



MANUAL ON
COMMUNITY-BASED
MENTAL HEALTH AND
PSYCHOSOCIAL SUPPORT
IN EMERGENCIES
AND DISPLACEMENT

The opinions expressed in the report are those of the authors and do not necessarily reflect the views of the International Organization for Migration (IOM). The designations employed and the presentation of material throughout the report do not imply expression of any opinion whatsoever on the part of IOM concerning legal status of any country, territory, city or area, or of its authorities, or concerning its frontiers or boundaries.

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental organization, IOM acts with its partners in the international community to: assist in the meeting of operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

This publication was made possible through the support provided by USAID - Office of U.S. Foreign Disaster Assistance (OFDA).

Publisher: International Organization for Migration
17 route des Morillons
P.O. Box 17
121 Geneva 19
Switzerland
Tel.: +41 22 717 9111
Fax: +41 22 798 6150
Email: hq@iom.int
Website: www.iom.int

Cover photo: Self-portrait elaborated by a Nigerian IDP and psychosocial worker, during a five-day workshop on autobiographical models through art, organized by IOM in Maiduguri, Nigeria @IOM 2018/Rola Soulheil.

ISBN 978-92-9068-784-9

© 2021 International Organization for Migration (IOM)

Suggested citation:

IOM (2021), *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement*. IOM, Geneva.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise without the prior written permission of the publisher.



Workshop on autobiographical models through art, organized by IOM in Maiduguri, Nigeria. © IOM 2018/Rola SOULHEIL

- ➔ ABBREVIATIONS
- ➔ ACKNOWLEDGEMENTS
- ➔ INTRODUCTION
- ➔ CHAPTER 1. CONCEPTS AND MODELS OF WORK
- ➔ CHAPTER 2. ENGAGING WITH COMMUNITIES
- ➔ CHAPTER 3. ASSESSMENT AND MAPPING
- ➔ CHAPTER 4. PSYCHOSOCIAL MOBILE TEAMS
- ➔ CHAPTER 5. SOCIORELATIONAL AND CULTURAL ACTIVITIES
- ➔ CHAPTER 6. CREATIVE AND ART-BASED ACTIVITIES
- ➔ CHAPTER 7. RITUALS AND CELEBRATIONS
- ➔ CHAPTER 8. SPORT AND PLAY
- ➔ CHAPTER 9. NON-FORMAL EDUCATION AND INFORMAL LEARNING
- ➔ CHAPTER 10. INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN CONFLICT TRANSFORMATION AND MEDIATION
- ➔ CHAPTER 11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT
- ➔ CHAPTER 12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION
- ➔ CHAPTER 13. COUNSELLING
- ➔ CHAPTER 14. COMMUNITY-BASED SUPPORT FOR PEOPLE WITH SEVERE MENTAL DISORDERS
- ➔ CHAPTER 15. TECHNICAL SUPERVISION AND TRAINING
- ➔ CHAPTER 16. MONITORING AND EVALUATION
- ➔ ANNEX 1. INTER-AGENCY COORDINATION
- ➔ ANNEX 2. ETHICAL CONSIDERATIONS
- ➔ ANNEX 3. GBV CONSIDERATIONS
- ➔ BIBLIOGRAPHY

ABBREVIATIONS

4Ws	Who is Where, When and doing What
AAD	adversity-activated development
AAP	accountability to affected populations
CB MHPSS	community-based mental health and psychosocial support
CCCM	camp coordination and camp management
ECHO	European Commission Humanitarian Aid Office
GBV	gender-based violence
HIG	Humanitarian Intervention Guide
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IDP	internally displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
INEE	International Network for Education in Emergency
IOM	International Organization for Migration
IPT	interpersonal therapy
MEAL	monitoring, evaluation, accountability and learning
mhGAP	Mental Health Gap Action Programme
MHPSS	mental health and psychosocial support
MNS	mental, neurological and substance use
NGO	non-governmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PFA	psychological first aid
PMT	psychosocial mobile team
PTSD	post-traumatic stress disorder
RSL	religious and spiritual leader
SFBT	solution-focused brief therapy
SMART	specific, measurable, attainable, relevant and time-bound
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

ACKNOWLEDGEMENTS



The *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement* was developed by the International Organization for Migration's (IOM's) Mental Health, Psychosocial Response and Intercultural Communication Section; field-based managers and coordinators of IOM's and other agencies' mental health and psychosocial support (MHPSS) programmes in emergencies; members of the Steering Committee, including representatives from academia, United Nations agencies, international organizations, non-governmental organizations (NGOs), donor agencies and individual experts; and the co-chairs and various members of the Inter-Agency Standing Committee (IASC) Reference Group for MHPSS in Emergency Settings, particularly the subgroup on Community-Based Mental Health and Psychosocial Support (CB MHPSS) Programming. Additionally, the first draft was reviewed in field workshops conducted with field-based MHPSS managers and focal points of several agencies currently engaged in MHPSS programmes in north-eastern Nigeria (Maiduguri) and Iraq (Erbil).

Editor: Guglielmo Schininà (IOM).

