has been widely adopted and introduced in a number of settings as it is "a basic building block, it is relatively easy to do, and something that people value. People are looking for something but they don't know quite what they are looking for. We can make the case that everyone needs some basic training in this, at least how to be supportive and how to refer. It makes intuitive sense for a lot of people." PFA is a concrete, skills-based approach that many in the humanitarian field have seen as valuable. Another respondent noted, in relation to general reflections on the impact of the Guidelines, that "where the Guidelines are most helpful is where they can be brought to the level of being very simple, very concrete, very direct. PFA is one example of this – not the only example, of course, but one example where people can really get their heads around something very quickly and have a skill that they can apply....It is one of the recommendations that we were able to articulate really simply and clearly."

PFA is an important intervention, and is a set of skills that can be easily communicated and provided to a range of fieldworkers, including in WASH, nutrition and shelter – either as a stand-alone orientation, or as an orientation incorporated into other training programmes. However, there is some concern that PFA will become the only tool that is recognized and adopted from the MHPSS Guidelines. Further work is needed to identify other core interventions or skills that can be delivered through orientation programmes or training sessions in emergency settings, in particular, community-based psychosocial interventions for those in need of support beyond PFA.

of the training noted that participants showed various levels of knowledge of the Guidelines' content. The training provided a structured opportunity to reflect on the content, participate in simulations of ways to use the Guidelines, and promote group dialogue and discussion on how the Guidelines could be contextualized and institutionalized in the region. One facilitator noted that participants "needed a structured space to read and reflect together," indicating that "the idea that you can just hand the Guidelines to busy workers in the field and get good comprehension is questionable." The training enabled practitioners and policy makers to move from awareness of the existence of the Guidelines, through to active engagement with components of the Guidelines, and improved awareness of the aspects and areas covered in the Guidelines.

Training is also included in academic settings, such as the University of Oxford Refugee Studies Center's Summer School, and other universities. IOM runs an annual course at the University of Pisa, *Psychosocial Interventions in Migration, Displacement and Emergency.* More recently, specific trainings on the Guidelines are less common, and are instead integrated into trainings on PFA. This ensures that field workers from a range of organizations both gain knowledge of the Guidelines and PFA understanding and skills.

Recommendations

- Develop short, tailored modules to address key content areas in the Guidelines for orientation trainings, especially in L3 emergencies;
- Develop dissemination and awareness-raising activities for local actors, including faith-based organizations and local municipalities in disaster-prone and conflict-affected countries;
- Focus awareness raising within the humanitarian system on key clusters, including child protection, nutrition and health; and
- Improve the web presence of the Guidelines, including increased collaboration with mhpss.net

© UNICEF/NYHQ2014-0938/BINDRA

Snapshot 4: Implementation of the Guidelines in Central African Republic

Tension and armed conflict increased and spread throughout Central African Republic (CAR), affecting the capital, Bangui, in early December 2013. Violent attacks on communities throughout the country by armed groups has resulted in significant displacement throughout CAR and to neighboring countries {OCHA, 2013 #5414}.

OCHA situation reports for CAR noted that internally displaced children were participating in child friendly

spaces established by a number of humanitarian actors, and that psychosocial activities were being conducted solely for children. Interviews with respondents in March and April 2014 confirmed that the MHPSS interventions that were part of the humanitarian response constituted child friendly spaces. The focus of the humanitarian response at the outset was on food, shelter, WASH and communicable disease, and MHPSS needs were seen as secondary. Initial lack of communication and coordination between agencies working on child friendly spaces has improved, with the development of a MHPSS working group occurring at the time of writing this case study.

Beyond these activities, respondents noted that there was not a high level of application of the Guidelines in the response to CAR, given general low levels of knowledge of the Guidelines, limitations on basic knowledge of psychosocial interventions and mental health issues, and lack of capacity, discussed further below.

One of the key obstacles to implementation of the Guidelines, described by respondents currently working in the humanitarian field in CAR, was lack of knowledge and understanding of psychosocial interventions. This impacted the quality of current psychosocial interventions, namely, child friendly spaces. Another respondent expressed concerns regarding the quality

of the psychosocial interventions, noting that many interventions that are categorized as psychosocial do not have significant psychosocial components. The concern about quality of psychosocial interventions also included a concern that psychosocial activities were potentially doing harm. As one respondent noted, "having space to talk for victims, either you know how to do it very properly, very specialized, and that can be helpful. But if you don't know what you did it, it can be harmful."

Respondents also noted that referral systems are not in place – partly because those who may be responsible for identifying vulnerable and distressed children do not have the skills or capacity to do so, and partly because there is nowhere to refer children with specific needs. Respondents noted the significant constraints on communication, coordination, referral systems and quality of programming. One respondent noted, "you cannot rely on anyone or anything on the ground that is already existing. That's a big challenge of how to implement the Guidelines in this context – how to address the issue in the country, where there is nothing?" Finally, respondents noted the lack of consideration for MHPSS within clusters, noting that food distribution and shelter had not been organized in ways that addressed the needs of the most vulnerable.

V. Utilization of the Guidelines

Utilization of the Guidelines refers to ways in which actors at various levels and in a range of settings use the Guidelines to influence policy and practice, including funding, programme design and implementation, as well as coordination mechanisms and structures. Utilization therefore encompasses a wide range of activities, some of which are more evident and easy to identify than others. For example, utilization may include practitioners in the field designing and implementing programmes that reflect the core principles in the Guidelines. It also includes establishment of coordination and working groups in emergency settings, which can more readily be identified and included in this review. Therefore, the following descriptions of components of utilization aims to present examples that characterize the nature of these different forms of utilization, while recognizing that the prevalence and effectiveness of these forms of utilization can-

not be assessed at this time. This section ends with a discussion of an important question that has implications for the implementation of the Guidelines: *who is utilizing the Guidelines?*

Respondents in the on-line survey indicated that they utilize the Guidelines in a range of ways. Over 60% of respondents use the Guidelines to prepare workshops/trainings, and for programme design or proposal writing. Just over half use the Guidelines for personal reading and instruction (53%) and less than half use them regularly in project implementation (44%). A quarter of respondents indicated they use the Guidelines for other purposes, such as advocacy, consultation, and planning.

Communication between and within agencies

The increased use of the term MHPSS and the RG's activities are both examples of communication between agencies that

have already been discussed in this review. For example, the yearly RG meeting is an opportunity to agencies to discuss their activities and responses in emergency settings, and to identify ways to collaborate or support joint activities. Another example of utilization of the Guidelines is their use for internal advocacy *within* agencies. MHPSS technical experts use the Guidelines to inform their response to programme proposals. For example, one respondent described using the Guidelines as a basis for a strong critique of a programme proposal from an in-country partner, noting that the proposed project lacked core aspects of community engagement, lacked discussion of a baseline assessment of needs, and did not adhere to key principles such as do no harm, recognition of refugees' resources and capacities, equity and participation. In this way, the Guidelines were an instrument through which a technical expert was able to engage with programme design and seek to ensure that the programming reflected the principles of the Guidelines.

Another method of utilization within agencies is in order to inform activities within non-MHPSS sectors, for example, WASH or shelter. One respondent noted that the Guidelines were supportive of internal advocacy between the MHPSS unit in the agency and other sectors, noting that because of the Guidelines, "it's not only my point of view but it's something that is held by different organizations and that has been validated by different organization…And this was helpful in terms of advocacy internally as well, to be able to say, 'No, it's not just my point of view but it's also a point of view of all these different organizations.' It was supportive to be able to say, we do this not only in mental health or child-care practices, but also in food security or in WASH….So we will be more able to push for this for the other sectors as well and to say that there are things that we can use here." Utilization of the Guidelines for communication, programme improvement and integration of MHPSS approaches within non-MHPSS activities has been one method through which active agencies and actors have used the Guidelines to seek to improve programme quality and impact.

Utilization of the Guidelines with donors

Donors interviewed for this review are aware of the Guidelines and seek to use them to inform funding decisions. Donors noted that the Guidelines have been very useful in informing them as to best practice, while noting that monitoring and evaluation indicators need improvement. This is an area in which the RG is already active and engaged, and the outcomes of the current work on monitoring and evaluation, and common indicators, can be used to influence donor support. Overall, given the small number of donors interviewed (3), this review cannot provide conclusions as to the influence of the Guidelines on levels and allocation of MHPSS funding.

One respondent from an international NGO noted that the Guidelines have provided a common language between agencies and donors, explaining "[w]e have used the different layers of intervention for donors because many times we have questions about, "But who are your target groups?" "Why do you implement this activity?" and so on. Referring to this common vocabulary makes it easier for the donor to understand what we are talking about." The Guidelines are seen as a way to validate proposals to donors. As another respondent from an international NGO explained, "[i]t helped me to find funding to provide psychological supervision to people in contact with the beneficiaries. It was not obvious to people [in the case of our programme in Jordan] that support was needed, but as it was written in the Guidelines, I could find a way to get it funded." Another respondent explained that she uses Action Sheets to specifically guide proposal writing, noting that donors are responsive to proposals that adhere to recommendations in the Guidelines, stating "one of the things the guidelines have helped is they have provided a much stronger arguments for new funding for the things I'm doing. I'm able to say… first of all, the action sheets provide a framework of action…Then you say, what we're doing is in line with the international consensus….I know it's possible to persuade donors to give you money to do this."

However, other respondents noted that lack of understanding of some core principles in the Guidelines – for example, the value of integrating MHPSS within other sectors – limits funding. One respondent from an international NGO explained, "[o]nce you do integration, you target a small number of beneficiaries for a really qualitative program. Donors usually say – that's nice, but it's not possible. Funding is the main problem for us. We tried to develop several projects like this one, but donors come back and say – it's too expensive for the number of people you target. We have many models to integrate MHPSS in WASH, for instance, like hygiene education and awareness is usually delivered through psychosocial support activities. The logic of the intervention is easy for us, the problem is the funding." There appears to be opportunities for increased advocacy with donors for integrated activities, using evidence to demonstrate the value-added of MHPSS approaches within core sectors.

© UNICEF/NYHQ2014-0121/PIROZZI

Snapshot 5: National level implementation of the Guidelines – key challenges

One question explored in this review was the forms of implementation of the Guidelines at national and local levels, including through Ministries and municipalities. Respondents described multiple challenges to this form of implementation, and there has been limited success in this area. As noted in the Philippines case study, national-level institutionalization of the Guidelines did not translate to effective engagement and coordination in the response to Typhoon Haiyan. The case of implementation at the national level in Colombia has been well-documented, however, the progress of that implementation and how it has influenced subsequent response is not known (Echeverri and Castilla 2008). The Guidelines are primarily directed at non-government actors. However, as noted below, lack of introduction and some degree of implementation of the Guidelines at a national- or local-level can stymie MHPSS efforts in emergency settings.

Actors at the national and local levels have often not been able to access the activities at the RG level. Participation in the RG is one key way in which agencies have learnt about, disseminated and institutionalized the Guidelines, however, this is often not accessible for national and local actors. There was significant attention and resources directed towards country-level implementation processes at the time of the release of the Guidelines, for example, in Nepal (Jordans, Upadhaya et al. 2008). However, as one respondent noted, concerted efforts for implementation at the country-level since then have been limited. He noted, "There needs to be more attention to a systems-change strategy in each country. It's easy to say that but hard to do. This remains the uncracked nut; with limited resources, how do we enable people to get in there and be effective change agents."

Some of the key challenges in national and local-level implementation include:

- Lack of general engagement with mental health and psychosocial issues prior to emergencies;
- Lack of capacity and technical expertise to engage with the Guidelines;
- Turnover and movement of key staff in relevant ministries and municipalities – those who receive training or act as champions may not stay in relevant influential positions;
- Resistance to external Guidelines and adherence to policies or practices already established in countries.

The importance of national level implementation, including awareness raising and capacity-building, is demonstrated by descriptions of MHPSS response from recent and ongoing emergencies. When the groundwork of introduction of the Guidelines has not been adequately laid, when an emergency occurs, or in the early phase of humanitarian response, it is very difficult to engage key actors and establish coordination mechanisms. One respondent noted that in South Sudan in 2014, many key local actors had limited knowledge of the Guidelines, and the MHPSS Working Group had to spend time discussing the basics of the Guidelines. She explained, "I found myself having to really encourage a lot of people to take a step back and really go back to basics and discuss what does psychosocial really mean, let's go back to the intervention pyramid, let's work through that. Let's think of some other examples of different interventions that might be in different layers. I felt like those sorts of conversations should already been had prior to people arriving at the table at the MHPSS working group in the middle of the Level Three crisis. We could have used the time to discuss the pressing issues in the response, but instead, we were having to educate on what psychosocial support was before we could even go into that. So unfortunately, lack of awareness of what psychosocial support means and what the guidelines say sometimes dominated the time that would have been better spent, actually discussing the issues existing in the response." One respondent who worked in the recent Philippines response noted the lack of co-ordination at a national level, which involved numerous departments sending staff for overlapping activities separately – there was a MHPSS cluster under the Department of Health, a MHPSS cluster under the National Institute for Mental Health and a psychosocial support coordination mechanism under the Department of Social Welfare and Development.

Influence on programmes and activities in the field

As noted in the introduction to this review, a core motivation behind the development of the Guidelines was that quality of MHPSS activities in emergencies was variable, and there was recognition that some mental health and psychosocial interventions were doing harm. As such, the question of how or to what extent the Guidelines have been utilized to improve the quality of programmes is central. Several questions emerged in the course of this review. Have the Guidelines influenced the *type* of activities that are selected and implemented? Have the Guidelines shifted the *focus* of specific activities? Have the principles in the Guidelines influenced the *way* in which activities are developed, for example, using participatory assessment methods or ensuring engagement with community members in planning and implementing activities? And finally, have these changes led to improvements in the *impact* of MHPSS activities, in terms of addressing symptoms of severe mental illness, improving well-being and building resilience? The answer to these questions can be somewhat encapsulated by this response to whether the Guidelines have improved practice: "I'd say yes. Am I willing to say that in each emergency, the way each emergency is done is fundamentally better? I'd say no. This depends on the context, the players, the resources." TThe review found that these questions can most effectively be answered within a specific context, thus the case studies in this review provide some answers, with general reflections provided below. In the on-line survey for this study respondents perceived the Guidelines to have had an impact on programmes, with 88% of respondents agreeing or strongly agreeing that the Guidelines have improved MHPSS programming in emergencies and 72% agreeing or strongly agreeing that the Guidelines have improved the efficacy of MHPSS programmes in emergencies.

As the majority of respondents noted, the question of whether MHPSS activities currently implemented are effective in achieving the stated outcomes of specific activities, and reaching the objectives of the MHPSS field more broadly, is unclear. This is due to the lack of clear indicators to measure change at the level of the individual, community or country. It is beyond the scope of this review to explore the question of monitoring and evaluation. There are currently concerted efforts on the part of the RG, and individual agencies within the RG, to improve monitoring and evaluation efforts, and to increase the evidence-base that informs MHPSS activities, so as to be able to more satisfactorily answer these questions.

Some respondents noted that they have been able to use the Guidelines for quality-control, as described earlier. One donor noted that the Guidelines can be used to "cut through some

Snapshot 6: Efforts to build the evidence-base – evaluation of Child Friendly Spaces through a partnership between Columbia University and World Vision

Research on the gaps between academic researchers' priorities and practitioners' priorities has noted "the power to set the research agenda [is] typically vested in researchers from outside of humanitarian settings." This can result in research approaches – methodologies, objectives and interventions selected by researchers – which do not respond to the needs of practitioners (Tol, Patel et al. 2011). A study on research priorities for MHPSS in emergency settings noted that the top ten research questions, identified by practitioners through focus group discussions in Peru, Uganda and Nepal and input from an advisory group, favored "practical initiatives with a strong potential for translation of knowledge into mental health and psychosocial support programming" (Tol, Patel et al. 2011). The strongest evidence exists for specialized interventions that are less commonly implemented in humanitarian settings, whereas there is very little evidence for interventions that are more commonly utilized (community-based supports, structured social activities and child friendly spaces) (Tol, Patel et al. 2012). There is a need for research that generates evidence on commonly implemented interventions, providing data that can improve and support feasible interventions in humanitarian contexts.

In the course of this review, many respondents noted that the gaps in the evidence-base for MHPSS interventions influence the level of support and commitment to MHPSS within humanitarian response. This challenge has recently been addressed through the Reference Group's Working Group on Monitoring and Evaluation, and efforts to develop outcomes indicators that can be used across agencies and throughout the field.

One recent effort to strengthen the evidence base for commonly implemented MHPSS interventions is the partnership between Columbia University and World Vision — as part of an inter-agency process under the aegis of the Child Protection Working Group (CPWG) and in partnership with UNICEF and Save the Children — to evaluate the impact of child friendly spaces [CFSs] in humanitarian settings. CFSs "provide children with protected environments in which they participate in organized activities to play, socialize, learn, and express themselves during the recovery process after a disaster or other emergency" (Save the Children 2009), and have the dual purposes of child protection and improving children's psychosocial well-being. Some guidelines exist that provide principles for CFSs, and outline aspects of assessment, planning and implementation, and monitoring and evaluation of CFSs (UNICEF 2009).

Inter-agency Guidelines have been developed in order to establish principles and key actions in implementing CFSs (Global Protection Cluster 2011), which include provision of psychosocial support and use of CFSs as a basis for referral to specialized supports and services. However, a systematic review of evaluations of CFSs in humanitarian settings found limited rigorous evaluations of the impact of CFSs, noting that, especially given how widespread their use is in the aftermath of disasters and in conflict-affected areas, it is important to "to develop and consolidate evidence regarding the protective, promotive and mobilising effects CFSs have on children and youth" (Ager, Metzler et al. 2013). The review found only one study that was able to attribute change in psychosocial outcomes to implementation of the CFS.

In recognition of this gap, World Vision and Columbia University are collaborating on a project to document "the impact of CFSs on children's social and emotional well-being, sense of security and protection" (Columbia University and World Vision 2012). One study, in Buramino Camp in Southern Ethiopia, collected baseline data from a sample of Somali children and caregivers, prior to implementation of a CFS, and then conducted a follow-up study with these children and caregivers 3-6 months after a CFS was implemented. The study found improved psychosocial well-being amongst children, whether or not they participated in the CFS, while those who participate d in the CFS showed slightly higher improvements (most notably amongst young boys) (Metzler, Savage et al. 2013). A second study, of CFSs for Congolese refugees in Uganda, showed that CFS attendance was associated with a higher level of psychosocial well-being and increase in developmental assets, and, moreover, that higher quality CFSs had a more significant impact on outcomes for children (Metzler, Kaijuka et al. 2013). A study of CFSs in Iraq for Syrian children, in collaboration with UNICEF and Save the Children, showed little impact of CFS attendance on psychosocial well-being, however, children attending a CFS were less likely to use negative coping strategies than those who did not (Metzler, Atrooshi et al. 2014).