Editorial support: Roza Copper, Michael Gibson, Valerie Hagger (IOM), Natalia Hortigüela Gallo (IOM), Renato Libanora (IOM), Leslie Snider and Emmanuel Streel.

Steering Committee members: Bashir Aboubakar (IOM Nigeria), Mazen Aboul Hosn (IOM Turkey), Nadia Akmoun (IOM Headquarters), Kathy Angi (Action by Churches Together), Tatsushi Arai (School for International Training), Amal Ataya (IOM Nigeria), Nancy Baron (Psycho-Social Services and Training Institute in Cairo (PSTIC), Pauline Birot (IOM Ethiopia), Antonio Bottone (IOM Lebanon), Martha Bragin (Silberman School of Social Work at Hunter College, City University of New York), Maria Bray (Terre des Hommes, IASC CB MHPSS Working Group), Elaine Duaman Joyce (IOM South Sudan), Fahmy Hanna (World

Health Organization (WHO), Co-Chair of the IASC MHPSS Reference Group), Sarah Harrison (International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre on Psychosocial Support, Co-Chair of the IASC MHPSS Reference Group), Zeinab Hijazi (United Nations Children's Fund (UNICEF), Co-Chair IASC CB MHPSS Working Group), Renato Libanora (IOM Iraq), Christopher Maclay (Mercy Corps), Chissey Mueller (IOM Headquarters), Renos Papadopoulos (University of Essex), Marine Ragueneau (IOM Brussels), Olga Rebolledo (IOM Cox's Bazar), Alessandra Rossi Ghiglione (University of Turin), Monica Noriega (IOM Headquarters), Jack Saul (International Trauma Studies Program, New York), Marian Tankink (Consultant), Peter Ventevogel (Office of the United Nations High Commissioner for Refugees (UNHCR)) and Alys Willman (World Bank).

Adjunct participants to Steering Committee: Chiara Giusto (European Commission Humanitarian Aid Office (ECHO)), Katharina Montens (GIZ Berlin), Elizabeth Stickman (United States Agency for International Development (USAID) Office for United States Foreign Disaster Assistance (OFDA)), Sharon Weinblum (ECHO) and Ann Willhoite (USAID).

FEEDBACK PROCESS

After its initial review in workshops in Iraq and Nigeria, the Manual underwent a year-long feedback process in 2020 to increase the effectiveness and relevancy of the Manual's contents, improve its usability for readers, and expand the resources proposed. Through the valuable feedback IOM received, the Manual was updated throughout the year and is now in its final edition. IOM thanks the Manual's Steering Committee and the following contributors for participating in the feedback process.

Feedback contributors:

Yaasmiin Abdicasis Osman (International

Organization for Migration (IOM)), Abdikadir Abdifitah (IOM), Abdifitah Abdikadir Jama (IOM), Amira Abdillahi Hassan (IOM), Hazim Abdulkarim (Premiere Urgence Internationale, PUI), Ghadah Abdullah (IOM), Thekra Ahmed (Mental Health Centre), Abdikadir Ahmed Gelle (IOM), Huda Ahmed Ismail (IOM), Hatem Alaa Marzouk (IOM), Lekaa Albakour (IOM), Ibrahim Al Dah (IOM), Hannatu Alh. Adamu (Borno Women Development Initiative (BOWDI)), Sandra Alhassany (IOM), Said Almadhoun (United Nations Human Rights Office of the High Commissioner (OHCHR)), Cassandre Amah (IOM), Asaph Andrew Rufi (Center for Community and Health Development International (CHAD)), Laura Anna Assman (IOM), May Aoun (Save the Children), Sonya Armaghanyan (IOM), Luther Atinya (International Medical Corps (IMC)), Ioannis Avdoulas (IOM), Japhet Ayele (Save the Children International (SCI)), Omar Aynte Abdirahman, Yenehun Azie Ashagrie (United Nations Population Fund (UNFPA)), Natalie Barillier (Yazda), Manjula Barnabas (IOM), Anna Bazelkova (IOM), Amira Beyer (IOM), Nadine Blankvoort (Amsterdam University of Applied Sciences, Maastricht University, OT-Europe), Tarryn Brown (IOM), Blandine Bruyère (IMC), Laura Carrillo, Hana Chakhari (International Rescue Committee (IRC)), Mona Chahla (World Vision International), Gulistan Chalabi (IOM), Christopher Chinedumuije Oguegbu (Goal Prime Organization Nigeria (GPON)), Matthew Conway (IOM), Rayane Dagher (IOM), Abeer Daham (INTEROS), Noemi Damasceno (PUI), Saido Daowwd Ali (Jesuit Refugee Service), Luzwellah Diaca (IOM), Ilova Dorylane Lorenzo (IOM), Amara Edeh (INTEROS), Sara El Hassrouny (IOM), Oya Erbas (IOM), Mary Everesta Lambert (IOM), Derya Ferhat (IOM), Emmanuel Gadzama (IRC), Wandanje Gaja Yohanna (IOM), Nemam Ghafouri (Swedish Charity Organization), Luana Giardinelli, Rawan Hamid, Homa Hasan (IOM), Kim Hwahyun (IOM), Reuben Ibaishwa (Street Child), Kennedy Ikwe (IOM), Giorgos Ioannou (IOM), MD. Saiful Islam (IOM), James Izang (Médecins du Monde (MDM)), Bryar

Jabbar Bagg (Green Desert), Nastazia Jabbour (IOM), Desalew Jember Tesema, Saleem Jemeen (IOM), Theresa Jones, Hana Jumah (IOM), Jonas Kambale (Transcultural Psychosocial Organization (TPO)), Robert Kakrah Ketor (IOM), Kateryna Katrashchuk (Step IN), Emre Karaçaylı (IOM), Rima Kilani (IOM), Edwige Kouamen, Ksenia Kubasova, Augustine Lambert (IOM), Mary Lambert (IOM), Nivethana Lazarus (IOM), Amira Magan, Shoeb Mahmud (IOM), Lyanna Matala (IOM), Maria Margarita Theocharopoulou (IOM), Mariam Moawi (IOM), Marwan Mohammed (Un Ponte Per (UPP)), Hodan Mohamoud Hassan (IOM), Mohammad Mousa (IOM), Walaa Musheer Ahmed (Better World Organization for Community Development), Fakhria Naistani (IOM), Dmytro Nersisian (IOM), Emile Ntampera (United Nations International Children's Emergency Fund (UNICEF)), Argiro Ntrouva (IOM), Moses Nyam (PUI), Khalil Omarshah (IOM), Burak Ozkan (IOM), Panagiota Papaioannou (IOM), Lia Pastorelli (UPP), Anoop Poudel, Ravindra Prasad Manathunge (IOM), Mustafa Qasim (Norwegian Church Aid), Ali Raad, Ali Ridvanogullari (IOM), Sarah Rizk (IOM), Simon Rosenbaum (UNSW, Australia), Maha Sabsaby (IOM), Sozan Safar (Dak Organization for Ezidi Women Development), Nour Said (IRC), Moe Saito (IOM), Suseeka Sandrasekaram (IOM), Erika Sasy Lumanta (IOM), Nino Shushania (IOM), Philippa Smith (IOM), Fadia Soheal (IMC), Maria Sonia Lopez (IOM), Ilknur Sonmez (IOM), Nemam Sophia Geroy (IOM), Fani Stampouli (IOM), Samuel Tarfa (WHO), Hizrat Tayib (Bishkoreen for the Development of Woman and Child), Bem Tivkaa (Neem Foundation), Kalypso Totti (IOM), Maya Tucker (IOM), Panagiotis Tzourakis (IOM), Abuhuraira Umar (IOM), İrem Umuroglu (IOM), Kosalina Vignarajah (IOM), Ursula Wagner (IOM), Fekadu Wakjira (UNICEF), Dennis Wani (IOM), Cafer Yuksek (IOM).

Thanks also to Catherine Panter-Brick (Yale University) and her collaborators for reviewing the chapters Assessment and mapping, and Monitoring and evaluation, and Alena Huss for supporting in compiling the bibliography.

Main authors per chapter:

Introduction: Introduction: Guglielmo Schininà;

Chapter 1. Concepts and models of work:

Guglielmo Schininà, Renos Papadopoulos and Jack Saul;

Chapter 2. Engaging with communities:

Marian Tankink, Guglielmo Schininà and Renato Libanora;

Chapter 3. Assessment and mapping:

Marian Tankink, Guglielmo Schininà, Emmanuel Streel and Renato Libanora;

Chapter 4. Psychosocial mobile teams:

Guglielmo Schininà and Emmanuel Streel;

Chapter 5. Sociorelational and cultural

activities: Guglielmo Schininà, Pauline Birot, Elaine Duaman Joyce and Natalia Hortigüela Gallo;

Chapter 6. Creative and art-based activities:

Guglielmo Schininà and Alessandra Rossi Ghiglione;

Chapter 7. Rituals and celebrations:

Renato Libanora, Kathy Angi and Guglielmo Schininà;

Chapter 8. Sport and play:

Maria Bray, Serena Borsani and Raphaële Catillion;

Chapter 9. Non-formal education and informal

learning: Sylvain Fournier;

Chapter 10: Integration of mental health and psychosocial support in conflict transformation

and mediation: Tatsushi Arai, Marine Ragueneau and Guglielmo Schininà;

Chapter 11. Integrated mental health and psychosocial support, and livelihood support:

Alys Willman and Christopher Maclay;

Chapter 12. Strengthening mental health and psychosocial support in the framework

of protection: Chissey Mueller, Nadia Akmoun, Guglielmo Schininà and Renato Libanora;

Chapter 13. Counselling:

Jack Saul and Guglielmo Schininà;

Chapter 14. Community-based support for people with severe mental disorders:

Theresa Jones, Guglielmo Schininà, Peter Ventevogel, Fahmy Hanna;

Chapter 15. Technical supervision and training:

- Technical supervision: Ann Willhoite, Martha Bragin and Roberto Biella Battista;

- Training: Guglielmo Schininà and Nancy Baron;

Chapter 16. Monitoring and evaluation:

Martha Bragin and Emmanuel Streel;

Annex 1. Inter-agency coordination:

Renato Libanora, Sarah Harrison and Guglielmo Schininà;

Annex 2. Ethical considerations:

compiled by Natalia Hortigüela Gallo;

Annex 3. GBV considerations:

Louise O'Shea, Victoria Nordli, Alisha Kalra, Natalia Hortigüela Gallo, Heide Rieder, Gladys Cherutos Kios and Guglielmo Schininà.