The evaluations use a combination of existing survey tools, such as the Strengths and Difficulties Questionnaire, to allow for comparison and the established validity and reliability of these tools, as well as participatory methodologies, to allow for adaptation of evaluation approaches and outcome measures to culture and context. Beyond generating valuable evidence as to the impacts of CFSs in three separate contexts, the studies demonstrate the feasibility of implementing rigorous study design, taking into account the contingencies and uncertainties of programme implementation in a humanitarian setting. Study designs included collection of baseline data in Ethiopia and Uganda (enabling analysis of the amount of change from the time of CFS implementation), as well as data from a non-CFS attending comparison group (allowing attribute of change to the CFS intervention). Furthermore, the project demonstrates the value of structured collaboration between an academic institution and a humanitarian organization, which has previously been highlighted as an important step towards improving the evidence-base and strengthening the capacity of humanitarian agencies to implement effective MHPSS activities (Meyer 2013).

of the confusion and misrepresentation that often occurs in emergencies … we're all aware that there's a tendency to label a wide variety of projects as mental health, but having some sense that there is a firm professional guideline, goes some way to helping the decision maker selecting X, Y or Z programme … you have a standard by which to measure programmes, you have a way … to filter out harmful interventions." Another respondent described the context of the response for Iraqi refugees in Jordan, noting a proliferation of psychosocial interventions proposed, and the way in which he was able to draw on the Guidelines as a resource to select appropriate programming and identify potentially harmful activities that were proposed. While the influence of this form of utilization on programmes cannot be systematically measured, these anecdotes indicate that utilization of the Guidelines, primarily through provision of technical expertise in line with the Guidelines, through staff members or staff units with dedicated time allocated to MHPSS activities, has reduced the number of inappropriate or harmful interventions.

Other respondents noted that improvements in interventions have largely been in the area of Level 3 and 4 interventions of the Intervention Pyramid, and that intervention packages and guidelines, such as the Mental Health Gap Action Programme [mhGAP], have influenced these improvements. In the example of Action Sheet 6.4, integrating mental health into primary health care, one respondent noted that his agency developed specific guidance, in line with mhGAP, to provide steps towards

© UNICEF/LAOA2011-00084/TATTERS

implementing this. He explained, "[t]he general principles in the IASC Guidelines need to be accompanied by intervention material. mhGAP is a very concrete tool that can be implemented and used. The PFA training package is very useful. Those are examples of tools that are rooted within the IASC MHPSS thinking that can be immediately implemented." Another respondent noted using Action Sheet 6.2 as a blueprint for donor funding. While perspectives on this issue varied, the majority of respondents perceived that the Guidelines had made Level 3 and 4 interventions clear and implementable, where resources and capacity exists.

However, in the area of Level 1 and 2 (and some Level 3) interventions, and those commonly classified as primarily psychosocial, a number of respondents noted that there is not enough included in the Guidelines to inform programming. One donor noted that guidance on selection of appropriate interventions "is still very much missing on the layer of community-based interventions." The Guidelines, one respondent explained, are useful at the level of coordination and advocacy, but in terms of "sitting down with people and saying, what's our strategy about community mobilization – not so much." Some respondents noted that further guidance is needed to improve psychosocial programming, noting "we need to stick out our necks a little more and say – here are five or six interventions that work, and start supporting them. We are too flimsy about it." The influence of the Guidelines on programme design, particularly in the area of Levels 1, 2 and some Level 3 interventions, appears to be limited.

Respondents also noted that the Guidelines have had limited impact in terms of quality improvement of psychosocial activities. Some respondents noted that in many contexts, there is still a proliferation of actors and agencies providing psychosocial activities, with varying levels of expertise and knowledge of the Guidelines. One donor noted that they receive a lot of proposals with vague and overly inclusive definitions of psychosocial, explaining "a soccer field is not a psychosocial intervention in itself." He noted that the lack of clarity, defined and achievable objectives, and strong indicators for psychosocial proposals results in programme officers asking "they want art therapy, they want focus groups – is this really important? Should I really cut back on water to fund this?" One respondent discussed the impact of this at the coordination level in Jordan, explaining that it results in a number of actors labeling anything that is not clearly protection or education as psychosocial. She explained that psychosocial is "such a widely used term and very broad term. So anything technically gets classified under psychosocial … And now there are so many agencies and actors actually working in psychosocial support. Sometimes, it doesn't seem for us that it provides the psychosocial value. However, everything that is unclear is classified under psychosocial. This is one of the challenges that we have had." The field of psychosocial activities appears to require additional work, in clarifying objectives, identifying best practices, and developing frameworks for implementation.

The Guidelines have had a limited influence on selection of programmes or activities. The Guidelines have not been employed to decide who *should* do what, when and where. The 4Ws mapping tool, and increased use of coordination mechanisms, allows a range of actors to have a clearer understanding of what activities are being implemented, and what gaps exist. However, knowledge of the

© INTERNATIONAL ORGANIZATION FOR MIGRATION

existence of these gaps does not currently significantly influence either funding streams or inclusion of MHPSS activities within agency responses in emergency settings. For example, whereas a 4Ws mapping exercise may identify lack of mental health capacity at primary health care level, current mechanisms apparently do not facilitate a health agency coming in to engage with mental health issues to fill such a gap. This is beyond the scope of what the Guidelines can achieve, but highlights the degree to which implementation of the Guidelines is reliant on coordination, capacity and structure of the humanitarian sector. This results in lack of coverage of some key interventions in the Intervention Pyramid in many emergency contexts. This can also limit referral mechanisms, which were identified as a significant challenge in many of the contexts explored for case studies and snapshots, such as Sri Lanka, Central African Republic and South Sudan.

The limitations of the influence of the Guidelines on programme design and implementation is connected to a strong theme that emerged in interviews for this review: the question of whether the Guidelines should have been more prescriptive, or should be revised to be more prescriptive, with a revision of the Guidelines leading to a document similar to, for example, the Child Protection Minimum Standards. Some respondents perceived limits in utilization of the Guidelines as being due to the general and broad nature of the Guidelines, and that they do not tell people how to implement the Guidelines. These respondents reflected that the Guidelines are daunting to field workers, not practical enough for practitioners, and do not speak adequately to the decisions that need to be made in an emergency settings. For example, one respondent explained that there "is no indication of how to use them," and therefore noted that in many contexts the question is "what do you do with them in practice?" Another respondent noted that, with evidence that has emerged since the Guidelines have been released, there is the scope for a revision of the Guidelines, towards including guidance on what interventions to implement for specific problems, and about timing of interventions. However, the predominant perspective regarding revision of the Guidelines towards a more prescriptive, practical document was that this is not the appropriate role of the Guidelines. The development of more specific and prescriptive Guidelines was primarily perceived to be part of the actions that agencies and other actors have to do themselves, as a part of implementation of the Guidelines. It was argued that prescriptive Guidelines in the field of MHPSS would be unable to capture the important contextual factors that influence MHPSS response in various contexts, and would be more likely to be rejected by actors who feel they are not relevant for their specific context. Some key informants noted that the responsibility for adaptation and contextualization of the Guidelines should not lie with the IASC RG, as these tasks should be

undertaken by specific agencies, with regard to their mandate, capacity and focus. One respondent identified the "dangers that the Guidelines become a set of rules. Organizations find it easy to use a by-the-rule book, rather than using the Guidelines as a flexible tool to show direction." He noted that by perceiving the Guidelines as a set of rules, the ability to identify and implement contextual responses, taking into account important political, social and human resources factors, is limited. One respondent noted, "what I appreciate about the Guidelines is that they are a common minimum denominator. The moment in which you're trying to transform them in modus operandi, a very precise way of operating, then that's not the case anymore." Whereas activities to tailor and operationalize the Guidelines – for example, the various documents that are guides for protection, health and camp management actors, which adapt the Guidelines for specific audiences – are useful, provision of more prescriptive guidance within the Guidelines themselves arguably goes beyond what the Guidelines can and should do. While utilization may have been influenced by the lack of prescriptive guidance in the Guidelines, it is unclear to many respondents if a more prescriptive document would have been able to adequately address the wide range of emergency contexts in the past few years, or more strongly informed programme design and implementation.

Respondents to the on-line survey provided some comments on this issue. One noted that the Guidelines need "more about "how" and "what" to implement – more practical than theoretical. Though the theoretical has been enormously useful for organisation-level policy and guidance, the practical is what the field staff (who are not at strategic programming levels) need to utilise them further." Another disagreed with the need for more prescriptive guidance, stating "The guidelines are aimed at MHPSS policies and best practice, they are not designed to tell agencies or individuals how to do programming in emergencies- that is the responsibility of individual agencies to decide (based upon their mandate and preferred are of expertise)." Finally, one noted, "[i]t may be useful to recognize several distinct roles for the guidelines and focus on building products that develop these. For example, the pyramid is a great communications and coordination tool (as is the 4Ws, which builds on this). Similarly, the cross-sectorial action sheets could be supplemented by more detailed sector-specific materials and resource kits that could be used by persons sensitized to MHPSS within those sectors." These perspectives reflect the two distinct perspectives heard throughout the review on the need for more prescriptive guidance vs. the need to recognize that this is not the role of the Guidelines, as well as the perspective that the guidance can be provided through off-shoot materials and products that strengthen the implementation of the Guidelines, however, do not lead to overall revisions at this time.

Snapshot 7: Contextual aspects of implementation of the Guidelines – the case of Sri Lanka

Prior to and during development of the Guidelines, local actors in Sri Lanka were heavily involved in a range of relevant processes, which informed and influenced the Guidelines. For example, a 2003 article discussed the difficulties and complexities involved with definition of psychosocial activities in Sri Lanka, noting that many actors in Sri Lanka recognized the "need to define what is clearly meant by psychosocial and [to establish] criteria in order to create some common understanding" (Galappatti 2003). There was recognition that a broad spectrum of activities were needed to respond to MHPSS needs, including sensitive implementation of humanitarian response in other sectors such as WASH and Shelter. Coordination for post-tsunami activities in Jaffna District, which "evolved spontaneously at the local level," in 2005, prior to the Guidelines, and acted as a structure that acts to avoid "fragmentation of MHPSS services, duplication and overlap, competition and rivalry as well as overwhelming and inappropriate interventions" largely reflected recommendations on coordination later included in the Guidelines, (Krishnakumar, Sivayokan et al. 2008). Similar approaches were adopted in many affected areas, and one example from Eastern Sri Lanka (http://www.themangrove.blogspot.com/) was even referenced in

the Guidelines action sheet on coordination). Analyses of post-tsunami response, in particular, brought to light many of the key challenges in the field of MHPSS, for example, duplication of assessments or lack of quality needs assessments (Marsden and Strang 2006). In many ways, Sri Lanka is an example of a context where interest and engagement with the Guidelines has been extremely high, where ongoing conflict and the tsunami brought to light the significant mental health and psychosocial needs of communities and individuals, and where knowledge and expertise existed that could be brought to bear on the sector.

However, Sri Lanka is also an example of the importance of the influence of the local political context on MHPSS activities and on the implementation of the Guidelines. After the end of Sri Lanka's war in 2009, all humanitarian activity (including psychosocial programming) in the North was subject to approval by a Presidential Task Force. Agencies reported the particular restriction of psychosocial projects, and the Jaffna coordination body was suspended. The Government appeared to be suspicious of psychosocial activities, including counseling, believing, as one respondent noted, that "information collected will go for war crimes kind of

a tribunal internationally." Another respondent noted that in the post-conflict areas, "there was a sense of awareness of the Guidelines – they were invoked. But the spirit and substance was not practiced. It was possible that that happened because the Guidelines were not a key touchstone for practitioners, even outside of the state. I do not think that they were utilized. Basically, you wouldn't have people using the pyramid, people using the action sheets to think about how they were structuring services, within their organization or collectively. That may have also been to do with that the sector as a whole had limited leadership. The whole humanitarian sector was struggling to cope with a very large scale and very complicated situation." In the MHPSS response in the North of Sri Lanka, political considerations were strongly influential on activities, specifically psychosocial activities, such that even organizations and practitioners with strong awareness of the Guidelines, and commitment to community mobilization and participation, were unable to implement these principles.

One respondent also noted that an important limiting factor in Sri Lanka has been that psychiatrists and psychiatric associations are very influential in the country. Social workers and psychologists and related ministries are not as involved as the Ministry of Health and psychiatrists. He noted, "the training of psychiatrists in Sri Lanka very much follows a bio-medical approach, which doesn't link with the psychosocial approach at all…. So it easily gets marginalized, neglected."

The presence of these challenges in Sri Lanka does not indicate, however, that there is not positive movement in the field of MHPSS. For example, one respondent discussed extensive work that the Ministry of Education is currently implementing, where there is a substantial Psychosocial care component to a Safe and Secure schools project – although not explicitly informed by the Guidelines. Following a South Asia regional 'advocates' training on the Guidelines, key policymakers in the mental health sector have gained familiarity with the Guidelines and have promoted aspects of them in disaster preparedness work.

However, the political and technical challenges noted here indicate the ways in which local politics, context, resources and capacity must be taken into account in national-level adoption and implementation of the Guidelines.

Coordination

One of the primary ways in which the Guidelines have been used is in coordination in emergency settings. MHPSS working groups have been established in the response to a number of emergencies since the release of the Guidelines, based on the Guidelines' recommendation to establish an intersectoral MHPSS coordination group in emergency settings, including health and protection actors. One expert noted, coordination has represented "a big sea change. Since 2007, every place I have worked would not think of establishing a psychosocial support coordination group that has no links with a mental health working group. It has become unthinkable." Apart from the existence of an intersectoral MHPSS working group, the Guidelines have provided MHPSS actors with a tool to use within coordination in clusters in emergency settings, for example, taking an action sheet to a WASH cluster or nutrition cluster meeting, and advocating for inclusion of social considerations in these interventions.

Working groups have been established mostly under the Health and/ or Protection clusters, depending on the context. This fluid- ity and the ability for MHPSS working groups to be situated in the most effective position, depending on the context, has been positive, giving local actors the opportunity to position MHPSS where it can most strongly be supported given the context. However, respondents noted that, at times, the lack of clarity about where the MHPSS working group should sit has also resulted in lack of coordination from the outset of large emergencies. One practitioner noted that in both Central African Republic and Philippines MHPSS coordination was a failure, arguing "with these Level 3 emergencies you don't have time to think – where should it sit, how and with who? It needs to be very well-defined, so that when a L3 emergency hits everyone knows where to go to. And it needs to be very normal that it's rolled out" (see case studies – CAR and South Sudan). There is a challenge in retaining the fluidity and flexibility that a non-prescriptive position for MHPSS entails, while also ensuring that MHPSS coordination is established and effective from the outset of an emergency. The question of the positioning of MHPSS within the humanitarian sector – at the field level, and the global level – is one that emerged continually throughout this review, and is addressed further below in a discussion of the utilization of the Guidelines in clusters throughout the humanitarian sector. Ef-

fective coordination and challenges to coordination are discussed throughout the case studies, which demonstrate the contextual factors influencing the strength and utility of coordination in emergency settings.

The existence of working groups can in and of itself be a means to promote the principles in the Guidelines. One respondent gave the following example from Za'atri camp, Jordan, when a French medical team wanted to conduct a prevalence survey of mental disorders using unvalidated instruments: "They came to the co-ordination group and said their plan, and we were able to bring in WHO and MoH, and the Guidelines, and were able to say – by the way, that's not recommended. We showed the UNHCR/WHO tool assessment kit, and were able to use those Guidelines as a tool to say – by the way, these are the global Guidelines we would like to stick with." Coordination is most effective when there is a dedicated focal point who is allocated by an agency to provide coordination, a "go to person for MHPSS who is the lead of the Working Group who is dedicated for a couple of months." Coordination activities involving 4Ws mapping exercises have also been noted as useful, supported by the development of the 4Ws manual in 2012 (IASC MHPSS Reference Group 2012).

© UNICEF/NYHQ2014-0291/

Snapshot 8: Use of the Guidelines for coordination – the case of the Syria response in Jordan

The response to the Syrian refugee crisis in Jordan demonstrates the importance of a strong basis and existing understanding of the Guidelines and the impact of an active Working Group on communication and coordination in the MHPSS field. The response to the Syrian refugee crisis was not the first time the Guidelines had been utilized in Jordan. The use of the Guidelines in the response to the Iraqi refugee crisis has been documented. Dissemination of the Guidelines and engagement of local and national actors introduced the Guidelines to a range of important actors and agencies providing MHPSS services (Horn and Strang 2008). An assessment of implementation of the Guidelines in the Iraqi response in Jordan concluded, "the main strength of implementation…has been the commitment of the agencies and individuals who have advocated strongly for guidelines. This has had a huge impact in terms of awareness of the guidelines among INGOs, and some local NGOs. The experience in Jordan illustrates the impact they [the Guidelines] can have on an individual or organization committed to the Guidelines, and with the ability and resources to advocate for them" (Horn and Strang 2008). It is within this context that the response to the Syrian refugee crisis, and the coordination of MHPSS activities for Syrian refugees in Jordan, can be understood.

The response to the Syrian refugee crisis built on strong capacity and structures that existed in Jordan from the Iraqi response. Existing systems – such as the MHPSS Working Group – were used in order to orient new actors and strengthen commitment to the Guidelines. One of the strongest areas has been in coordination. One respondent noted of the MHPSS Working Group in Za'atari camp, that "[t]hey have developed ways to deal with new initiatives. Many people come in to do things, and the Working Group has a system that every new actor should first visit the Working Group and discuss and start the activities based on a clear assessment of needs, and not just by themselves, but by the group as a whole. That seems to work, to avoid duplications." In 2012, the MHPSS Working Group in Jordan issued an inter-agency four-page document, that represents "consensus among the different actors and provides a coherent framework to organizations wishing to fund, develop or implement activities in this field" (MHPSS Working Group - Jordan 2012). The document highlights important principles in the Guidelines, defines key terms, and outlines the Intervention Pyramid. The document emphasizes the need for coordination, encouraging "joint assessments, sharing of information and mapping of the various MHPSS interventions implemented by responding organisations, MHPSS planning and harmonisation of action such as training and advocacy." Respondents noted that this has been a useful tool to engage new actors and ensure consensus amongst members of the Working Group.

In addition to coordination, the Guidelines have been used in other ways. 4Ws mapping exercises have highlighted some gaps and indicated areas that could be strengthened – for example, inclusion of local and national actors in working groups (IMC, UNICEF et al. 2012). Findings from assessments conducted in Za'atari camp use principles in the Guidelines, such as integration of MHPSS concerns within camp management, protection and education, and the Intervention Pyramid, to structure assessment and present findings (IMC and UNICEF 2013).

One respondent in Jordan described the utilization and impact of the Guidelines as follows: "The guidelines are not only for us, but also for agencies that don't really know where their activities are falling. So we always have the reference of the pyramid to guide us and say, "Okay, no, you're actually not…", or discuss with them that they're not really doing specialized care, they're doing more community based care and so on. So it helps to see where the gaps are. It helps to guide agencies to know exactly what levels they are providing and then it did help with identifying how much is in specialized care, how much is in community support, and so on. And the Guidelines provide the reference to advocate for specialized professionals being the ones providing the specialized care. So if an agency comes and they want to train like lay workers or health workers or volunteers on PTSD treatment, we have the reference to be able to say that in order to say – it should be layered health care and so on, all those components."