INTRODUCTION

Father-daughter recreational activity organized by IOM Psychosocial Mobile Teams, Gaziantep, Turkey. © IOM 2019



The present Manual aims to facilitate mental health and psychosocial support (MHPSS) experts and managers in designing, implementing and evaluating community-based MHPSS (CB MHPSS) programmes, projects and activities for emergency-affected and displaced populations in humanitarian settings. It is specifically designed to support managers and experts hired by the International Organization for Migration (IOM). However, it can also be used, in its entirety or in some of its components, by MHPSS experts and managers working for IOM's partners, including international and national governmental organizations, non-governmental organizations (NGOs), countries, donors and civil society groups. For this reason, the document is open source, refers to tools and researches of different agencies, and was conceived and reviewed by a variety of experts and practitioners from several **organizations**. Although it is written for an international intergovernmental organization, smaller non-governmental agencies can make use of parts of the manual, based on identified priorities of their own programmes.



WHY A MANUAL ON COMMUNITY-BASED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCY AND DISPLACEMENT

There has been a call in recent years to shift the focus of MHPSS programmes in emergencies from psychological symptoms, and their treatment and prevention, to collective and contextual elements of consequences of adversities. This includes the understanding of the importance of the collective reactions to adversity and of social cohesion, social supports, identities and social textures in determining individual and social well-being after disasters. It also includes the activation of context-specific, multidisciplinary support systems that build on existing strengths of affected communities, rather than limiting the intervention to the provision of services to respond to the deficits created by the emergency. In 2019, the Inter-Agency Standing Committee (IASC) Reference Group on MHPSS issued *Community-Based Approaches to MHPSS Programmes: A Guidance Note* (IASC, 2019a) to respond to this widely perceived need. The guidance aims at better defining principles of MHPSS in emergencies based on the understanding:

Box 1

Institutional background

IOM's engagement in MHPSS stems from the *IOM Migration Crisis Operational Framework* (2012a), which includes psychosocial support as one of the 15 priority areas of IOM's intervention in humanitarian and migration crises. The pursuit of the most attainable standards of health and psychological well-being of migrants and displaced populations is enshrined in both the United Nations *Global Compact for Safe, Orderly and Regular Migration* (2018) and the United Nations *Global Compact on Refugees* (2018). The Sustainable Development Goals, from the United Nations **2030 Agenda for Sustainable Development**, call for universal mental health care and psychosocial support that leave none behind, including migrants and refugees.

...that communities can be drivers for their own care and change and should be meaningfully involved in all stages of MHPSS responses. Emergency-affected people are first and foremost to be viewed as active participants in improving individual and collective well-being, rather than as passive recipients of services that are designed for them by others. Thus, using community-based MHPSS approaches facilitates families, groups and communities to support and care for others in ways that encourage recovery and resilience. These approaches also contribute to restoring and/or strengthening those collective structures and systems essential to daily life and well-being. An understanding of systems should inform community-based approaches to MHPSS programmes for both individuals and communities (IASC, 2019a).

This Manual aims to give operational and programmatic indications on how to make this happen within IOM MHPSS programmes, and those of partners working with relatable populations in similar contexts.

Box 2

Complementary resources

The Manual is complementary – not alternative – to a series of related tools, including:

- (a) **The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007);**
- (b) **The IASC Community-Based Approaches to MHPSS Programmes: A Guidance Note (IASC, 2019a),** available in **Arabic, French, Portuguese, Spanish and Urdu;** and its accompanying **webinar;**
- (c) **The United Nations Children's Fund (UNICEF) Operational Guidelines: Community-Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-Tiered Support for Children and Families (UNICEF, 2018);**
- (d) **The United Nations Children's Fund (UNICEF) Compendium of Community-Based MHPSS Resources (UNICEF, 2021).**

It differs from those in that it is a programmatic manual and not a guideline or compendium, and is not age- or gender-specific. Reference will be made to the above-mentioned tools throughout the Manual.

than 70 countries worldwide. Based on its experiences and engagements, the Organization has developed holistic and systemic practices of MHPSS that are community based. Community is indeed a central concept in the Organization's MHPSS approach, due to its mandate and target populations. The psychosocial well-being of migrants is indeed strongly linked to factors that are strictly interrelated with the concept of community. These include a sense of belonging, social roles, culture and cultural adaptation, the dynamic between tradition and change, differences in paradigms of social support, a sense of identity, and in-group and out-group relations and stigma.

For many years, the harmonization of IOM MHPSS programmes in emergencies has been based on face-to-face trainings for the IOM experts and managers, but this approach has proved difficult to sustain, unless accompanied by a factual manual. From the one side, requests for MHPSS programmes have increased dramatically in the last few years, making it difficult to deploy managerial and expert teams that are already trained, or to train the deployed teams in a timely manner. On the other side, the need for a manual that could instruct newly hired managers and experts in the various steps of setting up a CB MHPSS programme with displaced populations has emerged in the evaluation of several IOM MHPSS programmes in emergencies, such as those in **Libya** in 2013 and the Syrian Arab Republic in 2016.

The Manual can be used by:

- IOM managers, to be instructed on IOM's approach to CB MHPSS programming;
- Managers and experts in the wider MHPSS community, to respond to the need to identify and harmonize practices of CB MHPSS.

IOM has provided MHPSS to emergency-affected, migrant, displaced, returnee populations and host communities since 1999, in more

Box 3

Background knowledge

IOM, as with most agencies, hires MHPSS experts and MHPSS programme managers based on relevant academic background and prior experience in relatable programmes. This Manual is therefore designed with an expert reader in mind, although anyone engaging with MHPSS in an emergency could find it of use.



HOW THE MANUAL IS ORGANIZED

The Manual has three versions:

- A printed version that contains only essential knowledge;
- A PDF version that complements the printed version, and contains more in-depth readings, annexes and hyperlinks; and
- A web-based version, that can be found [here](#). This version will be a living document and will be regularly updated based on new research, identified best practices and feedback from the field.



The Manual is organized into **16 chapters and three annexes**. The first chapter introduces concepts, models and principles of CB MHPSS work; the other chapters are operational and programmatic. These chapters are of two types:

- Those that have to do with the process of a CB MHPSS programme:
 - Engaging with communities;
 - Assessing and mapping;
 - Psychosocial mobile teams;
 - Technical supervision and training;
 - Monitoring and evaluation;
 - Plus two annexes on coordination and ethical considerations.
- Those that introduce specific CB MHPSS activities:
 - Sociorelational and cultural activities;
 - Creative and art-based activities;

- Rituals and celebrations;
- Sport and play;
- Non-formal education and informal learning;
- Integration of mental health and psychosocial support in conflict transformation and mediation;
- Integrated mental health and psychosocial support, and livelihood support;
- Strengthening mental health and psychosocial support in the framework of protection;
- Counselling;
- Community-based support for people with severe mental disorders.

Each chapter:

- Provides a short theoretical background.
- Lists essential information on the topic useful for managers. This can include the mapping out of the activity against the various tiers of the IASC pyramid of MHPSS.
- Describes step-by-step the process that needs to be undertaken by an MHPSS manager to allow the implementation of the relevant activity in a community-based fashion.
- Refers to the relevant points of the IASC *Community-Based Approaches to MHPSS Programmes: A Guidance Note*.
- Presents examples and best practices.
- Refers to relevant internal and external tools, models of work and case studies. These are hyperlinked and can be directly accessed with a simple click.
- Identifies challenges.
- Provides a short list of additional readings, on the top of the articles and tools already hyperlinked in the text.

No chapter provides financial, logistical or other administrative indications that are embedded in each agency's rules and regulations.

The Manual can be read in its entirety, or by a single chapter of interest. Indeed, each chapter

contains internal hyperlinks, bringing the reader with a click to parts of other chapters that are to be read to comprehend the issues at stake. Each chapter can be read autonomously, making use of the hyperlinks.

The Manual contains three kinds of hyperlinks:

- Some hyperlinks are indicated by this icon  and will bring the reader with a click to other parts of the Manual. They are particularly important if one reads the Manual starting from any given chapter.
- Other hyperlinks are indicated by this icon  and will bring the reader to further information on the same topic, in-depth readings and supporting materials, including original material developed by experts specifically for this Manual.
- Other hyperlinks  will bring the reader with a click to videos, tools, trainings or

guidelines that are available in the public domain and provide a practical complement to the processes described in the chapters. The corresponding materials have been researched and vetted by the authors, the Steering Committee and the editorial team.

COVID-19 Pandemic Response

It should be noted that the Manual was validated and finalized during the COVID-19 pandemic, and that while the Manual's contents were not changed to reflect the pandemic response, IOM developed a specific toolkit to help practitioners adapt MHPSS programmes and activities to these new circumstances. The toolkit includes materials developed by a variety of actors, including the IASC MHPSS Reference Group, and is organized per spaces of displacement. **The toolkit** will be further referenced in the following chapters. 



1. CONCEPTS AND MODELS OF WORK



This chapter introduces the main concepts at the basis of this Manual and presents a few models that link theory and programming, and can be helpful in designing and managing CB MHPSS interventions. The chapter introduces theories and paradigms, not practical actions. These theories and paradigms are fundamental to understanding an approach to CB MHPSS and to contextualizing the chapters that will follow.