Another particularly strong aspect of use of the Guidelines in the Syria response has been the emphasis on social considerations within clusters. For example, MHPSS assessments have focused on the role of shelter and site planning, camp management, orientation and access to information, distribution of water and non-food items, and approaches to food and nutrition, in order to emphasize the actions that WASH, shelter, nutrition and other clusters can take in order to reduce stress, encourage community mobilization and support, and improve psychosocial well-being (IMC and UNICEF 2012; IMC 2013)

One challenge in the Jordanian context is coordination in areas with fewer MHPSS actors. One respondent, overseeing a MHPSS project in Irbid, noted that while at the central/ national level in Jordan, the working group is very organized and effective, in Irbid, the health cluster focuses on communicable diseases, and MHPSS does not have an adequate role in coordination mechanisms.

Utilization and influence in clusters

The Guidelines include action sheets that refer specifically to "social considerations in sectoral domains," identifying the key activities necessary in food security and nutrition, shelter and site planning, and water and sanitation. The structure of the humanitarian system, whereby the cluster system is used for non-refugee situations, was identified as a key challenge to integration of MHPSS activities, recognition of MHPSS activities from the outset of an emergency, and overall implementation of the Guidelines. Respondents noted that integration of MHPSS within clusters has been somewhat limited and challenging, as one expert explained, recognition and use of the Guidelines within the cluster system "would be best described as moderate success. And at times a much slower process and more frustrating than one could ever imagine. Each sector has an enormous amount of work and their own technical issues and language and structures and institutions, and so I think MHPSS has appeared not only soft but peripheral." One concrete representation of this is the lack of discussion of the role of MHPSS within humanitarian reform and within recent publications from the IASC on the cluster system. For example, the 2012 Reference Module for Cluster Coordination at the Country Level referenced mental health and social well-being once, as a cross-cutting issue (IASC Sub-Working Group on the Cluster Approach 2012) (while MHPSS is not formally recognized as a cross-cutting issue).

The impact of the positioning of MHPSS within the cluster system, and how, or if, MHPSS is taken up by clusters has a significant impact on funding, support and quality of MHPSS response in emergencies. One respondent noted, "where MHPSS sits strategically at both a global level and an organizational level is where part of the challenges exist," explaining that opportunity for MHPSS experts to provide input into protection programmes, for example, are largely ad hoc and without a systematic, structural basis. As one respondent commented, "the MHPSS RG seems really disconnected from the wider cluster coordination agenda, the transformative agenda. They really need to get back in there…it would be helpful for the new reference module if cluster coordination specifically talked about where MHPSS fits. At the moment it's nowhere – if you look at the latest indicator registry, there's nothing on it. Each sector has its own little bit on PSS, but no overall – no one has had a look at all of this, and tried to connect them, or tried to check if every sector has something on MHPSS. It feels like we're not really in the system anymore." The co-chairs of the RG were engaged with the indicator registry process, however, the decision was made at the RG Annual Meeting in 2013 to work on common indicators for M and E within the RG before engaging with the indicator registry further. Some clusters or working groups within the cluster system have more systematically taken up MHPSS

issues – the Child Protection Working Group being one that was mentioned as demonstrating strong uptake by a number of respondents. The CCCM cluster has been engaged with MHPSS, and the CCCM-specific document has been important, as one respondent noted, "It has been politically important because it somehow ratifies two things. The importance of the consideration of psychological support within camp management. But also the necessity – as the booklet says, and the CCCM cluster approved it, that psychosocial experts should be always part of the core team of the CCCM cluster." However, overall recognition and integration of MHPSS within the cluster system appears to be an ongoing challenge.

MHPSS is not formally recognized as a cross-cutting issue, yet is often grouped alongside other cross-cutting issues (such as gender or age and disability), and faces many of the same challenges as the cross-cutting issues. As a review of coordination and funding for cross-cutting issues found, cross-cutting issues "are not adequately – and often not at all – reflected in the way humanitarians plan and execute their operations"(OCHA 2012) Ultimately, as the OCHA report noted, many of the cross-cutting issues have faced the same challenges of integration and prioritization. Since the cluster system was established in 2006, there has been a fragmented approach to cross-cutting issues, with representatives from each cross-cutting issue often conducting advocacy and meetings separately. One expert on gender as a cross-cutting issue consulted for this review noted that the clusters are tired of hearing about cross-cutting issues; "they say – we had gender, now we have HIV, now age and disability," and that the clusters "put on the brakes and said – enough." As the OCHA report states, "[l]iterally bombarded with a variety of themes, subjects and approaches, global policy makers and field practitioners react with an overall rejection of whatever is perceived not to be essential, making any integration all the more difficult." There have been some recent initiatives, through informal meetings and advocacy, to reinvigorate a cross-cutting issues working group, or review team, as was established in 2006/2007. The OCHA report recommended consolidating the cross-cutting issues around the concept of diversity, which is already adopted by some agencies, for example, in UNHCR's Age, Gender and Diversity mainstreaming. This may present an opportunity for MHPSS to promote integration of MHPSS within the cluster system, however, there are also challenges in applying the concept of diversity – which usually brings to mind demographic characteristics – to some key MHPSS concerns, for example, pre-existing severe mental disorders. The issue of how to include MHPSS within the group of cross-cutting issues, work strategically within that group to promote MHPSS as a cross-cutting issue, and ensure recognition of all the facets of MHPSS within that approach, should be at the core of the RG and member agencies' current discussions, strategies and activities.

© UNICEF/NYHQ2012-1686/DORMINO

Snapshot 9: Implementation of the Guidelines in Peru

On August 15th 2007 an earthquake of 7.9 degrees on the Ritcher Scale occurred close to the southern coast of Peru. The epicenter was located in the sea 64 km away from the coast of the Department of Ica. The earthquake was felt in most of the Peruvian territory and even in neighboring countries. The most affected areas were those of the cities of Chincha and Pisco where 80% of the housing was destroyed.

In Peru the MHPSS guide was introduced by Medicos del Mundo [Doctors of the World] (MdM), a member of the task force of the IASC. The Guidelines were published in December, so were only implemented in Peru a few months after the earthquake. It was a phase in which the affected areas were still considered under a state of emergency. People needed food, water and shelter. In the early stages the application of the Guidelines facilitated the dialogue between the different teams that were in the field. Initially a significant time was invested in lobbying with different organizations for the use of the Guidelines. Some organizations quickly adopted them and recognized the importance of psychosocial support in order to mobilize the population, promote their agency and move forward in the reconstruction. Others however, were more resistant since they did not know about the

MHPSS Guidelines nor did they understand why they should follow the Guidelines when they did not receive any order from their organizations.

One aspect of the Guidelines that proved to be helpful was the Intervention Pyramid. Through the pyramid, health workers, and also the population, better understood that mental health not only concerned those who had mental illnesses but that also mental health was part of daily life and that it could be promoted in different way by many actors. The list of 'Dos and Don'ts' was also consulted constantly by health professionals as well as the core principles.

Soon after the earthquake Emergency Operation Committees (COE) were established to attend the different needs of the affected population: food, water, sanitation, shelter, among others. The MdM team started meeting with these committees in order to make psychosocial support integral to the work in different sectors, and ensure that international and national organizations followed the principle of 'do no harm' and ensured practices that were sustainable and appropriate to the population.

The local team promoting the use of the MHPSS guidelines sought to incorporate the principles and practices of the guide to official documents in Peru so that they could be applied in the future by government institutions. Members of the team that were part of academic institutions worked together with psychologists from the Health Ministry to write a guide about how to do communitarian mental health work after emergencies, and then sought to develop a public policy to support this approach. The process of writing this policy, which is called "Guidelines of Community Mental Health in situations of emergency and disaster", started in 2010. This policy has adopted some of the core principals of the MHPSS Guidelines, as for example Human Rights and Equity and specialized attention to vulnerable groups; and also content from the action sheets, especially from Action Sheet 5 (community mobilization and organization, and traditional, cultural and religious practices). The document of this policy proposal is ready and it was presented in 2013 to the Health Ministry. However, changes in the authorities that occurred in December 2013 have delayed the approval of this policy.

There have been many challenges to implementing the MHPSS guidelines and sustain its practices. A great difficulty is the high level of mobility and instability of health workers in the ministry. Soon after the guidelines were published health professionals working in the field were trained in the use of the guide with very good results. However, most of these workers did not remain in their positions for a long period of time, and thus all the knowledge conveyed through the training was lost. One challenge for applying the Guidelines in Peru is that health workers have a clinical and individual approach that is predominant in their work. Similarly another challenge is the low priority that mental health has within the broader health system in Peru. Very few professionals, other than psychologists, recognize the importance of conducting work in mental health and psychosocial support.

A challenge regarding international organizations, as mentioned previously, was that many of them had practices that were not in line with the principals of the MHPSS Guidelines. Furthermore, there were organizations working in the post-earthquake context that did not know about the existence of the Guidelines even though their organizations had signed it. The MHPSS Guidelines have influenced the curricula of graduate programmes in universities. The Master Programme in Community Psychology of the Pontifical Catholic University of Peru (PUCP) included in its courses the MHPSS Guidelines. However, respondents noted limited awareness and acknowledgement of the Guidelines amongst health workers, due to lack of public policy that institutionalizes the use of the Guidelines.

Despite the lack of acknowledgment of the guidelines, it has had an important influence over certain practices in the Peruvian context. The 2007 earthquake and the difficulties to respond to it made evident the importance of a coordinated response to emergencies. Due partly to these past circumstances, government institutions are now more aware of the role they have to take on as coordinators of the assistance that arrives from other organizations. The health ministry in particular, is more aware of its role in coordinating the work in mental health. Along the same lines, the need for coordination has also facilitated group work among several key actors, who are now more open to collaborating with each other, and even asking for support in areas or activities where they might need it. Furthermore, the way to understand mental health work more generally started changing. Before it was thought that to improve the attention in mental health more psychiatrist and psychologist were needed. Now more health professionals (nurses, technicians, doctors, etc.) are more aware of how the work in mental health is a collective task, and that those who require specialized attention, as the one provided by psychiatrists, are only a small proportion of the population.

Who is using the Guidelines?

In the course of this review, it became evident that there is a core group of strongly engaged and active members of the RG. They have been effective at developing new products to support the Guidelines, integrating the Guidelines into their agencies, implementing trainings and other activities to support dissemination, and supporting implementation of the Guidelines through a range of approaches, including policy development and technical support. However, despite concerted efforts throughout this review to reach outside of this group – to donors, leads in the cluster system, and to agencies not involved in the RG, there was a lack of strong participation in this review beyond the RG. The extent to which this reflects a broader disengagement of actors in the field, beyond active RG members, with the Guidelines, is unclear. On one hand, in the course of the review, it was evident that there are cluster leads, donors and agencies who should be aware of and utilizing the Guidelines who are largely disengaged from the RG and from the Guidelines. On the other hand, in the course of interviews with field workers for the case studies, there were individuals who, often due to personal interest, previous training on the Guidelines, or recognition of the need to use the Guidelines in their specific context, demonstrated high levels of engagement and utilization. Some principles and practices supported in the Guidelines are often utilized in the field without it being explicitly recognized that they come from the Guidelines. One manager based in Turkey noted that her staff would not be aware of the Guidelines per se, but that the programmes that they work on are directly in line with and developed in reference to the Guidelines. While it appears from some case studies and difficulty obtaining wide participation in this review that the Guidelines have not significantly permeated the humanitarian sector, this review actually indicates that limitations of implementation are often due to context – for example, lack of capacity of local health systems to provide any mental health care, or lack of funding to support community-based interventions, rather than lack of recognition of the role and importance of MHPSS as part of humanitarian response, and with it, the importance of the Guidelines in providing the basis for that response.

Recommendations

- Continue to pursue and strengthen monitoring and evaluation [M and E] frameworks that can demonstrate the impact of common MHPSS activities;
- Support in-depth case studies that demonstrate implementation of the Guidelines, including field-level data collection, to inform the evidence-base on contextual factors influencing implementation;
- Develop and implement strategies to enable national and local-level implementation of the Guidelines in selected disaster and conflict-affected countries;
- Develop toolkit of options for community-based psychosocial interventions, providing examples of best practices;
- Focus attention to the requests for additional guidance in implementation of the Guidelines to developing off-shoot materials, and building products that respond to the specific needs for more practical guidance;
- Encourage and support agencies (RG members and others) to develop practical guidance materials based on the Guidelines for their agency;
- Develop guidance on coordination mechanisms, including examples of how coordination has effectively occurred in recent emergencies;
- Support a focal point for MHPSS, deployed by a RG member, to all L3 emergencies, to ensure coordination mechanisms are established; and
- Prioritize discussion and development of strategy around cross-cutting issues, including issuing a short MHPSS strategy paper on MHPSS as a cross-cutting issue within the humanitarian system.

© UNICEF/NYHQ2012-0165/DIFFIDEN

Snapshot 10: Emergency as a catalyst for coordination and consensus – the case of Libya

Unrest in Libya in 2011 escalated to intense armed conflict, resulting in deaths and injuries of civilians, significant displacement, disruption of social services, and damage to infrastructure. A 2011 MHPSS assessment identified a number of challenges to addressing MHPSS needs in Libya, including centralization of psychiatric services and limited integration of mental health into primary health care (IMC 2011).

In 2012, the National Center for Disease Control in Libya convened a workshop, inviting all national and international stakeholders involved with MHPSS in Libya – including INGOs, UN agencies, Government agencies (with seven ministries represented) and national organizations. Two days of discussion and planning on a strategy for MHPSS in Libya resulted in a National Consensus Statement, "Call for action for a multi-sectoral approach for mental health and psychosocial support in Libya." One respondent noted that the National Consensus Statement was "inspired and influenced by the Guidelines," representing a clear example of a process through which the Guidelines were contextualized for the challenges, resources and structures available in a specific context. This process

in Libya was an example of the Guidelines facilitating communication, awareness and knowledge. The workshop provided an opportunity for professionals throughout the country to meet together, to learn about each others' work, and establish connections and professional associations.

The WHO Country Office has continued to provide support for designing a national strategy for mental health in Libya, as well as technical support for activities in the Ministry of Health and Ministry of Social Affairs. Other activities include programmes to strengthen mental health services in the South and West, and in Misruta, a city heavily affected by the conflict. After an assessment of MHPSS needs in Misruta, WHO also supported a mental health and psychosocial programme there, aiming to enhance access to mental health and psychosocial services, raise awareness of mental health and psychosocial needs, and equipping a multidisciplinary team of professionals with necessary skills and knowledge of mental health and psychosocial interventions (WHO Libya 2012).

The conflict had led to a proliferation of new actors and activities in the MHPSS field, and a 4Ws mapping exercise

carried out in 2011, "was a useful exercise for organising and sharing information that was previously unavailable, and as a systematic process involving various actors in mapping" (Fitzgerald, Elkaied et al. 2012). In the post-conflict period, the WHO is playing a significant role in health systems reconstruction and strengthening, and, building on positive attitudes and engagement from all sectors during the post-conflict phase, including prioritization of mental health as a national priority by the Ministry of Health, are implementing trainings on mhGAP, providing support for integration of mental health into primary health care, and supporting decentralization of mental health services. Key activities in the MHPSS field include establishing a Diploma in Primary Mental Health Care, conducting a Training of Trainers on mhGAP, awareness raising to support a shift from an institutional-based approach to mental health towards mainstreaming of mental health into primary health care and establishment of community-based mental health services, and establishment of a national mechanism for coordination of mental health services. These activities were largely motivated by coordination, awareness-raising and engagement that emerged in the post-conflict period.

VI. Institutionalization

The RG is made up of agencies with different mandates, reflected by focus on different populations of interest, different strategic goals or different core principles. As such, forms of institutionalization of the Guidelines within agencies in the humanitarian sector differ. A checklist previously developed by the RG to assess levels of institutionalization assessed institutionalization in the following areas:

- Policies and procedures
- Human resources
- Projects and programmes
- Inter-agency coordination

The topics of projects and programmes and inter-agency coordination have already been addressed, and therefore this section focuses on policies and procedures and human resources.

Policies and procedures

Implementation at the level of policies and procedures is a central aspect of implementation. Ideally, it serves as a process to identify the key relevant elements of the Guidelines. It should also identify ways to implement the Guidelines within existing agency activities, and use the Guidelines to inform programming. Moreover, by issuing agency-specific policies and procedures, agencies highlight commitment to the Guidelines as a component of their work in humanitarian settings. As one respondent explained, "It helps to have an agency-specific translation of the Guidelines…It really helps to translate or tailor the Guidelines – which are principles, not really a set of protocols, to translate it into more agency-specific actions." Another respondent noted that the actions taken by RG members are at the core of implementation of the Guidelines, that "improving the practice in the field comes very much down to individual agencies, their ability to institutionalize the guidelines, and also explain its organization as well, how to use the principles in the

guidelines." Review of policy documents and procedures, as well as in-depth interviews with RG members, found that many RG members have taken significant efforts within their agencies to develop and disseminate policies, adapting the Guidelines to the specific mandates and activities of their agency. Moreover, 73% of respondents to the on-line survey agree or strongly agree that the Guidelines are incorporated into their agency's policies and procedures.

In the course of this review, a number of examples of policy and procedures within agencies were identified. For example, in 2013, UNHCR released its Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations (UNHCR 2013). This guidance introduces the term MHPSS to UNHCR programming, notes the existing policies and strategies upon which the guidance is based (including UNHCR-specific strategies as well as the Guidelines), and introduces principles to guide UNHCR's MHPSS activities that are based on the Guidelines, for example, using a multi-layered system of care and do no harm. The guidance notes that "a standardized format for programme implementation cannot be offered because this depends to a large extent on existing national capacities and local opportunities," and within UNHCR, a focal point at UNHCR Geneva, in the Public Health Section, is tasked with providing technical support to contextualize and adapt the guidance for specific contexts. Within Plan International, the Disaster Response Manual identifies MHPSS as a cross-cutting issue, as well as including community-based psychosocial support within the child protection in emergencies section. The Plan Disaster Response Manual notes the Guidelines as a basis for provision of "responsive and appropriate care in emergencies," emphasizing that the "Guidelines include actions in all sectors, making it clear that the responsibility for psychosocial support lies with all actors in a humanitarian response." The Manual emphasizes Plan's expertise, in Level 1, 2 and 3 interventions, and notes that they do not provide clinical treatments for mental disorders, while emphasizing the actions within assessment, information dissemination and programme design that are important in the first weeks after an emergency (Plan International 2013).

The International Federation of Red Cross and Red Crescent Societies [IFRC] Psychosocial Delegate Manual is another example of an agency document that incorporates the Guidelines, with the Manual stating that delegates are required to be familiar with the Guidelines prior to deployment, outlining the dos and don'ts included in the Guidelines, and including the Intervention Pyramid and community mobilization as key principles guiding the IFRC'S psychosocial work. World Vision International has released a number of products outlining its position on MHPSS, including a description of the Intervention Pyramid and the aspects of the pyramid that World Vision programming will cover, and examples of World Vision programmes that have integrated MHPSS activities (World Vision 2011). IOM's Migration Crisis Operational Framework includes Psychosocial Support as a specific sector, with the objective of "promot[ing], protect[ing] and support[ing] the well-being of crisis-affected populations, with activities aimed at reducing psychosocial vulnerabilities, promoting community resilience and ownership, and supporting aid that takes into account psychosocial and cultural diversity issues" (IOM 2012). A 2012 Guidance Note, designed to help IOM staff to "apply appropriate standards of the organization in performance of their functions," emphasizes MHPSS as a continuum, discusses vulnerabilities that different groups of displaced persons may experience, identifies the legal and policy framework, general parameters of IOM's MHPSS activities within emergency response, and guiding principles for IOM's MHPSS activities, which are based on its own experience, the Guidelines, and expert recommendations (IOM 2012).

Human resources

One of the central challenges to implementation of the Guidelines is availability and quality of human resources in emergency settings, whether within local and national Government systems or international agencies. To some degree, MHPSS is institutionalized in many of the RG member agencies through job descriptions and expectations of staff members that include knowledge and understanding of the Guidelines. For example, one respondent noted, "part of our interview questions, when we interview people for jobs, we ask them if they are aware of them [the Guidelines], if they have used them, and if they can give an example. And if people have not heard of them, and cannot talk about them in an intelligent way, it's a big minus." This is one step towards both improving knowledge of the Guidelines throughout the field, and ensuring that staff members of agencies developing and implementing MHPSS-related activities are aware of and experienced in using aspects of the Guidelines. However, this may in fact be quite limited in scope. Only 32% of respondents in the on-line survey agreed or strongly agreed that the Guidelines are incorporated into their agency's human resources documentation and practices.

Beyond this, this review found that institutionalization of the Guidelines requires a stronger level of MHPSS capacity throughout the humanitarian sector. In many of the case studies explored, and in more general discussions with RG members, the issue of implementation, or lack of implementation, comes down to capacity and interest. In many cases, having

© UNICEF/NYHQ2014-1020/dÍAKI

Snapshot 11: Implementation of the Guidelines in the State of Palestine

Gaza and the West Bank (the State of Palestine) have experienced chronic conflict for decades, and the situation has deteriorated after military incursions in recent years. Specific military incursions – Operation Cast Lead in 2008 and Operation Pillar of Defense in 2012 – have led to more displacement, significant casualties and injuries, and destruction of infrastructure. The impacts of these stressors on mental health and psychosocial well-being are widely recognized. For example, the Office of the High Commission for Human Rights noted "the environment of fear and intimidation that repeated violence and harassment creates, has a serious psychological impact on victims of and witnesses to violent attacks, and affects the psychosocial well-being of women, men, girls and boys in affected communities" {OHCHR, 2013 #5366}. Recognition of the impact of exposure to distressing events, ongoing stress, and lack of access to basic services and livelihoods has led to development and implementation of MHPSS services and activities in the State of Palestine.

Prior to introduction of the Guidelines to this context, coordination of MHPSS was very limited, given competition over resources, resulting in duplication of

services and gaps in services for some populations. The context of ongoing humanitarian crisis, combined with outbreaks of violence, entails that in the State of Palestine, many actors did not feel that the Guidelines could be easily applied. One donor noted, "many of the stakeholders, UN, INGOs and many of the national ministries working in the field of mental health and psychosocial, they were all worried that those guidelines cannot really be applied to the Palestinian context. And they need to be adapted to become more responsive to a protracted crisis where it's not like you have an emergency and after a while you go into a recovery, and after a while, you go into rehabilitation and development." This process of adaptation and implementation has been described by actors in the State of Palestine as strong, collaborative and successful.

The Guidelines were utilized in the State of Palestine to address the core challenge of coordination and duplication of services. One significant challenge was duplication of services, whereby after a specific event, seven or eight agencies would separately provide MHPSS activities in one community, whereas another affected might receive limited services. The MHPSS sub-cluster is co-chaired by UNICEF and WHO, and falls under the

Protection Cluster. This mechanism has resulted in active participation of 30 to 40 agencies in each meeting, and in recent emergencies, improved communication and coordination between different levels of service providers. The Guidelines were also used in conjunction with donors. In particular, ECHO engaged the MHPSS Working Group in order to utilize the Guidelines as a core component of technical review for proposals. The Working Group provides feedback on proposals as part of the Consolidated Appeals Process [CAP]. The MHPSS Working Groups in both Gaza and West Bank have worked closely with OCHA to ensure that all proposals with mental health or psychosocial components, even those submitted under the Health or Education clusters, are also sent to the MHPSS Working Groups for review. Some challenges in MHPSS coordination and activities in the State of Palestine remain. Some of these challenges include lack of comprehensive referral mechanisms, which are due to the political context of relationships between Government ministries and international NGOs. Another challenge is integration of MHPSS within clusters – one aspect of implementation of the Guidelines in the State of Palestine was presentations and workshops with clusters, including WASH, education, protection and health, on the Guidelines. However, there has been limited follow-up to this, and MHPSS has not been explicitly integrated into contingency planning in these clusters. Another challenge is donor perceptions of MHPSS. Key actors described ongoing challenges in engaging donors in MHPSS activities, noting that given psychosocial work, in particular, does not fit neatly within specific clusters, nor is it considered a life-saving activity. Finally, coordination of needs assessments remains a significant issue. Respondents noted that the Guidelines have introduced useful principles in the area of assessment. However, during and after emergencies, there is still "chaos of assessment," with multiple agencies conducting similar needs assessments.

an individual who previously worked on the issue, has built strong inter-sectoral relationships, or takes a specific interest in the topic, has been the decisive factor behind outcomes such as good coordination or programme quality. One respondent noted, "I think the reason why the Guidelines have taken off in some countries or some parts of the world, it's literally been down to individuals. Individuals, or two or three people that just happened to be on the ground, in that particular emergency, and have got the right personality or characteristic and they've really push forward. This is not a sustainable way and we can't advocate for this particular approach." Coordination is most effective when there is a designated person in the field to lead the process, however, this is not always the case as there is no structure from which to draw these individuals, as is the case for gender, child protection, health and other clusters, who have a roster for emergencies. One RG member explained, "it's all about systems of making sure that the right people are available…if you had a roster for community psychosocial support, then when emergency happens, you can get them employed and gather them. A roster of skilled and experienced individuals who can be deployed for emergency situations is lacking. Development of roster would be a major step move from implementation taking place on the level of individual agencies, towards strengthening of the field overall and ensuring that MHPSS concerns do not drop off the agenda in emergency settings.

Guidance for institutionalization

While a significant number of RG members have developed policies and procedures to adapt the Guidelines to their mandates, it is evident that there are some gaps in institutionalization. The Inter-Agency Network for Education in Emergencies has issued a comprehensive checklist for institutionalization of the education in emergencies Minimum Standards, with checklists for UN agencies, donor agencies and Government agencies, education clusters, NGOs, and Ministries of Education. These checklists vary in structure according to the audience, but comprehensively lay out actions in the areas of human resources, knowledge management, programme quality, accountability and advocacy. A checklist for institutionalization developed at the release of the Guidelines was located during the course of this review, however, it was not publicly available and could be updated. Simple checklists for institutionalization, developed by the RG for a number of key actors, would be a useful approach to highlighting the key steps in institutionalizing the Guidelines, and promoting institutionalization in a range of domains.

Recommendations

- Develop institutionalization checklists for humanitarian agencies, donors, and Governments;
- Develop a MHPSS roster and fund capacity for deployment of MHPSS experts to support implementation of the Guidelines in emergencies.

VII. Conclusion

© WORLD VISION

The various methods of research conducted for this review conclusively demonstrate that the impact of the Guidelines has been widespread and significant. The fact that the Guidelines are the product of an interagency process, are endorsed at an agency-level, and are readily identifiable as an IASC product, has strengthened the role of MHPSS in emergencies. Beyond specific influences on the field in terms of awareness, utilization and institutionalization of the Guidelines, the Guidelines introduced and popularized the term MHPSS, which has strengthened understanding and concrete linkages between mental health and psychosocial actors and activities in emergencies.

Levels of awareness of the Guidelines are mixed, depending on the context, however, overall knowledge of the existence of the Guidelines is high, while deeper knowledge of the content may require additional efforts. The Guidelines have been used to improve programme quality, yet further guidance on psychosocial programming may be useful. The influence of the Guidelines on programmes and activities in the field appears to be positive, however, this influence depends on resources, context and capacity. One of the primary impacts of the Guidelines has been in coordination, whereby MHPSS working groups have been established in the response to a number of emergencies since the release of the Guidelines. Many RG members have taken significant efforts within their agencies to develop and disseminate policies, adapting the Guidelines to the specific mandates and activities of their agency, while availability and quality of human resources for MHPSS is an ongoing challenge in the humanitarian field.

References

Action Contre La Faim (2006). Manual for the Integration of Child care Practices and Mental Health within Nutrition Programmes. Paris, ACF.

Ager, A. (2008). "Consensus and professional practice in psychosocial intervention: political achievement, core knowledge-base and prompt for further enquiry." Intervention 6(3/4): 261-264.

Ager, A., J. Metzler, et al. (2013). "Child friendly spaces: a systematic review of the current evidence base on outcomes and impact." Intervention 11(2): 133-147.

Baca, M. J., K. Fayyad, et al. (2012). "The development of a comprehensive mapping service for mental health and psychosocial support in Jordan." Intervention 10(2): 177-187.

Baingana, F. (2006). "A public mental heath perspective on the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings." Intervention 6(3/4): 236-238.

Baingana, F. and P. O. Mangen (2011). "Scaling up of mental health and trauma support among war affected communities in northern Uganda: lessons learned." Intervention 9(3): 291-303.

Baron, N. (2009). Global Toolkit of Orientation and Training Materials used to Disseminate and Implement the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings IASC MHPSS Reference Group

Barrett, T., J. Fox, et al. (2011). "The IASC Guidelines and the International Disaster Psychology Program at the University of Denver." Intervention 9(2): 159-163.

Bass, J., R. Neugebauer, et al. (2006). "Group interpersonal psychotherapy for depression in rural Uganda: 6-month outcomes: randomised controlled trial." Br J Psychiatry 188: 567-573.

Bass, J. K., J. Annan, et al. (2013). "Controlled trial of psychotherapy for Congolese survivors of sexual violence." N Engl J Med 368(23): 2182-2191.

Batniji, R., M. Van Ommeren, et al. (2006). "Mental and social health in disasters: relating qualitative social science research and the Sphere standard." Soc Sci Med 62(8): 1853-1864.

Betancourt, T. S. and K. T. Khan (2008). "The mental health of children affected by armed conflict: protective processes and pathways to resilience." Int Rev Psychiatry 20(3): 317-328.

Child Protection Sub-Cluster - South Sudan (2014). Who is Doing What Where – Overview – April 2014. Juba, Global Protection Cluster.

Columbia University and World Vision (2012). Child Friendly Spaces in Emergencies: Research and Learning Project: Briefing Note #1. New York, Columbia University and World Vision

Echeverri, C. and J. Castilla (2008). "A case study in Colombia: implementation of the IASC Guidelines on Mental Heath and Psychosocial Support in Emergency Settings." Intervention 6(3/4): 284-290.

Fitzgerald, C., A. Elkaied, et al. (2012). "Mapping of mental health and psychosocial support in post conflict Libya." Intervention 10(2): 188-200.

Galappatti, A. (2003). "What is a Psychosocial Intervention? Mapping the field in Sri Lanka." Intervention 1(2): 3-17.

Global Protection Cluster (2011). Guidelines for Child Friendly Spaces in Emergencies: Field testing version. Geneva, Global Protection Cluster.

Grantham-McGregor, S. M., L. Fernald, et al. (2014). "Effects of integrated child development and nutrition interventions on child development and nutritional status." Ann. N.Y. Acad. Sci. 11308: 11-32.

Hijazi, Z., I. Weissbecker, et al. (2011). "The integration of mental health into primary health care in Lebanon." Intervention 9(3): 265-278.

Hobfoll, S. E., P. Watson, et al. (2007). "Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence." Psychiatry 70(4): 283-315; discussion 316-269.

Horn, R. and A. Strang (2008). "A Jordanian case study: the implementation of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings." Intervention 6(3/4): 291-293.

Horn, R. and A. Strang (2008). "A Kenyan case study: implementation of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings." Intervention 6(3/4): 294-297.

Humanitarian Country Team - South Sudan (2014). Response Plan - South Sudan. Juba, Humanitarian Country Team

Hustache, S., M. R. Moro, et al. (2009). "Evaluation of psychological support for victims of sexual violence in a conflict setting: results from Brazzaville, Congo." Int J Ment Health Syst 3(1): 7.

IASC (2011). Advocacy Package: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva, IASC MHPSS Reference Group

IASC MHPSS Reference Group (2012). Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes. Geneva, IASC.

IASC Sub-Working Group on the Cluster Approach (2012). Reference Module for Cluster Coordination at the Country Level. Geneva, IASC.

IMC (2011). IMC Libya: Mental Health and Psychosocial Support Assessment Report. Tripoli, IMC.

IMC (2013). Mental Health and Psychosocial Considerations: Azraq Camp. Amman, IMC.

IMC (2013). Mental Health in Health Facilities: Situational Analysis and Strategy. Juba, IMC.

IMC (2014). Interim report on rapid mental health needs assessment in Philippines Typhoon Haiyan/ Yolanda Affected Areas: Capiz Province and Southern Leyte. Washington DC, IMC.

IMC and UNICEF (2012). Displaced Syrians in Za'atri Camp: Social Considerations. Amman, IMC and UNICEF.

IMC and UNICEF (2013). Mental Health/Psychosocial and Child Protection Assessment for Syrian Refugee Adolescents in Za'atari Refugee Camp, Jordan. Amman, IMC and UNICEF.

IMC, UNICEF, et al. (2012). Who is Where, When, doing What (4Ws) in Mental Health, Psychosocial and Protection Support in Jordan. Amman, IMC, UNICEF and WHO.

IOM (2012). IOM Migration Crisis Operational Framework Geneva, IOM.

IOM (2012). Mental Health and Psychosocial Support to Migrant, Displaced, and Crisis-affected Populations, including Returnees Geneva, IOM.

IOM (2014). A rapid assessment of psychosocial needs and resources in South Sudan following the outbreak of the 2013/2014 conflict. Geneva, IOM.

Jones, L. (2008). "Responding to the needs of children in crisis." Int Rev Psychiatry 20(3): 291-303.

Jones, L., J. Asare, et al. (2007). "Mental health in disaster settings." BMJ 335(7622): 679-680.

Jordans, M., N. Upadhaya, et al. (2008). "Introducing the IASC Mental Health and Psychosocial Support Guidelines in Emergencies in Nepal: a process description." Intervention 8(1): 52-63.

Jordans, M. J., I. H. Komproe, et al. (2010). "Evaluation of a classroom-based psychosocial intervention in conflict-affected Nepal: a cluster randomized controlled trial." J Child Psychol Psychiatry 51(7): 818-826.

Jordans, M. J., I. H. Komproe, et al. (2010). "Practice-Driven Evaluation of a Multi-layered Psychosocial Care Package for Children in Areas of Armed Conflict." Community Ment Health J.

Jordans, M. J., W. Tol, et al. (2009). "Systematic review of evidence and treatment approaches: psychosocial and mental health care for children in war." Child and Adolescent Mental Health 14(1): 2-14.

Jordans, M. J., W. A. Tol, et al. (2010). "Development of a multi-layered psychosocial care system for children in areas of political violence." Int J Ment Health Syst 4: 15.

Krishnakumar, G., S. Sivayokan, et al. (2008). "Coordination of psychosocial activities at the Jaffna District Level in Sri Lanka." 2008 6(3/4): 270-274.

Marsden, R. and A. Strang (2006). Assessing Psychosocial Needs: What are we looking for and why? Analysing psychosocial needs assessment in Sri Lanka post-tsunami. Colombo, UNICEF Sri Lanka.

McGrath, M. and A. Schafer (2014). "Integrating psychosocial support into nutrition programmes in West Africa during the Sahel food crisis." Intervention 12(1): 115-126.

McKay, S., A. Veale, et al. (2011). "Building meaningful participation in reintegration among war-affected young mothers in Liberia, Sierra Leone and northern Uganda." Intervention 9(2): 108-124.

Metzler, R. Kaijuka, et al. (2013). Evaluation of Child Friendly Spaces: Uganda Field Study Summary Report. New York, Columbia University and World Vision

Metzler, K. Savage, et al. (2013). Evaluation of Child Friendly Spaces: Ethiopia Field Study Summary Report. New York, Columbia University

Metzler, J., A. Atrooshi, et al. (2014). Evaluation of Child Friendly Spaces - Iraq Field Study Report: A MoLSA-Implemented CFS in Domiz Refugee Camp. New York, Columbia University and World Vision

Meyer, S. (2013). UNHCR's Mental Health and Psychosocial Support for Persons of Concern: Global Review. Geneva, Policy Development and Evaluation Service, UNHCR.

MHPSS Working Group - Jordan (2012). Inter-Agency Guidance Note for Mental Health and Psychosocial Support Jordan Response to Displaced Syrians. Amman, MHPSS Working Group - Jordan.

Mollica, R. F., B. L. Cardozo, et al. (2004). "Mental health in complex emergencies." Lancet 364(9450): 2058-2067.

Morris, J., L. Jones, et al. (2012). "Does combining infant stimulation with emergency feeding improve psychosocial outcomes for displaced mothers and babies? A controlled evaluation from northern Uganda." Am J Orthopsychiatry 82(3): 349-357.

MSF (2014). In the eye of the typhoon: MSF's Typhoon Haiyan response Geneva, MSF.

Mueller, Y., S. Cristofani, et al. (2011). "Integrating mental health into primary care for displaced populations: the experience of Mindanao, Philippines." Confl Health 5: 3.

O'Connell, R., B. Poudyal, et al. (2012). "Who is Where, When, doing What: mapping services for mental health and psychosocial support in emergencies." Intervention 10(2): 171-176.

OCHA (2012). Coordination and Funding of Cross-Cutting Issues in Humanitarian Action. Geneva, OCHA.

OCHA (2014). Situation Report - South Sudan. Juba, OCHA - South Sudan.

Plan International (2013). Plan Disaster Response Manual Book 3 - Programme Guide, Plan International.

Psychosocial Working Group (2003). Psychosocial Intervention in Complex Emergencies: A Conceptual Framework. PWG. Edinburgh, PWG.

Raphael, B. and H. Ma (2011). "Mass catastrophe and disaster psychiatry." Mol Psychiatry 16(3): 247-251.

Rose, N., P. Hughes, et al. (2011). "Integrating mental health into primary health care settings after an emergency: lessons from Haiti." Intervention 9(3): 211-224.

Rubenstein, L. and A. Kohli (2010). Mental health services during and after armed conflict: the state of knowledge and practice. Peacebrief USIP. Washington DC, United States Institute of Peace 57.

Save the Children (2009). Child Friendly Spaces: Facilitator Training Manual Westport, Save the Children.

Save the Children (2013). Psychological First Aid Training Manual for Child Practitioners. Copenhagen, Save the Children.

Schafer, A., L. Snider, et al. (2010). "Psychological First Aid: Haiti emergency response." Intervention 8(3): 245-254.

Scholte, W. F., F. Verduin, et al. (2011). "The effect on mental health of a large scale psychosocial intervention for survivors of mass violence: a quasi-experimental study in Rwanda." PLoS One 6(8): e21819.