Box 4

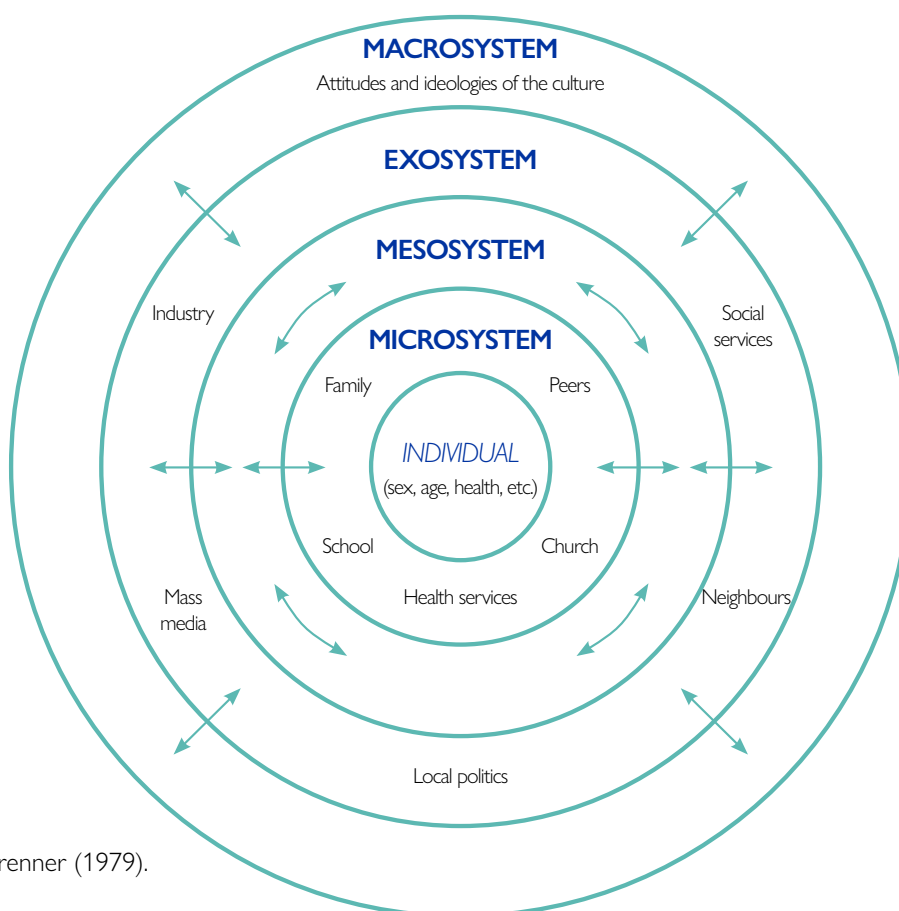
Chapter Video

The following concepts and models of work are explained in [this video](#), which was developed as a complement to the Manual. For a visual explanation of the information presented in this chapter, please watch before or after reading the material.



The informing principle of this Manual is that individuals are part of a socioecological system that includes families, larger human systems and communities (see fig. 1), and therefore communities are a cornerstone of MHPSS programmes that usually tend to focus on individual needs instead.

Figure 1: Socioecological system



Source: Bronfenbrenner (1979).

→ 1.1. CONCEPTS

1.1.1 The meaning of community

In its widest sense, “community” refers to a group whose members share certain commonalities – such as geographical location or location of perceived origin, language, interests, beliefs, values, tasks, political affiliation, ethnic or cultural identity, sense of belonging and others – and whose size varies from very small, such as a nuclear family, to extremely large, such as inhabitants of an entire continent. More precisely, communities are human systems characterized by interrelationships and interactions among their members in a given context. As such, a community is a composite of clusters of:

- Individuals;
- Nuclear and/or extended families;
- Tribes and/or clans;
- Confessional groups;
- Political parties;
- Congregations;
- Men’s, women’s, disability and youth associations;
- Professional associations;
- Amateur artistic groups;
- Sports teams;
- Interest groups, such as people who like a certain kind of music, or a football club, or a star;
- Many others.

The interrelationships and interactions between these groups are also informed by less actual and more constructivist elements, and include:

- Cultures;
- Belief systems;
- Epistemologies;
- Ideologies;

- History and historical perceptions;
- Sociopolitical interests;
- Visions of the future;
- Historical artefacts and monuments;
- Societal discourses and narratives.

Finally, community includes institutions such as political representative bodies, schools, health centres, and religious and civil society organizations.

Box 5

Power dynamics in communities

Hierarchical and non-hierarchical interrelationships among individuals, groups and systems of meaning characterize each community. Power is an important element to consider when engaging communities, especially after disasters and in **migration**.



Communities are dynamic and changing, not only in terms of their actual membership, but also in terms of their characteristics and preoccupations. Communities, like all systems, need both a degree of *stability* and a degree of *change* in order to survive and thrive. If there is too much stability, the system stagnates; and if there is too much change, the system is put into chaos. Communities always need to keep a viable contact with their roots and traditions, while they also need to adapt to the new circumstances and challenges they face along the time continuum, especially when encountering adversity.