Semlitz, L., K. Ogiwara, et al. (2013). "Psychological first aid training after Japan's triple disaster: changes in perceived self competency." Int J Emerg Ment Health 15(3): 181-196.

Strang, A. and A. Ager (2003). "Psychosocial interventions: some key issues facing practitioners." Intervention 1(3): 2-12.

Sullivan-Owomoyela, J. (2006). Inter Agency Network for Education in Emergencies Minimum Standards for Education in Emergencies, Chronic Crisis, and Early Reconstruction: A Uganda Case Study. Washington D.C., USAID.

Tankink, M. and P. Ventevogel (2014). "From the editors … a widening diversity and dynamism: A new look and (sub)title, a new Editor in chief and a new diversity of voices." Intervention 12(1): 2-6.

Tol, W. A., C. Barbui, et al. (2011). "Mental health and psychosocial support in humanitarian settings: linking practice and research." Lancet 378(9802): 1581-1591.

Tol, W. A., I. H. Komproe, et al. (2010). "Mediators and moderators of a psychosocial intervention for children affected by political violence." J Consult Clin Psychol 78(6): 818-828.

Tol, W. A., I. H. Komproe, et al. (2014). "School-based mental health intervention for children in war-affected Burundi: a cluster randomized trial." BMC Med 12(1): 56.

Tol, W. A., I. H. Komproe, et al. (2012). "Outcomes and moderators of a preventive school-based mental health intervention for children affected by war in Sri Lanka: a cluster randomized trial." World Psychiatry 11(2): 114-122.

Tol, W. A., V. Patel, et al. (2011). "Research priorities for mental health and psychosocial support in humanitarian settings." PLoS Med 8(9): e1001096.

Tol, W. A., V. Patel, et al. (2012). "Relevance or excellence? Setting research priorities for mental health and psychosocial support in humanitarian settings." Harv Rev Psychiatry 20(1): 25-36.

Tol, W. A., V. Stavrou, et al. (2013). "Sexual and gender-based violence in areas of armed conflict: a systematic review of mental health and psychosocial support interventions." Confl Health 7(1): 16.

UNHCR (2013). Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations. Geneva, UNHCR.

UNICEF (2009). A Practical Guide for Developing Child Friendly Spaces. New York, UNICEF.

UNICEF (2014). Three month consultancy report for Psychosocial Support in the Philippines - Draft UNICEF.

UNICEF and WHO (2012). Integrating Early Childhood Development (ECD) activities into Nutrition Programmes in Emergencies. Why, What and How. Geneva, UNICEF and WHO.

Van Ommeren, M., L. Jones, et al. (2010). "Orienting psychiatrists to working in emergencies: a WPA-WHO workshop." World Psychiatry 9(2): 121-122.

van Ommeren, M., S. Saxena, et al. (2005). "Mental and social health during and after acute emergencies: emerging consensus?" Bull World Health Organ 83(1): 71-75; discussion 75-76.

Weiss, M. G., B. Saraceno, et al. (2003). "Mental health in the aftermath of disasters: consensus and controversy." J Nerv Ment Dis 191(9): 611-615.

Wessells, M. (2008). "Do No Harm: Challenges in organizing psychosocial support to displaced people in emergency settings." Refuge 25(1): 6-14.

Wessells, M. and M. van Ommeren (2008). "Developing inter-agency guidelines on mental health and psychosocial support in emergency settings " Intervention 6(3/4): 199-218.

Wessells, M. G. (2009). "Do no harm: toward contextually appropriate psychosocial support in international emergencies." Am Psychol 64(8): 842-854.

WHO (2011). Psychological first aid: Guide for field workers. Geneva, World Health Organization, World Vision and War Trauma Foundation

WHO Libya (2012). "From Humanitarian and Emergency Response to Health System Re-engineering": An Overview of Activities of the WHO Representative's Office in Libya during 2012. Tripoli, WHO.

WHO/ UNHCR (2012). Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva, WHO and UNHCR.

World Vision (2011). What is Mental Health and Psychosocial Support (MHPSS) within World Vision?, World Vision

World Vision International and War Trauma Foundation (2010). Anthology of Resources: Psychological First Aid for Low and Middle Income Countries World Vision International and War Traum Foundation.

Worthen, M., A. Veale, et al. (2012). "'I Stand Like A Woman': Empowerment and Human Rights in the Context of Community- Based Reintegration of Girl Mothers Formerly Associated with Fighting Forces and Armed Groups." Journal of Human Rights Practice 2(1): 49-70.

Annexes

Annex 1: On-line survey questions

Introduced in 2007, the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support (MHPSS) are the key policy guidelines on the provision of mental health and psychosocial support services in emergency settings. The Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support is currently undertaking a review of the implementation of the guidelines. This initiative is supported by UNICEF.

For one aspect of this review, we are inviting you as a stakeholder to complete a brief survey on the impact of the IASC Guidelines for Mental Health and Psychosocial Support in Emergencies on Mental Health & Psychosocial programmes in the field. All responses to the survey will be anonymous. To help us with this review, please respond to the following on-line survey by May 5, 2014.

It will take you approximately 10 minutes to respond.

Thank you very much for your contribution.

If you have any questions about this survey, please contact one of the consultants conducting the review: Dr. Maryanne Loughry (loughry@bc.edu).

_____   I consent to taking this survey

_____   I do not consent to taking this survey

IASC Guidelines for Mental Health and Psychosocial Support in Emergencies

Survey Questions

The survey is structured as follows:

- Respondent information
- Existing practices with the IASC Guidelines for Mental Health and Psychosocial Support in Emergencies ('the guidelines'); the perceived impact of the guidelines on programmes in the field; levels of institutionalization & mainstreaming of the guidelines
- Ideas for improvement

Respondent Information

Where are you currently located? (country)

Your primary organization is:

- ☐ UN agency
- ☐ INGO
- ☐ NGO
- ☐ Government agency
- ☐ University/institute of higher learning
- ☐ Other (please specify)

You are primarily:

- ☐ HQ staff
- ☐ Humanitarian field worker
- ☐ Government worker
- ☐ Academic
- ☐ Consultant
- ☐ Intern
- ☐ Other (please specify)

Your position is primarily based:

- ☐ In HQ
- ☐ In the field
- ☐ Other (please specify)

What percentage of your job is directly related to mental health and psychosocial support in emergencies?

- ☐ 10%,
- ☐ 25%,
- ☐ 50%
- ☐ 75%
- ☐ 100%

Existing Practice

Are you familiar with the IASC Guidelines for Mental Health and Psychosocial Support in Emergencies?

- ☐ Yes
- ☐ No (If selected, skip to end of survey)

How did you first learn about the guidelines?

- ☐ Agency orientation
- ☐ Website/internet
- ☐ Training/education
- ☐ Other (please explain)

How do you use the guidelines? (select all that apply)

- ☐ Personal reading/instruction
- ☐ Regular use in project implementation
- ☐ Use in programme design and proposal writing
- ☐ To prepare workshops and trainings (If selected, skip to next question)
- ☐ Other (please explain)

Who did you train on the guidelines? (select all that apply)

- ☐ Agency staff
- ☐ Partner agency staff
- ☐ Students/interns
- ☐ Government partners
- ☐ Other

In which language do you primarily use the guidelines?

☐ Arabic
☐ Chinese
☐ English
☐ French
☐ Japanese
☐ Nepali
☐ Spanish
☐ Tajik

In what form do you use the guidelines? (select all that apply)

☐ Paper copy or hard copy
☐ Electronic copy
☐ CD-ROM
☐ Other (please explain)

Which of the following supplementary implementation tools that accompany the guidelines have you used? (select all that apply)

☐ Checklist for Field Use
☐ What should protection programme managers know?
☐ What should humanitarian health actors know?
☐ What should camp coordination and camp management actors know?
☐ Who is where, when, doing what (4W's) in mental health and psychosocial support?
☐ None (Skip)

The following items relate to your opinions about the IASC Guidelines for Mental Health and Psychosocial Support in Emergencies. Please let us know if you agree or disagree with the level of impact these guidelines have had on:

Perceived Impact					
	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The guidelines have improved the efficacy of humanitarian programmes in emergencies					
The guidelines have improved mental health & psychosocial programming in emergencies					
The guidelines have facilitated the integration of mental health & psychosocial concerns in other sector programmes					

How well integrated are the guidelines within programmes in your organization?

Levels of Institutionalization					
	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The guidelines are incorporated into your agency's policies and procedures					
The guidelines are incorporated into your agency's human resources documentation and practices					
The guidelines are integrated into all projects and programmes in my agency					
The guidelines are integrated into some projects and programmes in my agency					
The guidelines are used in Mental Health and Psychosocial Support programmes only					

Ideas for Improvement

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I found what I needed within the guidelines to provide mental health and psychosocial support in emergency settings					

What additional information would have made the guidelines more useful to you?

Any other comments on the guidelines?

Annex 2: In-depth Case studies

Case Study – Central African Republic:

1. Background and context:

Tension and armed conflict throughout Central African Republic [CAR] increased and spread throughout CAR, affecting the capital, Bangui, in early December 2013. Violent attacks on communities throughout the country by armed groups has resulted in significant displacement throughout CAR and to neighboring countries (OCHA 2013). CAR was designated a Level 3 emergency on December 11 2013. Priority needs have included food and non-food items, WASH and shelter. A situation report in December 2013 showed that half of internally displaced persons throughout the country were food insecure, there are significant barriers to basic health care, and there were significant security constraints to delivery of humanitarian assistance. Humanitarian workers interviewed for this case study described high levels of violence to which entire communities had been exposed, and symptoms of distress that were present in adults and children throughout affected communities. OCHA situation updates from May 2014 reported that violence is ongoing in some parts of the country, preventing IDPs from going home.

Elements of MHPSS within the humanitarian response in CAR are described below, based on interviews conducted in March and April. Given the constantly changing context, the reflections below reflect the situation at the time of the interviews, and the context – including types of programming, presence of specific actors, and forms of coordination – may have changed since the time of writing.

2. Application

OCHA situation reports for CAR noted that IDP children were participating in child friendly spaces established by a number of humanitarian actors, and that psychosocial activities were being conducted solely for children. Interviews with respondents in March and April 2014 confirmed that the MHPSS interventions that were part of the humanitarian response constituted child friendly spaces. The focus of the humanitarian response at the outset was on food, shelter, WASH and communicable disease, and MHPSS needs were seen as secondary. Initial lack of communication and coordination between agencies working on child friendly spaces has improved, with the development of a MHPSS working group occurring at the time of writing this case study. The intersection between caregiver well-being

and child nutrition and development is recognized by Action Contre La Faim [ACF], who has trained psychosocial agents to work with caregivers and malnourished children. Beyond these activities, respondents noted that there was not a high level of application of the Guidelines in the response to CAR, given general low levels of knowledge of the Guidelines, limitations on basic knowledge of psychosocial interventions and mental health issues, and lack of capacity, discussed further below.

3. Challenges

One of the key obstacles to implementation of the Guidelines, described by respondents currently working in the humanitarian field in CAR, was lack of knowledge and understanding of psychosocial interventions, impacting the quality of the current psychosocial interventions (which are, as noted above, child friendly spaces). One respondent noted that in child friend spaces, most organizations are "more focused on the social than the psycho," and that many of the adults working in child friendly spaces do not have capacity to support quality psychosocial activities or identify children with specific needs, including symptoms of distress. As one respondent explained, "[t]his is something we are currently addressing and we want to be reinforced…we are searching for higher competency in this field of "psycho.""

Another respondent expressed concerns regarding the quality of the psychosocial interventions, noting that many interventions that are categorized as psychosocial do not have significant psychosocial components. She explained, "for instance, if there is an organization that is doing reporting for the victims – reporting how many victims, etc. sometimes they would call that psychosocial intervention. They give the victim a space to talk, but to me, they don't give a space for the victims to talk about what happened to them in a psychosocial way. They just give a space to talk about what happened in a reporting way….but giving the space to victims to talk half an hour because you need to know what happened to her is not a psychosocial intervention." The concern about quality of psychosocial interventions also included a concern that psychosocial activities were potentially doing harm, as one respondent noted, "having space to talk for victims, either you know how to do it very properly, very specialized, and that can be helpful. But if you don't know what you did it, it can be harmful."

Respondents also noted that referral systems are not in place – partly because those who may be responsible for identifying vulnerable and distressed children do not have the skills or capacity to do so, and partly because there is nowhere to refer children with specific needs. As the RG Conference Call in 2013 noted, "Specialized services related to MHPSS are extremely limited in CAR and there is an urgent need to scale up and improve specialized services in order to meet the growing community and individual needs regarding MHPSS of children, families, teachers, health workers and other humanitarian staff." Respondents noted the significant constraints on communication, coordination, referral systems and quality of programming. One respondent noted, "you cannot rely on anyone or anything on the ground that is already existing. That's a big challenge of how to implement the Guidelines in this context – how to address the issue in the country, where there is nothing?" Finally, respondents noted the lack of consideration for MHPSS within clusters, noting that food distribution and shelter had not been organized in ways that addressed the needs of the most vulnerable. The need for dedicated resources to support integration of MHPSS within clusters was emphasized. As one respondent explained, ensuring that clusters are integrate MHPSS concerns is "nearly kind of job itself….the clusters take three hours. So if you spent your week all over the clusters, you spend the whole week doing only this. So it's really difficult for us who are doing implementation and management of teams, and coordination and direct case follow-up to do that."

4. Outcomes

At the stage of conducting interviews for this case study, the outcomes of implementation of the Guidelines were difficult to identify. However, through interviews with respondents it was evident that there is:

- Recognition of the need to coordinate;
- Recognition of the need to establish referral systems;
- Recognition of the need to improve quality of psychosocial interventions and ensure training and capacity-building within child friendly spaces

Case Study: South Sudan 2013-2014

1. Background and context:

Decades of conflict and lack of infrastructure and capacity have presented significant challenges to provision of MHPSS in South Sudan A 2009 description of a multi-layered MHPSS intervention in Yei noted that primary challenges in the area of MHPSS include that "[l]ocal government structures are weak and the health care system is hardly functioning at the primary health care level in terms of human resource, infrastructure and medical equipment" (Boniface, Khasim et al. 2009). Availability of clinical and specialized mental health services is very limited, there is extremely low capacity and availability of human resources, and there is a lack of availability of psychotropic drugs (IOM 2014). A 2013 assessment of mental health facilities in South Sudan noted that the mental health system is "rudimentary and centralized," and very limited involvement of INGOs in mental health or psychosocial programming (IMC 2013). One respondent noted that in South Sudan there was "no real foothold in terms of psychosocial programming, and general lack of awareness of the Guidelines and mental health."

Interest in and commitment to MHPSS had been emerging in South Sudan. In 2012, a Mental Health Platform was established under the Ministry of Health, with Healthnet TPO coordinating the Platform and implementation of the strategy. A dedicated UNICEF MHPSS specialist had been mapping community support and psychosocial resources, working to identify, as one child protection specialist currently in South Sudan noted, "what is genuinely available on the ground, not just what were the NGOs are doing but what were the people on the ground, the local NGOs, the religious organizations, doing, and what communities' own coping mechanisms and own psychosocial support systems are." However, in December 2013, political tensions escalated to armed civil conflict, resulting in significant displacement, within South Sudan and to neighboring countries (Humanitarian Country Team - South Sudan 2014). Ongoing conflict has resulted in lack of humanitarian access to a large proportion of displaced persons (OCHA 2014), and a 2014 humanitarian needs assessment concluded that, due to the conflict, "modest gains on the humanitarian front made in 2013…are likely to be reversed, with a serious impact on people's health and nutritional status" (Humanitarian Country Team - South Sudan 2014).

An IOM assessment in February 2014 noted that ongoing insecurity and lack of humanitarian access to individuals and communities affected by the violence has influenced psychosocial and mental health impacts of the conflict (IOM 2014). Humanitarian actors noted the need for MHPSS interventions and activities in Protection of Civilians camps in South Sudan, given that "individual and collective uneasiness have been evident from the onset of the crisis" (IOM 2014). The IOM assessment found that in a Protection of Civilians camp in Bor, Jonglei State, respondents noted that they were affected by "fears and concerns, a general feeling of being emotionally unwell, uncertainty and confusions about the future, anxiety and frustrations." The IOM assessment identified the following stressors: family separation, ongoing conflict, lack of freedom of movement, lack of access to education and socialization activities for adolescents, concerns about return, and concerns about the long-term impacts of ethnic conflict and divides (IOM 2014). A number of planned MHPSS assessments and interventions have not been implemented due to the conflict, and as one MHPSS specialist in the field stated, "[s]ince the crisis, everything has changed completely. We just went back as well square one in most locations."

Elements of MHPSS within the humanitarian response in South Sudan are described below, based on interviews conducted in March, April and May 2014. Given the constantly changing context, the reflections below reflect the situation at the time of the interviews, and the context – including types of programming, presence of specific actors, and forms of coordination – may have changed since the time of writing. This case study focuses specifically on MHPSS in the humanitarian response since the escalation of conflict in December 2013, highlighting the challenges of implementation of the Guidelines in a context lacking capacity, infrastructure and existing structures for MHPSS activities. Moreover, while this case study identifies significant challenges in implementation of the Guidelines in South Sudan, it was evident from interviews and document review conducted for this case study that there are a number of agencies and individuals working tirelessly to introduce and prioritize MHPSS within the humanitarian response, and that these efforts are helping to strengthen the MHPSS field in South Sudan.

2. Application

Application of the Guidelines in the case of South Sudan is limited, and is primarily reflected in coordination efforts. A MHPSS Working Group, as part of the Child Protection Sub-Cluster, was established in January 2014, and meets weekly in Juba, with key responsibilities and activities noted in its Terms of Reference including:

1. To provide a forum for sharing of activities of national and international organizations providing MHPSS, while maintaining an updated matrix on who is doing what and where, including target populations and specific responses.

2. To ensure for the implementation of IASC Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings for quality provision of MHPSS in the context of the emergency response in South Sudan; and

3. To build the capacity of relevant stakeholders, including service providers, government counterparts, and the community, to comply with the IASC Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings (MHPSS Working Group - South Sudan 2014).

A child protection 5Ws exercise (who is doing what, where and when, for whom) indicates that the vast majority of MHPSS activities are Child Friendly Spaces (Child Protection Sub-Cluster - South Sudan 2014)

In addition, principles and tools associated with the Guidelines have informed recent MHPSS assessments. For example, a 2014 IMC Rapid Mental Health Situational Analysis drew on the 4Ws mapping tool, and principles including integration of mental health into primary health care (IMC 2014).

3. Challenges

The core challenges to implementation of the Guidelines in the humanitarian response in South Sudan are related to lack of capacity, in terms of health systems and human resources, to support mental health and psychosocial activities (see for example, IMC 2014). Knowledge about mental health and capacity for identification of mental disorders at a primary health care level is extremely limited. Some PFA training and orientation sessions are planned for these health care providers, which could strengthen the capacity to provide some basic supports.