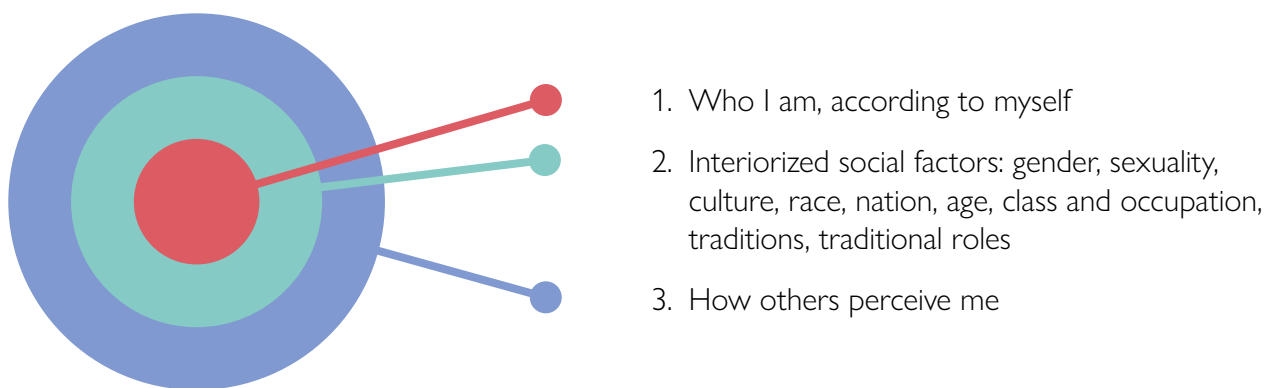
The interactions between individuals, human systems, and these systems and more transcendent elements – such as culture, beliefs and epistemologies – create a sense of belonging and safety and are central in defining identity. Identity is a cornerstone of a sense of community and of psychosocial well-being, and is central to understanding the psychosocial well-being of crisis-affected and migrant populations.

1.1.2 The meaning of identity

Identity is a central concept in the psychosocial well-being of individuals and groups, and remains so after adversity, disruptions and displacement. The simple definition of identity refers to the characteristics determining who a person is (OED, 2019), and the same would apply to collective identities, including community and group identities. Generalizing for the use of a manual the common elements to most underlying psychological and sociological theories, identity can be considered a system constructed by the interrelation of three components:

- The first component (illustrated in red in Figure 2), is the self-concept, which corresponds to who one is to himself or herself (for instance, individual differences, self-attributions).
- The first component is not entirely neutral, since one self-attributes qualities, characteristics, cultural beliefs and roles based on interiorized societal factors, such as the culture, beliefs, education, gender and learned social roles. Dynamic theories add the influences of archetypes, and the subconsciously inherited cultural elements that are informed by the hegemonic and secondary cultures one belongs to, either for assimilation or for contraposition. (This part is illustrated in green in Figure 2).
- Finally, there is a relational component to identity, which is determined by how one is perceived by others: family, friends, colleagues, clients, neighbours, persons of authority (in blue in Figure 2). These three components are continuously feeding back on each other.

Figure 2: Identity



Source: Schininà (2012).

Identity is multifaceted. The self is composed of different selves, for instance the parent self, the family self, the professional self, the partner self, and so on. The three components can have different “weights” in different communities in shaping an individual’s identity, and identity is the result of a continuous negotiation that the individual conducts with themselves, their culture and their community. Therefore, identity is in continuous evolution, and changes based on one’s own experiences, encounters, education and cultural transformations at the level of the system, among others. These changes are organic.

Adversity and forced displacement affect identity, on all levels. Self-concepts are questioned by victimization, inhumanity, torture and violence. The adherence to interiorized societal factors,

such as belief systems, is put into question by the causes of an emergency (especially in the case of conflict). In the case of migration and displacement, the hegemonic culture in the host community may not share the same societal factors as that of the migrants, since language, understanding of social roles, systems of meaning and simpler elements, such as sense of humour, may differ. More importantly, the feedback migrants receive from significant others suffers due to the loss of some of them, the fact that significant others are left behind, and finally by the fact of being immersed in a new community where one is not known and often stigmatized. Identities need to be readapted. This process may be painful and challenging, but its outcomes are not necessarily negative. In the process, however, confusion, disorientation and polarization can happen. In situations of war, in particular, the individual core of the identity tends to be assimilated to the hegemonic narrative of identities in war. The adherence to a core of values that are determined by opposition to the values of the other conflicting party becomes a fundamental prerequisite to be considered as part of a community.

In the emergency environment, humanitarian workers become significant others for affected individuals. In this respect, humanitarian actors are co-constructing the identity of the affected populations they serve from a peculiar position of power.

It is therefore important that humanitarian workers do not contribute to creating a negative identity of the affected populations, basing the relationship only on their deficits and vulnerabilities, which risks creating a victim **identity**, or relying on predetermined categorizations. A community-based approach stems from the protection of the richness of the identities of the populations of concern to the CB MHPSS programme, and from the awareness that a humanitarian organization is part of a system that determines to a certain

extent the evolution of these identities. As a consequence:

- Identity should be understood in its community-relational and more individual components.
- Identity should be respected, as for the fact that identities may be in a crisis or a transition.
- Identity should be empowered, restoring a sense of agency and efficacy.

1.1.3 The meaning of culture

Although the definitions of “culture” greatly vary in literature, for the purposes of this Manual, culture is considered to be a system of shared beliefs, symbols, myths, behaviours, canons, images, narratives, metaphors, artistic productions, rituals, values and customs that the members of a society use to signify their world and relate with one another. They are transmitted from generation to generation through learning, and are interiorized to varying degrees by individuals. Culture encompasses collective materials and immaterial elements that allow a specific community to represent itself as distinct and cohesive.