The case of South Sudan brings to light some of the systemic and structural challenges to implementation of the Guidelines in a Level 3 emergency. One respondent noted, "execution of the Guidelines on the ground" has been quite limited – "not due to lack of willingness by the staff or the lack of understanding but just due to the circumstances can often be quite difficult. We do try to use them and stick to them wherever possible… But in terms of actually ensuring that the practical application on the ground, sometimes that is just beyond and you have to best that you can."

The lack of resources, capacity and awareness of MHPSS within South Sudan poses a significant challenge to provision of a range of MHPSS activities. One child protection practitioner in South Sudan summarized, "in terms of awareness amongst health professionals and in general, in the country, even of general MHPSS concerns, there isn't a high level of awareness at all. So it's very hard to provide even non-specialized support to people, let alone some of the top of the pyramid, the more specialized support as well. However, given the extend of the conflict in the country, the extent of poverty in the country, lack of access to basic needs, the fragmentation of community and community norms and traditions and so forth over the past decades because of ongoing conflict, you could argue that the need would be so much more than in other contexts…The investment in MHPSS in South Sudan definitely does not align with the need on the ground, and the existence of MHPSS resources in country are definitely under serious pressure and therefore, referring people on to quality support is basically impossible….all we can do is basically focus on do no harm, as opposed to actually responding to most of the needs, given the lack of resources available."

Integration of MHPSS within clusters, apart from child protection, is limited by the significant pressure on international and national agencies to provide basic MHPSS supports. One respondent noted that integration varies from location to location, and that "how much time and energy they've been able to spend on doing any work in other sectors is entirely depending on which agency is, how many people they've got, how much funding they've got. And then also who are the other agencies are in that location – what capacity do they have to actually engage in the MHPSS discussion or in main streaming is entirely, it's different on location by location."

Other aspects of the overall humanitarian situation that pose significant challenges to MHPSS activities are the ongoing insecurity and humanitarian lack of access to affected populations, as well as the fact that proposed activities in the protection cluster are severely underfunded (only 12% of proposed activities are funded), limiting capacity to provide psychosocial activities that fall under the protection cluster (OCHA 2014).

Finally, while the MHPSS Working Group within the Child Protection Sub-cluster has acted to bring together child protection actors working on psychosocial activities (the majority on child friendly spaces), there are concerns that the Working Group is comprised primarily of psychosocial actors, and does not have strong links to the Health Cluster or to actors with mental health expertise. An IMC assessment in 2014 noted that

the group "is currently organized under the child protection sub-cluster and is largely focused on psychosocial support. There is no participation on part of the local authorities, nor WHO and no strong mental health technical lead has been identified, although efforts are being done to work closely with members of the health cluster" (IMC 2014). The primary focus on psycho-social activities and on children entails that mental health issues, and a focus on adults, is not currently evident. In terms of mental health, there is a Platform for Mental Health, which had been established prior to the crisis in 2013, which has linkages with the Ministry of Health and is currently led by Healthnet TPO. There are some efforts to link the MHPSS Working Group and the Platform for Mental Health. While the gap between the groups is currently a challenge, respondents noted current efforts to improve the linkages and ensure attendance at each others' meetings, and communication between the groups.

4. Outcomes

- Establishment of a Psychosocial Support Working Group, as part of the Child Protection Sub-cluster;
- Mapping of national and international agencies' activities in psychosocial support; and
- Tools and principles associated with the Guidelines have informed MHPSS assessments

Case Study – Philippines, Typhoon Haiyan:

1. Background and context:

Typhoon Haiyan hit the Philippines on November 8, 2013, killing 6,200 people and affected the housing and livelihoods of over 16 million (MSF 2014). The impacts of the typhoon included destruction of infrastructure, including damage to health facilities and schools, risk of disease, separation of children and youth from families, disruption of education, disruption of livelihoods, and exposure to stressful events, including witnessing death and destruction (Save the Children 2013). The IASC principals designated the disaster a Level 3 emergency, which requires that IASC members act according to agreed protocols and will be held accountable to specific outputs.

The Guidelines had previously been introduced in the Philippines through a process lead by WHO Philippines, and engaging Government, NGO actors (local and international), UN agencies, academics and faith-based organizations. A series of consultations and workshops resulted in the creation of a Technical Working Group on MHPSS within the National Disaster Coordination Council [NDCC], with the Department of Health and Department of Social Welfare and Development as lead agencies. This resulted in the 2008 Joint Resolution for the adoption of NDCC member agencies, to guide implementation of the Guidelines. The Philippines Department of Health's Pocket Emergency Tool, a reference tool for fieldworkers involved in health emergency management response, has a section on MHPSS, noting the Guidelines and the Intervention Pyramid, and identifying key actions and standards for different actors in the Philippines in the areas of coordination, monitoring and assessment, protection, human resources, community mobilization and support, health services and education in line with the Guidelines (Philippines Department of Health 2012).

However, despite these processes, many respondents noted the limitations of this adoption and institutionalization by the Government that became evident in the response to Typhoon Haiyan. One respondent noted, "the Philippines was the first country to adopt the IASC Guidelines….all the main departments signed and said, this is it – health and education and protection and defense, this is what we are going to do. Then they adapted it their way to the Philippines, and changed it so much it was hardly the IASC Guidelines. In the recent crisis, you can see that their institutionalization meant nothing." Another respondent explained, "Everything on paper was great because they created committees, they assigned people, they have forum to discuss all this in MHPSS. Of course there was no real emergency happened at that time; there were a little bit

of typhoons here and there, and so on and so forth….In the meantime MHPSS kind of slept in the hands of Department of Health, and in the hands of a few people in the Department of Health it barely moved. It was in the hands of psychiatrists, and the psychologist, the social workers and other practitioners not directly invited or we were not kind of active in the participation of MHPSS sort of discussions, implementations and so on. MHPSS…was never factored into the Disaster Relief and Management plans and programmes of the entire country…. the PSS portion was totally neglected, the mental health part was then given to the National Center for Mental Health, which was also a government arm. But even within the Department of Health and the National Mental Health Center, the right arm didn't know what the left arm was doing." Therefore, while the introduction of the Guidelines in the Philippines appeared to have been one of the most successful cases of adopting of the Guidelines by a Government, at a national level, the influence of this adoption was unclear and limited in the response to Typhoon Haiyan.

This case study focuses on the ways in prior engagement with the Guidelines influenced or informed MHPSS activities and coordination in the humanitarian response to Typhoon Haiyan, some of the specificities of the field of MHPSS activities in the Philippines, as well as ways in which the initial MHPSS response has influenced ongoing activities, including Government engagement with MHPSS and the Guidelines. Some key challenges to implementation of the Guidelines in this context, including levels of awareness of the Guidelines, lack of engagement with key local actors and limitations in initial coordination structures. It should be noted that interviews with a range of respondents (local actors and MHPSS experts deployed from international agencies) represent the situation at various points of the humanitarian response, and that the post-emergency phase, which has emphasized "early recovery," differs greatly from the coordination and implementation and MHPSS activities at the earliest stages of the humanitarian response. This case study attempts to captures some components of the activities and challenges at the initial phases of the response, as well as how these initial activities have developed and changed throughout the months following the emergency.

2. Application

Despite some of the challenges noted below, in the month after the initial response to the typhoon, key local and international actors were able to mobilize support for MHPSS, implement PFA trainings across affected areas, conduct a 4Ws mapping of

MHPSS activities, and initiate improved institutionalization of the Guidelines within Government ministries.

Respondents noted high levels of cooperation, interest and commitment from local actors. One respondent explained, "[t]his was a country in which I have had the best cooperation from the people designated at regional health office level to deal with mental health. These people were totally IASC naïve but they… came to all my trainings, they increased the drug budget for psychotropic drugs, because of the work we did, showing that people weren't getting drugs. They completely engaged in whole process." While respondents reported varied levels of awareness of the Guidelines amongst a range of actors, the introduction of the Guidelines earlier, as noted previously, did have some influence on coordination and planning. For example, when a MHPSS Working Group needed a Terms of Reference, the local health coordinator introduced a TOR that had been used in another part of the Philippines response. A respondent noted, "they quoted large bits of the IASC guidelines. Which meant that somewhere in the Philippines, people were using the IASC guidelines as terms of reference for the MHPSS sub-cluster… That to me was evidence in the Philippines, the Guidelines there are accepted as an official way of working; that people are trying to implement them even if not everybody had read them."

One key impact of the humanitarian response on the implementation of the Guidelines in the Philippines appears to be improved and renewed engagement from Government departments in MHPSS in general, and in using the Guidelines as a framework for funding and implementing MHPSS activities. As noted above, while the Government had officially adopted the Guidelines, this adoption did not translate to effective action, and the adoption of the Guidelines was largely on paper, and often neglected within the Department of Health. One respondent explained that the Government is now asking her to provide input and review MHPSS proposals, providing an opportunity to introduce and reinforce the Guidelines through this process. Government ministries, and the Department of Education and Social Welfare in particular, are soliciting input on MHPSS proposals from local experts, providing an opportunity to use the Guidelines to inform new programmes and policies. This increased engagement from Government actors has also provided concrete opportunities to introduce mhGAP training and mental health training programmes at the primary health care level. One respondent noted, "the emergency provided the opportunity to introduce two things: A framework of training which is written out in the IASC guidelines, and a curriculum which is the MH-gap curriculum. And we introduced both those and hopefully they will run with those." Respondents noted that the MHPSS

component of the humanitarian response has provided some opportunities for institutionalizing MHPSS within the disaster response framework at a national level, which had not adequately happened despite previous attempts at institutionalization.

As noted below, one of the challenges in the Philippines was the focus on psychosocial processing [PSP], which includes elements of critical incident debriefing, which is recommended against in the Guidelines. The Philippines Department of Health defines PSP as a formal group session "to help the survivors deal positively with the severe emotional impact of crisis and provide education about current and anticipated stress responses, and information about stress management…[it] allows the ventilation and sharing of experiences, feelings, and reactions" (Philippines Department of Health 2012). Some respondents noted a shift in the focus in the response in the Philippines from PSP to a greater focus on use of PFA. One respondent explained, "In the beginning, when we were on the ground it was always trauma release, stress de-briefing, etc. And even when we were training, they would always say, "Can you give us de-briefing exercises? Can you give us release from trauma? We're all traumatized." So at least after we implemented PFA, we managed to correct or clarify this labelling." In the humanitarian response, there was widespread use of PFA training, interest from local actors and willingness to learn from consultants and international agencies who advocated for use of PFA, and a process of adaptation of the PFA training for the Philippines context. One respondent noted that the use of PFA in the Typhoon Haiyan response is "an achievement for MHPSS because now you can really say that we took it, but we used it in our own way for what was useful for us and what was culturally appropriate for us, and what we as practitioners on the ground felt was necessary and needed by the victim survivors. I think that's the best way we can complement the MHPSS Guidelines at the global level." The context in the Philippines is one that brings to light a specific type of challenge that can exist in implementation of the Guidelines – whereby a prevalent and accepted practice at the local level conflicts with the recommendations in the Guidelines. From the reports of many respondents interviewed for this case study, the way in which this challenge was addressed – in a non-confrontational way, using discussion, presentations and meetings to introduce the ideas of PFA, and identifying aspects of PSP (such as mobilizing resources and support) – appears to have some impact, although this issue remains a challenge, as discussed further below.

The initial gaps and limitations of coordination are noted below. However, due to support from the WHO and through a UNICEF consultant, effective coordination structures were

developed. In the early phase of the response, key actors such as the Department of Social Welfare and Development were not participating in the MHPSS coordination mechanisms. Following efforts, specifically by the UNICEF consultant tasked with this role, the coordination mechanisms were strengthened, with an established TOR and engagement of key actors. The Working Group is co-chaired by the Department of Health and the Department of Social Welfare and Development. One respondent noted that the working groups "were a big success… They became a forum for sharing information….Because at one point, I remember my colleague telling me that that forum is not useful at all. I think the other point was that there was more discussion on mental health and there was no discussion on psychosocial support. But I think the coming up of UNICEF and also ensuring that everybody was together, we're able to balance the discussion." The Working Group in Tacloban also established mechanisms through which to represent MHPSS in different clusters and sub-clusters. Specific organizations in the MHPSS Working Group were tasked with representing the working group in cluster and sub-cluster meetings, reporting on the MHPSS working group's activities, encouraging engagement with MHPSS in clusters and sub-clusters, and reporting back about the cluster and sub-cluster activities to the MHPSS Working Group. This mechanism has been particularly effective in the case of education, and several linkages between the education cluster and MHPSS have resulted in referrals from education actors to MHPSS and harmonization of training materials for teacher training in psychosocial-support (UNICEF 2014).

3. Challenges

While noting the application of the Guidelines that occurred in a range of ways in the response to Typhoon Haiyan, a number of respondents described some significant challenges that bring to light some important aspects of the barriers to implementation of the Guidelines. One respondent noted that, as has been the case previously in large-scale emergencies, large numbers of international and local actors mobilized, some of whom did not have previous experience or expertise in MHPSS activities. One respondent noted that many actors had "never heard of or seen the Guidelines." Some of these actors tended to support and implement MHPSS activities that do not adhere to the principles of the Guidelines. One respondent explained, "many other types of psychological, mental health support groups have been coming in. Name it, we have it. Neuro-linguistic programming, trauma release, whatever name it is; of course, critical incidence stress de-briefing is there. And all other labels. Child play therapy, art therapy, yoga, breathing, etc. They're all under the name psychosocial support." It was an on-going challenge

to identify these activities and the actors implementing them, seek to ensure that the adhered to basic principles, such as 'do no harm,' and improve the quality of these services. Moreover, in the case of the Typhoon Haiyan response, large numbers of private individuals arrived to provide humanitarian support – for example, Filipino-Americans – many of whom were not aware of the Guidelines, and were not adequately engaged in the MHPSS working group.

The use of PSP is an ongoing challenge. One respondent noted that PFA training, while effective, had not adequately addressed the use of PSP, noting that what is needed is "a much bigger cultural shift at the level of universities and psychologists, and with the disaster management communities, and with the church." The IMC found that "[w]hile the Department of Health agreed to stop using PSP and start using PFA after advocacy from the WHO, this message had not filtered down to the local level weeks after the emergency" (IMC 2014). Elements of PSP overlap with PFA, and as the IMC report continued, many local Filipino MHPSS staff and experts do not require PFA training, and "[i]t is important that in explaining the problems with critical incident debriefing and advocating PFA we do not sell it as another intervention which you cannot do unless you are trained. The emphasis should be on reinforcing the numerous natural coping skills that exist here" (IMC 2014). One local respondent noted significant concerns as to the way in which PSP has been criticized by international actors in the typhoon response, noting that this marginalized and excluded local actors who had been supporting and implementing PSP for many years.

Another challenge noted in some MHPSS assessments and in key informant interviews is the lack of services for severe mental disorders, and that the "majority of agencies doing MHPSS work are focused on PFA, counseling, supporting children through CFSs and community services" (for example, IMC 2014). The only agencies that were engaged with specialized mental health services were IOM, IMC and CBM, despite assessments that identified a number of significant gaps in provision of these services. As part of this response, IMC has begun a mental health capacity building project, including training in order to support integration of mental health into primary health care.

There were significant initial challenges in the area of coordination. The challenge of MHPSS as a cross-cutting issue emerged from the beginning. One respondent noted, "I arrived a month on, and there are people sitting in there child protection cluster were not fully aware that there was a MHPSS cross-cutting cluster going on. So there's a lot of duplication. So then I went

to the MHPSS cross cutting cluster, and a lot of those people were obviously not going into a child protection process. It was a complete muddle.

And then it became clear that perhaps we want to be under health. So, that old question was still not resolved." An IMC report explained the situation as better than in previous emergencies, "[h]owever MHPSS is not visible anywhere as a sub-cluster in the Cluster list on the home page of the Philippines Humanitarian response, nor is it listed as a cross cutting issue" (IMC 2014). Despite improvements, respondents noted that some key local actors – most notably, faith-based organizations and the Church, which was providing aid directly to survivors – were not adequately engaged by international humanitarian actors. As one respondent explained, "the entire Filipino and the international humanitarian community which failed to do proper outreach to the church… And why would we expect busy bishops to come to UN coordination meetings? We should be going to them." Finally, a UNICEF consultancy report notes a number of significant gaps in coordination at a national level, including that psychosocial issues are the responsibility of a number of agencies who are not coordinating, noting that "it was evident there was very limited coordination of psychosocial support activities at national level. Whenever there is an emergency, the national response was not coordinated. Each department acted independently" (UNICEF 2014).

4. Outcomes

The use of the Guidelines in the humanitarian response to Typhoon Haiyan had key outcomes in the following areas:

- Renewed interest in and commitment to the Guidelines from Government actors;
- Opportunity for international NGOs to introduce key concepts in the Guidelines, for example, PFA and integration of mental health into primary health care; and
- Following the immediate emergency phase, improved coordination structures for MHPSS that had input into clusters and sub-clusters.

Case study: State of Palestine

1. Background and context:

Gaza and the West Bank (the State of Palestine) have experienced chronic conflict for decades, and the situation has deteriorated after military incursions in recent years. Specific military incursions – Operation Cast Lead in 2008 and Operation Pillar of Defense in 2012 – have led to more displacement, significant casualties and injuries, and destruction of infrastructure. A UNICEF assessment after Operation Cast Lead noted the multiple forms of impact on the population in Gaza, including direct violence, destruction of health and education facilities, widespread displacement, and restricted access to humanitarian aid (UNICEF 2009). There are also ongoing protection and human rights concerns, including daily violence against Palestinians, damage to property and housing, restricted freedom of movement, forced evictions, and arbitrary arrest and detention (Protection Cluster 2012). There is widespread and extreme poverty in both Gaza and the West Bank, and the humanitarian responses includes activities to respond to elements of rapid onset emergencies (i.e. military incursions, forced displacement) and chronic humanitarian concerns (i.e. issues associated with ongoing poverty and lack of infrastructure, such as access to and quality of education and health services) (Protection Cluster 2012). Research and advocacy has focused on the needs of specific groups, including children, noting, for example, that children in the State of Palestine may become, deliberately or incidentally, the victims of extreme acts of violence and brutality, such as targeted and/or negligent killings, indiscriminate attacks on their homes, schools, camps and neighbourhoods, maiming, and other forms of physical and psychological violence – including torture, arbitrary arrest and detention, house demolitions, land confiscation and obstruction of livelihoods, discrimination and harassment" (UNICEF 2010).

The impacts of these stressors on mental health and psychosocial well-being are widely recognized. For example, the Office of the High Commission for Human Rights noted "the environment of fear and intimidation that repeated violence and harassment creates, has a serious psychological impact on victims of and witnesses to violent attacks, and affects the psychosocial well-being of women, men, girls and boys in affected communities" (OHCHR 2013). The Protection Cluster in the State of Palestine explained that the impacts of Operation Cast Lead resulted in compromised mental health and psychosocial status, and that "[c]ommunity coping mechanisms are nearly exhausted, resulting in a breakdown in structures that are essential to maintaining community cohesion and a sense of wellbeing (Protection Cluster 2012). Recognition of the impact of exposure to distressing events, ongoing stress, and lack of access to basic services and livelihoods has led to development and implementation of MHPSS services and activities in the State of Palestine.

The MHPSS Working Group coordinates emergency response for cases of violence, house demolitions and displacement, and in January 2014 noted an increase in demand for services for emergency response (Protection Cluster 2014). Prior to introduction of the Guidelines to this context, coordination of MHPSS was very limited, given competition over resources, resulting in duplication of services and gaps in services for some populations. The context of ongoing humanitarian crisis, combined with outbreaks of violence, entails that in the State of Palestine, many actors did not feel that the Guidelines could be easily applied. One donor noted, "many of the stakeholders, UN, INGOs and many of the national ministries working in the field of mental health and psychosocial, they were all worried that those guidelines cannot really be applied to the Palestinian context. And they need to be adapted to become more responsive to a protracted crisis where it's not like you have an emergency and after a while you go into a recovery, and after a while, you go into rehabilitation and development." This process of adaptation and implementation has been described by actors in the State of Palestine as strong, collaborative and successful.

This case study focuses on the ways in which coordination have strengthened the MHPSS response in the State of Palestine, activities that have been effective in institutionalizing principles of the Guidelines, and ongoing challenges in implementation in this context.

2. Application

The Guidelines were utilized in the State of Palestine to address the core challenge of coordination and duplication of services. Key actors described the psychosocial area as "chaotic," "not very well organized or coordinated," and lacking tools to map and organize where and how agencies were working, and how to complement the activities of other agencies. One significant challenge was duplication of services, whereby after a specific event, seven or eight agencies would separately provide MHPSS activities in one community, whereas another affected might receive limited services. Agencies were driven by commitments to donors, "to provide x psychosocial sessions to x number of persons in one site, and nobody would go to provide the same services for people who are still affected and live in another area." The MHPSS sub-cluster is co-chaired by UNICEF and

WHO, and falls under the Protection Cluster. This mechanism has resulted in active participation of 30 to 40 agencies in each meeting, and in recent emergencies, improved communication and coordination between different levels of service providers. One respondent explained that the introduction of the IASC Guidelines had a significant and lasting impact on coordination, noting "we started by improving the coordination between different characters by applying the hierarchy of classification of function and responsibilities of different mental health and psychosocial organizations. And the guideline helped to provide this framework, that everybody started to feel that this organization or that organization that they can fit in this hierarchy." A respondent noted that by the 2012 crisis, the coordination mechanisms were used to improve response and reduce duplication, explaining "[w]hen you have all the stakeholders around the table, you are better able to put your finger on the target areas and the target beneficiaries, and the needs."

The Guidelines were also used in conjunction with donors. In particular, ECHO engaged the MHPSS Working Group in order to utilize the Guidelines as a core component of technical review for proposals. The Working Group provides feedback on proposals as part of the Consolidated Appeals Process [CAP]; as explained by one respondent, "it's part of our responsibility as cluster coordinators to review all the projects submitted to the CAP mechanism and provide technical feedback and guidance, to donors, to help them to accept or not to accept those projects. So through this technical review, we use the Guidelines as a framework….[we use the Guidelines] as a kind of criteria that can help them to accept or not to accept projects that they don't use the guideline as a framework of intervention and assistance. So, this being one of the issues that help them [the donors] to understand the value of the Guidelines, and after that, after a shortfall they have been putting the guideline as one of their criterion for submitting psychosocial projects and mental health projects for funding. So I think it was one of the achievements, getting donors more on board." The MHPSS Working Groups in both Gaza and West Bank have worked closely with OCHA to ensure that all proposals with mental health or psychosocial components, even those submitted under the Health or Education clusters, are also sent to the MHPSS Working Groups for review, A respondent who worked for ECHO in the State of Palestine noted that ECHO was highly involved in and supportive of MHPSS activities, and was involved in activities to adapt the Guidelines for the context of chronic conflict.

This process is perceived to have resulted in improved quality of programmes, increased use of evidence-based programming. The capacity of the MHPSS Working Group to reduce funding

and support for potentially harmful practices, such as critical incident debriefing, and increase support for evidence-based activities, is a significant achievement of the implementation of the Guidelines in the State of Palestine.

3. Challenges

Some challenges in MHPSS coordination and activities in the State of Palestine remain. Some of these challenges include:

- **LACK OF COMPREHENSIVE REFERRAL MECHANISM,** which are due to the political context of relationships between Government ministries and international NGOs. It can be challenging for international NGOs to create formal relationships with Government bodies, and therefore referral mechanisms to public health clinics, for example, are limited

- **INTEGRATION OF MHPSS WITHIN CLUSTERS** – one aspect of implementation of the Guidelines in the State of Palestine was presentations and workshops with clusters, including WASH, education, protection and health, on the Guidelines. This was an important first step in making these clusters "aware of the minimal response, the emergency response, how it can be integrated into emergency response to provide throughout cluster and education services and protection services." However, there has been limited follow-up to this, and MHPSS has not been explicitly integrated into contingency planning in these clusters. The cluster mechanism itself was identified as a challenge to prioritization of and recognition of MHPSS activities. As one key actor noted, "[t]he guidelines make it really clear and highlighted that psychosocial protection issues are supposed to be cross-cutting, in all different clusters. But looking at the relationship between the clusters and the whole cluster system and mechanism, it really lacks a proper coordination and follow-up mechanism to ensure that other clusters are really looking at the psychosocial component within their service providers that it is in integrated within their delivery system."

- **DONOR PERCEPTIONS OF MHPSS** – key actors described ongoing challenges in engaging donors in MHPSS activities, noting that given psychosocial work, in particular, does not fit neatly within specific clusters. As one respondent explained, donors "look at quick response, at life-saving services, and psychosocial services cannot fit in that framework. We can't heal people in three months and go…it's not the same as just using drugs or shelters or whatever water. This can be done immediately and quickly and can save lives, psychosocial is something different. So we keep advocating

for this, since sometimes we find some good response [from donors]…[but] donors are not very aware of the value of psychosocial services and paradigm of these services".

- **COORDINATION OF ASSESSMENT:** Respondents noted that the Guidelines have introduced useful principles in the area of assessment. However, during and after emergencies, there is still "chaos of assessment," with multiple agencies conducting similar needs assessments, and additional guidance is needed on the ways in which to do needs assessments, given the results of the current approach to needs assessments in Gaza, in particular, is "discrepancies and contradictory figures, and no understanding of the actual needs and burden of psychosocial problems after an emergency in Gaza." The WHO/ UNHCR MHPSS needs assessment toolkit was recognized as a useful tool towards improving needs assessments, though this is an ongoing challenge in the State of Palestine.

4. Outcomes

The introduction of the Guidelines in the State of Palestine had key outcomes in the following areas:

- Improved communication between and coordination of mental health and psychosocial actors;
- Improved quality of MHPSS activities and use of evidence-based interventions; and
- Strong engagement with donors and involvement of MHPSS experts within technical review of proposals to emergency funding mechanisms.

All references from case studies:

Boniface, D., T. Khasim, et al. (2009). "Developing mental health and psychosocial support interventions in an extremely resource poor context: a case example from Southern Sudan." Intervention 7(2): 138-144.

Child Protection Sub-Cluster - South Sudan (2014). Who is Doing What Where – Overview – April 2014. Juba, Global Protection Cluster.

Humanitarian Country Team - South Sudan (2014). Response Plan - South Sudan. Juba, Humanitarian Country Team

IMC (2013). Mental Health in Health Facilities: Situational Analysis and Strategy. Juba, IMC.

IMC (2014). Interim report on rapid mental health needs assessment in Philippines Typhoon Haiyan/ Yolanda Affected Areas: Capiz Province and Southern Leyte. Washington DC, IMC.

IMC (2014). Rapid Mental Health Situational Analysis - South Sudan: Mental health priority conditions, community practices and available services and supports. Juba, IMC

IOM (2014). A rapid assessment of psychosocial needs and resources in South Sudan following the outbreak of the 2013/2014 conflict. Geneva, IOM.

MHPSS Working Group - South Sudan (2014). Terms of Reference 2014. Juba, MHPSS Working Group

MSF (2014). In the eye of the typhoon: MSF's Typhoon Haiyan response Geneva, MSF.

OCHA (2013). Central African Republic: Situation Report No.1. Bangui, OCHA.

OCHA (2014). Situation Report - South Sudan. Juba, OCHA - South Sudan.

OHCHR (2013). Update on Settler Violence in the West Bank, including East Jerusalem. Jerusalem, Protection Cluster, Occupied Palestinian Territories

Philippines Department of Health (2012). Pocket Emergency Tool. Manial, Department of Health

Protection Cluster (2012). Consolidated Appeals Process (CAP) - Needs Assessment Framework 2012-2013. Jerusalem, Protection Cluster,.

Protection Cluster (2014). Protection Cluster Monthly Update - January 2014. Jerusalem, Protection Cluster

Save the Children (2013). After Yolanda: What Children Think, Need and Recommend. Manila, Save the Children.

UNICEF (2009). Briefing Notes: Fact Sheet on the Gaza Crisis Jerusalem, UNICEF.

UNICEF (2010). The situation of Palestinian children in The Occupied Palestinian Territory, Jordan, Syria and Lebanon. Jordan, UNICEF.

UNICEF (2014). Three month consultancy report for Psychosocial Support in the Philippines - Draft UNICEF.

WHO/ UNHCR (2012). Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva, WHO and UNHCR.

Annex 3: Detailed recommendations

Review of Stakeholder's Perceived Impact of the inter-agency Guidelines on MHPSS programmes in the field

Recommendation document

This document has been developed in conjunction with the "IASC MHPSS Guidelines Draft Report" authored by the lead reviewer Dr. Sarah Meyer in consultation with Dr. Maryanne Loughry

This review adopted a broad definition of implementation focusing on awareness, utilization, and institutionalization of the Guidelines. The review consisted of interviewing key informants, reviewing relevant academic literature, support documents and grey material, an on-line survey, and the writing up of in-depth and brief case studies of the use of the Guidelines in specific emergency contexts.

Overall findings of the review

The review found that the Guidelines have strengthened the role of MHPSS in emergencies.

- This was attributed to the Guidelines being the product of an interagency process and an IASC product;
- The activities of the Guidelines Reference Group[1];
- The term MHPSS itself which has made more explicit the linkage between mental health and psychosocial actors;
- And the Intervention pyramid which has made more explicit the core principles of the Guidelines.

This document, to be read in conjunction with the "IASC MHPSS Guidelines Report" highlights recommendations and

strategies for further strengthening the awareness, utilization, and institutionalization of the Guidelines.

Awareness of the Guidelines

Overall the review noted that awareness of the Guidelines at Headquarters level, and particularly within agencies represented at the RG, was high. However, the level of awareness of the Guidelines varied widely, and awareness often did not translate to knowledge of the content of the Guidelines. In field contexts, the presence of strong leadership, usually in the form of coordination groups, was considered necessary in order for the awareness of the Guidelines to translate into practices and utilization. A significant gap was identified in awareness-raising activities with local actors, including faith-based organizations.

Strategies identified as necessary for increasing awareness of the MHPSS Guidelines in field contexts:

Suggested Strategies to increase awareness of the Guidelines

OBJECTIVE: To develop further knowledge of the Guidelines by increasing awareness-raising activities and trainings with local **actors** in emergencies as well as disaster-prone and conflict-affected countries.

- Design and conduct orientation workshops for psychiatrists on the Guidelines, with the goal of improving psychiatrists' capacities to act as advocates for those with moderate and severe mental disorders in emergencies, as well as undertaking a public health approach to mental health in emergencies

- Design and conduct orientation workshops for social workers, mental health nurses and other mental health workers on the Guidelines, with the goal of improving their capacity to act as advocates for those with moderate and severe mental disorders in emergencies, as well as undertaking a public health approach to mental health in emergencies.

- Conduct orientation workshops on the Guidelines for faith-based organizations and local municipalities in disaster-prone and conflict-affected countries.

---

1   The objectives of the Guideline Reference Group are as follows:
- To facilitate integration of the core principles of the Guidelines into all sectors of emergency response;
- To foster collaboration amongst agencies and diverse stakeholders (such as governments and communities);
- To support interagency coordination for MHPSS at global, regional and national levels;
- To support interagency activities for MHPSS at global, regional and national levels;
- To develop relevant tools linked to the guidelines and share these with countries;
- To encourage individual agencies to institutionalize the guidelines;
- To promote and support ongoing capacity building to enable effective use of the guidelines;
- To share experiences of implementation among countries;
- To interface with the UN Cluster System to include MHPSS into policies, tools, capacity building and budgets;
- To facilitate printing, dissemination and language translations of the guidelines;

- Design orientation material for new staff in agencies that have a focus on or collaborate with MHPSS in the field
- Develop mechanisms for follow-up after trainings on the Guidelines including how to familiarize trainees on the availability of new resources as they become available
- Develop new forms of dissemination e.g. web-based and social media (see relevant section below) of the Guidelines that can rapidly and effectively orient new fieldworkers to the Guidelines and ensure integration of key principles into MHPSS work and clusters in emergency settings.
- Develop and disseminate a take home resoue of suggested content for brief orientation sessions for all emergency workers
- Develop a training strategy that enables practitioners and policy makers to move from awareness of the existence of the Guidelines through to active engagement with components of the Guidelines and improved awareness of the aspects and areas covered in the Guidelines.
- Encourage centers of learning and training to conduct dedicate training on the Guidelines and/or to incorporate MHPSS training into existing training programmes
- Publication of scholarly articles that reference the Guidelines

OBJECTIVE: To develop further knowledge of the Guidelines by increasing awareness-raising activities and trainings with key clusters in emergencies

- Develop awareness-raising activities for **key clusters**, including child protection, nutrition and health such as workshops, conferences and strategic gatherings;
- Prioritize discussion and development of strategy around cross-cutting issues, including issuing a short MHPSS strategy paper on MHPSS as a cross-cutting issue within the humanitarian system;
- Commission research evidence on the impact of specialized interventions for populations of concern to key clusters where there is a direct relationship with MHPSS such as survivors of SGBV.

OBJECTIVE: To develop further knowledge of the Guidelines with key donors

- Increase advocacy efforts about the Guidelines and their possible use with donors including the hosting of donor focused gatherings;
- Use and reference the Guideline Action Sheets when proposal writing;
- Build on the outcome of the current work on monitoring and evaluation, and common indicators, to influence donor support.

Awareness of the Guidelines through coordination

Throughout the Review the presence of strong leadership, usually in the form of coordination groups, was reported to be a key way through which the awareness of the Guidelines was translate into practices and utilization in emergencies.

Suggested Strategies to further strengthen awareness of the Guidelines through coordination efforts:

- Continue and strengthen the MHPSS Reference Group and its role;
- Provide further guidance on where a MHPSS working group should be ideally located in relation to the cluster system. This could be done through case studies as well as at relevant international gatherings on emergency responses
- In field contexts, ensure the presence of strong leadership, usually in the form of coordination groups, in order for awareness of the Guidelines to translate to practices and utilization;
- Develop and disseminate case studies of effective inter-sectoral MHPSS coordination groups;
- Develop and disseminate materials for different clusters that demonstrate how MHPSS assessments can focus on the role of shelter and site planning, camp management, orientation and access to information, distribution of water and non-food items, and approaches to food and nutrition, in order to emphasize the actions that WASH, shelter, nutrition and other clusters can take in order to reduce stress, encourage community mobilization and support, and improve psychosocial well-being;
- Develop and disseminate materials that give examples of best coordination practice in the field e.g. the inter-agency four-page document developed in the Syria response in Jordan, representing "consensus among the different actors and provides a coherent framework to organizations wishing to fund, develop or implement activities in this field"(MHPSS Working Group, Jordan 2012)
- Develop a policy and practice that facilitates a focal point for MHPSS, deployed by a Reference Group member, to all L3 emergencies, to ensure coordination mechanisms are established;
- Develop a MHPSS roster and fund capacity for deployment of MHPSS experts to support implementation of the Guidelines in emergencies;

Awareness of the Guidelines and related materials and their dissemination

The Guidelines were first disseminated in 2007 when a number of agencies and key actors were highly involved. There are now new actors and settings experiencing disasters and conflict. The Review identified the challenge to engage with these new actors in anticipation of emergencies and also in the midst of emergencies.

Suggested strategies for to increase wider dissemination of the Guidelines and related materials:

- Improve the web presence of the Guidelines, including increased collaboration with mhpss.net and other online platforms
- Regularly update the current IASC MHPSS website (http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_mhps-default). There is an opportunity to use the website as a mode of dissemination of key products, including and beyond the Guidelines.
- Develop short, tailored modules to address key content areas in the Guidelines for orientation trainings, especially in Level 3 emergencies

Utilization and Influence of the Guidelines on programmes and activities in the field

The Review identified a need to have improved monitoring and evaluation mechanisms in place to better assess the impact of MHPSS activities in the field. The content of the Guidelines was based on the empirical literature available at the time of authoring the Guidelines. There is now existing and emerging literature that provides evidence for some of the core principles and actions promoted in the Guidelines. There is also literature that suggests that some current approaches to MHPSS that were not as familiar when the Guidelines were being written.

OBJECTIVE: To enhance the efficacy of the Guidelines in relation to programme development

Suggested Strategies for strengthening the influence of the Guidelines on programme development in the field:

- Strengthen and develop monitoring and evaluation [M and E] frameworks that can demonstrate the impact of common MHPSS activities;
- Further resource the Reference Group's Working Group on Monitoring and Evaluation;
- Strengthen efforts to develop outcomes indicators for MHPSS interventions that can be disseminated across agencies

and throughout the field. Develop and disseminate examples of defined and achievable objectives, and strong indicators for psychosocial programme results;
- Identifying and disseminate examples of best practices of MHPSS programmes;
- Support in-depth case studies that demonstrate implementation of the Guidelines, including field-level data collection, to inform the evidence-base on contextual factors influencing implementation;
- Develop toolkit of options for community-based psychosocial interventions, providing examples of best practices;
- Focus attention to the requests for additional guidance in implementation of the Guidelines to developing off-shoot materials, and building products that respond to the specific needs for more practical guidance;
- Encourage and support agencies (RG members and others) to develop further practical guidance materials based on the Guidelines for their agency;
- Build on the improvements in monitoring and assessment methodologies (WHO/ UNHCR 2012);
- Circulate among Reference Group members literature as it becomes available that demonstrates evidence for specialized interventions
- Commission published research studies on Level 1 and 2 interventions, other than the impact of child-friendly spaces in emergency settings. In the area of Level 1 and 2 (and some Level 3) interventions, and those commonly classified as primarily psychosocial, further guidance needs to be given on a selection of appropriate interventions for these levels;
- Develop structured collaboration between an academic institution and humanitarian agencies, as a means towards improving the evidence-base and strengthening the capacity of humanitarian agencies to implement effective MHPSS activities;
- Within agencies engage with relevant programme design staff using Guidelines as an instrument to ensure that the programming reflected the principles of the Guidelines;
- Create training material that maps the general principles in the Guidelines with intervention material that could be used. Both the mhGAP Intervention Guide and Psychological First Aid training packages highlight very concrete actions that can be implemented and used.

Institutionalization of the Guidelines

Many of the Reference Group members interviewed in the review reported significant efforts have been made within their agencies to develop and disseminate policies, adapting the Guidelines to the specific mandates and activities of their agency. This effort

has not been replicated in all relevant agencies.

OBJECTIVE: To institutionalize the Guidelines within relevant humanitarian agencies and Governments

Suggested Strategies for institutionalizing the Guidelines across relevant humanitarian agencies:

- Develop institutionalization checklists for humanitarian agencies, donors, and Governments. The Reference Group commenced work on the Institutionalization of the Guidelines in 2010. (See attached document). This earlier work could be modified and built upon by the present Reference Group;
- Encourage the Human Resources department of humanitarian agencies to include knowledge of and experience with using the Guidelines in job descriptions. Previous experience using the Guidelines, and capacity to discuss components of the Guidelines should be key expectations of new staff that are hired to MHPSS positions;
- Recommend to relevant agencies that they appoint a dedicated MHPSS specialist, technical advisor or unit at Headquarters level;
- Actively work with key agencies to incorporate reference to the Guidelines in their internal Policy and Procedures Handbooks (See UNHCR Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations, 2013 as an example)

The need to revise the present Guidelines

While not a question for the present review of the Guidelines, two distinct perspectives were heard throughout the review regarding the present status of the Guidelines. One perspective was that the Guidelines should be revised so as to meet the needs of the field by providing more prescriptive guidance. The alternative perspective was to keep the Guidelines as they are as and to develop more prescriptive add-on material.

Suggested strategies for reviewing whether the Guidelines need to be revised

In the light of the Review determine a suitable process for considering whether the Guidelines need to be revised at this time.

Is consideration of a revision of the Guidelines consistent with IASC practice?

If there were to be consideration of a revision:

- Who should be part of this process?
- What would be a suitable timeline?

Emerging from this review are questions that could be considered when making the decision as to whether to revise the Guidelines. These include:

- What should be the format of the Guidelines today and do the present Guidelines represent this format?
- What role should Guidelines play? Should they be more a reflection of principles or should they be more prescriptive of best practice?
- In the light of social media and on-line platform development how should Guidelines be disseminated in the future?
- Has the nature and frequency of emergencies have changed to such a degree that the present Guidelines need to be revised so as to be relevant to today's emergencies?
- The language and concepts in humanitarian work, psychology, mental health and MHPSS programming has evolved significantly since 2007. The present Guidelines do not reflect these changes. In the future how can the Guidelines reflect and incorporate present good practice?
- Since 2007 when the Guidelines were written other relevant materials including the Child Protection Minimum Standards have been written. These materials are more prescriptive in nature and are much appreciated by those requesting more explicit guidance in the field. Should the Guidelines now be more prescriptive?

Annex 4: Report from on-line survey

1. Participant Information

Participants responded from 35 countries (N=67). The largest segment was from the USA (16.7%), followed by Syria/Turkey (9.8%), Jordan (6.9%), Sweden (5.6%), and the State of Palestine (4.2%), with the remaining respondents totaling fewer than 3 per country.

Respondents' primary organizations (N=71) included UN Agency (42.3%), INGO (26.8%), NGO (15.5%), University/Institute of Higher Learning (8.5%), Government Agency (1.4%) or Other (5.6%).

Respondents' primary roles included Technical (45.1%), Managerial (16.9%), Advisory (11.3%), Field Level Implementation (8.5%), Research/Evaluation (8.5%), Trainer (4.2%) or Other (5.6%) which included coordination and psychological attention in emergency.

Participants were asked to estimate the percentage of their job related to mental health and psychosocial support in emergencies. Responses ranged from 0.0% to 100.0%, with an average of 56.0% (SD=34.3%), a median of 60.0% and a mode of 100.0%.

2. Familiarity with Guidelines

Respondents first learned about the guidelines from a variety of sources (N=68), including orientation within their agencies (30.9%), Training/education (26.5%), and website/internet (22.1%). Several indicated other sources (20.6%), including being part of planning and development of the guidelines, and learning about the guidelines from colleagues.

3. Use of Guidelines

Respondents indicated a number of ways they use guidelines in their work (N=72; see Figure 1).

Figure 1. Use of Guidelines
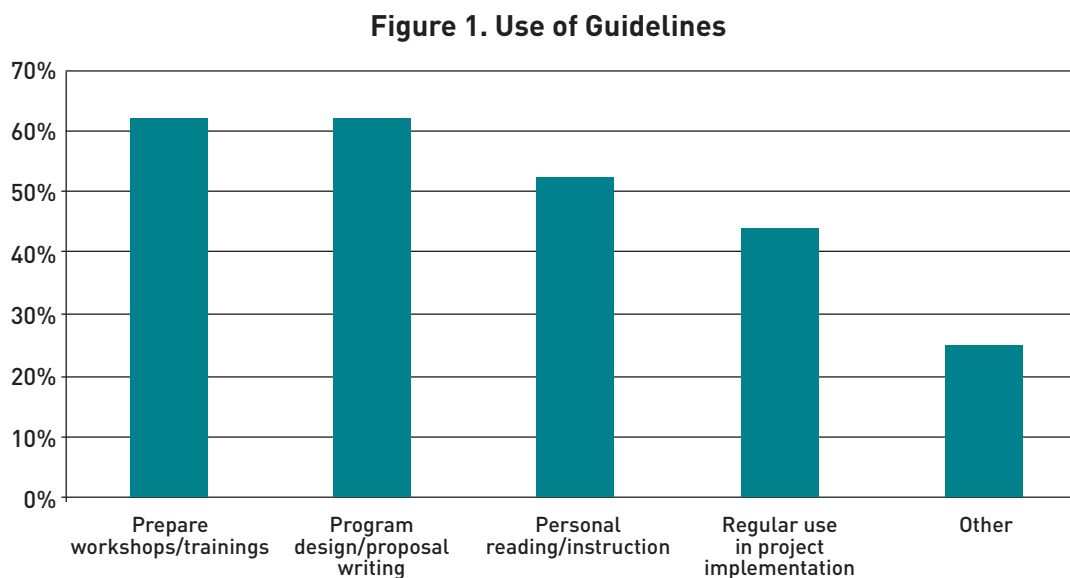
The majority of respondents use the guidelines to prepare workshops/trainings (62.5%) and for programme design or proposal writing (62.5%). Just over half use the guidelines for personal reading and instruction (52.8%) and less than half use them regularly in project implementation (44.4%). A quarter of respondents (25.0%) indicated they use the guidelines for other purposes, such as advocacy, consultation, and planning.

The patterns of uses of guidelines are presented in Table 1 below, which includes all possible combinations of responses. Nearly a quarter (23.6%) selected all categories. Those who did not use the guidelines for workshops or trainings were more likely to use the guidelines for personal reading (9.7%) or Programme Design (6.9%).

| Table 1. Use of Guidelines (N=72)	N	%
Workshops + Programme Design + Personal Reading + Regular Use	17	23.6
Workshops + Programme Design + Personal Reading	4	5.6
Workshops + Programme Design + Regular Use	7	9.7
Workshops + Personal Reading + Regular Use	0	0.0
Workshops + Programme Design	5	6.9
Workshops + Personal Reading	6	8.3
Workshops + Regular Use	1	1.4
Workshops	5	6.9
Programme Design + Personal Reading + Regular Use	1	1.4
Programme Design + Personal Reading	3	4.2
Programme Design + Regular Use	3	4.2
Programme Design	5	6.9
Personal Reading + Regular Use	0	0.0
Personal Reading	7	9.7
Regular Use	3	4.2
None Selected	5	6.9
TOTAL	72	100.0

Figure 2 presents results for the 45 respondents who indicated they used the guidelines for workshop/training purposes. About 46% reported training partner agency staff, followed by 42% of respondents' agency staff, 33% for government agency partners, 24% for students and interns, and 10% for other, including cluster members, donors, non-specialized workers, and school instruction.

Figure 2. Training Recipients
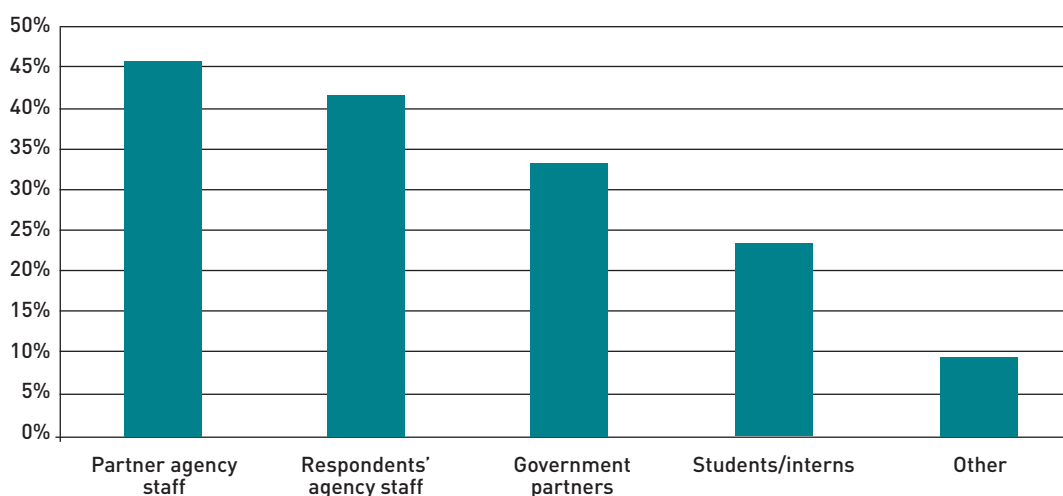
The survey asked respondents (N=72) about the form in which they use the guidelines (see Figure 3). Nearly 70% use a paper or hard copy, and 60% use an electronic copy. 25 of respondents indicated using both these formats (34.7%). Only 4 people (5.6%) stated they used a CD-Rom version and 2 people selected other (2.8%).

Figure 3. Format of Guidelines
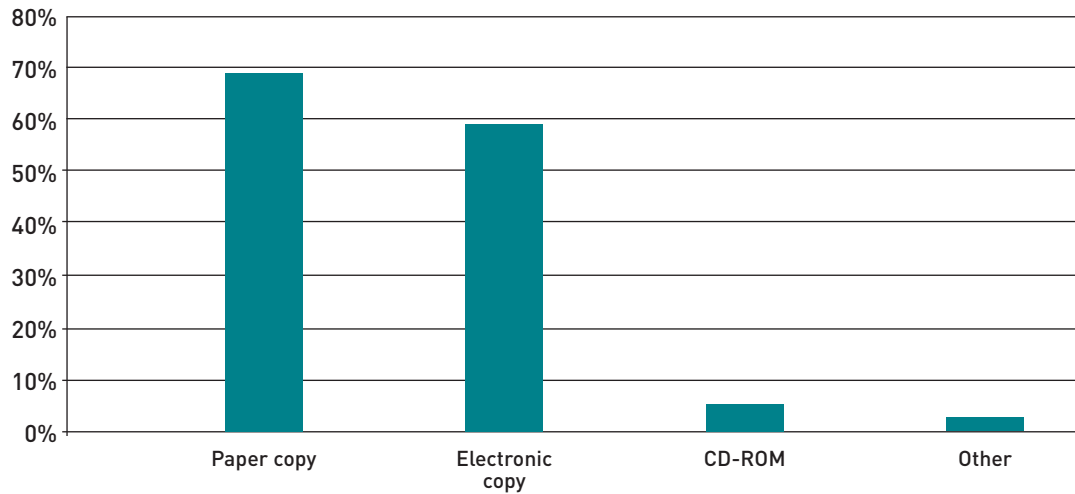
4. Supplementary Tools

Respondents were asked to select which of the supplementary tools accompanying the guidelines they use (see Figure 4). 48.6% indicated using the "Checklist for Field Use" and "The 4W's" respectively, followed by 38.9% for "What Should Humanitarian Health Actors Know," 36.1% for "What Should Protection Programme Managers Know," 15.3% for "What Should Camp Co-ordination and Camp Management Actors Know," and 15.3% stated they used none of the tools.
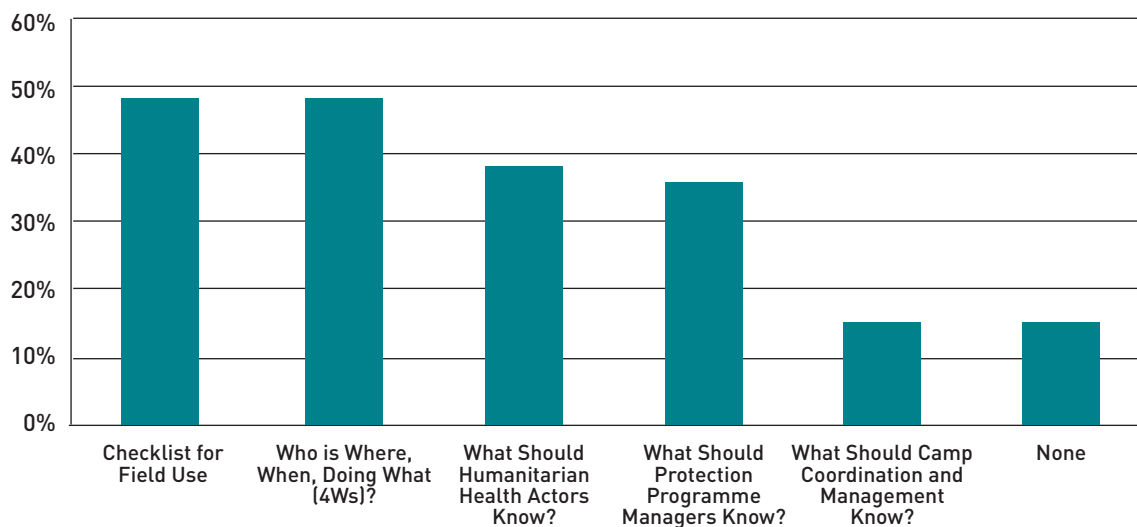
Figure 4. Supplementary Tools

Table 2, below, displays all possible combinations of how respondents could use the supplementary tools, and these patterns show a wide variety in how these tools are used. The largest percentage (22.0%) reported using none of the tools. Eight respondents (11.0%) indicated using the 4Ws only, and 6 (8.3%) reported using the Checklist only. Seven respondents (9.7%) reported using all of the tools except "What Should Camp Coordination and Management Know", and 5 respondents (6.9%) reported using all of the tools together. The remaining responses fell across other categories at a rate between 0 and 4.

Table 2. Use of Supplementary Tools (N=72)*	N	%
4Ws + CCCM + HHA + CHK + PPM	5	6.9
4Ws + CCCM + HHA + CHK	0	0.0
4Ws + CCCM + HHA + PPM	2	2.8
4Ws + CCCM + CHK + PPM	0	0.0
4Ws + CCCM + HHA	0	0.0
4Ws + CCCM + CHK	1	1.4
4Ws + CCCM + PPM	0	0.0
4Ws + CCCM	0	0.0
4Ws + HHA + CHK + PPM	7	9.7
4Ws + HHA + CHK	4	5.6
4Ws + HHA + PPM	0	0.0
4Ws + HHA	2	2.8
4Ws + CHK +PPM	3	4.2
4Ws + CHK	3	4.2
4Ws + PPM	0	0.0
4Ws only	8	11.0
CCCM + HHA + CHK + PPM	1	1.4
CCCM + HHA + CHK	1	1.4
CCCM + HHA + PPM	0	0.0
CCCM + CHK + PPM	0	0.0
CCCM + CHK	1	1.4
CCCM + PPM	0	0.0
CCCM only	0	0.0
HHA + CHK + PPM	0	0.0
HHA + CHK	1	1.4
HHA + PPM	2	2.8
CHK + PPM	2	2.8
HHA only	3	4.2
CHK only	6	8.3
PPM only	4	5.6
None Selected	16	22.0
TOTAL	72	100.0

* Acronyms are as follows:

4WS Who is Where, When, Doing What in Mental Health and Psychosocial Support?

CCCM What Should Camp Coordination and Camp Management Actors Know?

HHA What Should Humanitarian Health Actors Know?

CHK Checklist for Field Use

PPM What Should Protection Programme Managers Know?"

5. Perceived Impact

Respondents were asked to rate their perceptions of how the Guidelines have impacted Mental Health and Psychosocial Support in Emergencies (MHPSE), using 3 items on a 5-point Likert scale. Respondents indicated that the Guidelines have improved MSPSE (87.7% agree or strongly agree, mean rating = 4.1 out of 5.0, standard deviation = 0.6) (see Table 3). Respondents also agreed that the Guidelines improved the efficacy of humanitarian programmes in emergencies (M=3.9, SD=0.8) although fewer agreed to this item (72.0% agree or strongly agree) compared with perceptions of overall improvement. Respondents rated similarly that the Guidelines facilitated integration of MHPSE in other sector programmes (M=3.8, SD=0.8, 71.9% agree or strongly agree).

Table 3. Perceived Impact of Guidelines	N	Range	Mean (SD)	% Agree or Strongly Agree
The Guidelines Improved Mental Health and Psychosocial Programming in Emergencies	57	2-5	4.1 (0.6)	87.7%
The Guidelines Improved the Efficacy of Humanitarian Programmes in Emergencies	57	2-5	3.9 (0.8)	72.0%
The Guidelines Facilitated the Integration of Mental Health and Psychosocial Concerns in Other Sector Programmes	57	2-5	3.8 (0.8)	71.9%

6. Levels of Institutionalization

Respondents were asked to rate their perceptions of the extent to which the Guidelines have been integrated into their organizations, using 4 items on a 5-point Likert scale (see Table 4). Most agreed that the Guidelines are incorporated into their agencies' policies and procedures (M=3.8, SD=1.1, 73.2% agree or strongly agree) and fewer believed that the Guidelines are only used in MHPSE programmes (M=3.5, SD=1.1, 60.7% agree or strongly agree). However, only a third of respondents believed that the Guidelines are incorporated into agency human resources policies and procedures (32.1%), and a similar low number believed that the Guidelines are integrated into all programmes within agencies (32.5%).

Table 4. Perceived Levels of Institutionalization of Guidelines	N	Range	Mean (SD)	% Agree or Strongly Agree
The Guidelines are Incorporated into Your Agency's Policies and Procedures	56	1-5	3.8 (1.1)	73.2%
The Guidelines are Used in Mental Health and Psychosocial Support Programmes Only	56	1-5	3.5 (1.1)	60.7%
The Guidelines are Incorporated into Your Agency's Human Resources Documentation and Practices	49	1-5	3.1 (1.1)	32.1%
The Guidelines are Integrated Into All Projects and Programmes in my Agency	53	1-5	3.0 (1.1)	35.7%

7. Ideas for Improvement

Respondents were asked about their ideas for improvement through 1 5-point Likert scale item (see Table 5), and 2 open-ended questions which asked the following: (1) "What additional information would have made the guidelines more useful to you?" and (2) "Any other comments on the guidelines?"

Most respondents agreed that they found what they needed within the Guidelines (75.9%; see Table 5) although some variability existed. Open-ended comments revealed specific critiques and suggestions for improvement.

Table 5. Ideas for Improvement				
	N	Range	Mean (SD)	% Agree or Strongly Agree
I Found What I Needed Within the Guidelines to Provide Mental Health and Psychosocial Support in Emergency Settings	54	1-5	3.8 (0.9)	75.9%