In this perspective, culture and its elements might offer protective, restorative and transformative support after disruptions, promoting participation, a sense of continuity, acceptance, resilience and a venue for positive social interactions in emergency settings.

Culture can't be understood as a closed system, and the perfect juxtaposition of one culture, including language and religion in one social group in one territory, is a rare occurrence. It is most likely that culture derives from the coexistence of subcultures with their own characteristics. Usually, the main culture and subcultures are not exclusive or necessarily alternative to each other, and cultural and subcultural elements will both coexist in the same individuals and groups, and they will feed back on each other.



These dynamics are also at work in emergency settings and with migration, where even main cultures may differ between migrants and their hosts, with the problems to a sense of identity that this can bring to both communities. On the positive side, subcultures can cross-cut the main cultural frameworks with alliances, fostering integration. In fact, subcultures allow for mutual recognition and converging interests between people of the same subculture within different main cultures, such as migrants and members of the host communities who share a cultural or subcultural identity (for example, same religion, same musical culture, LGBTQI individuals).

Culture is immaterial in essence, but it brings objective manifestations, relations among specific sets of individuals, artistic productions, cultural canons, narratives of exclusion and practices of inclusion and care, and, more inherently to MHPSS work:

- Rituals, liturgies, commemorations and **celebrations**;
- Spiritual and healing practices, aetiologies and explanatory models of **diseases**;
- Legends and myths, novels and poems, proverbs and **jokes**;
- Memories and oral **histories**;
- Emotional expressions, social customs and courtesy etiquettes;
- Visual and plastic arts, songs and dances, theatre, drama, storytelling and **performance**;
- Handcrafts, dressing and ornaments, cooking and **hospitality**;
- **Sport and play**;
- **Learning**.

These elements will be tackled in more programmatic terms in the following chapters.

Box 6

Cultures

Cultures should never be read in hierarchical (better or worse, superior or inferior), ethical (good or bad, advanced or backward) or functional (competitive or cooperative) ways. Rather, an MHPSS programme manager should look at cultures as systems that need to be understood in their essence and respected in their values to inform effective programming.



1.2. THE NECESSARY LINKS BETWEEN COMMUNITY, MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING

Community is a fundamental aspect of mental health, as enshrined in the relevant World Health Organization (WHO) definition, which identifies good mental health as:

A state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community (WHO, 2012).

Likewise, community is central to the definition of the adjective “psychosocial”, which refers to the interrelations between mind and society (OED), since communities are a pillar of the larger society, and its more concrete manifestations.

In humanitarian action, the composite term “mental health and psychosocial support” has been used since 2007 to define “any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental **disorder**”.

Community is central to this construct as well.



Indeed, war and disasters, forced migration and displacement are not only disruptive to the individual, but they lead to shared injuries to a community's social and physical ecologies, which affect psychosocial well-being. As Erikson (1976:154) wrote, they represent:

[A] blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality... a gradual realization that the community no longer exists as an effective source of support and that an important part of the self has disappeared..."I" continue to exist, though damaged and maybe even permanently changed. "You" continue to exist, though distant and hard to relate to. But "we" no longer exist as a connected pair or as linked cells in a larger communal body.

These injuries require not only individual but also collective responses to promote psychosocial recovery and well-being, which often involve the restoration of moral, social and political agency through the creation of shared meaning and narratives.

In 2019, the IASC Reference Group on MHPSS issued *Community-Based Approaches to MHPSS Programmes: A Guidance Note* (IASC, 2019a) available in **Arabic, French, Portuguese, Spanish** and **Urdu**, to respond to a widely perceived need to better define principles of MHPSS work based, as already mentioned, on the understanding:

Box 7

Migration and the definition of Mental Health

The simple definition of good mental health is challenged by the specific situations created by migration and displacement. Find additional information [here](#).

...that communities can be drivers for their own care and change and should be meaningfully involved in all stages of MHPSS responses.

Emergency-affected people are first and foremost to be viewed as active participants in improving individual and collective well-being, rather than as passive recipients of services that are designed for them by others. Thus, using community-based MHPSS approaches facilitates families, groups and communities to support and care for others in ways that encourage recovery and resilience. These approaches also contribute to restoring and/or strengthening those collective structures and systems essential to daily life and well-being. An understanding of systems should inform community-based approaches to MHPSS programmes for both individuals and communities. (IASC, 2019a)

On the other side, a superficial understanding of a community-based approach could be summarized in the slogan "Communities know it all". Yet, disruptions and displacement can create situations where the sense of a community is under question, and the networks and interrelations that usually bring communities together are severed, while values and cultures are under redefinition. Disasters often pull communities apart (including creating fault lines and divisions between national humanitarian workers). Strengthening the resilience of the community is a crucial factor in recovering from adversity, and in preventing long-term mental health and social difficulties. (Norris et al., 2008; Padgett, 2002).

In other cases, different communities are brought by the emergency to cohabit in one geographical location, without sharing the other, more constructivist elements that build a community.

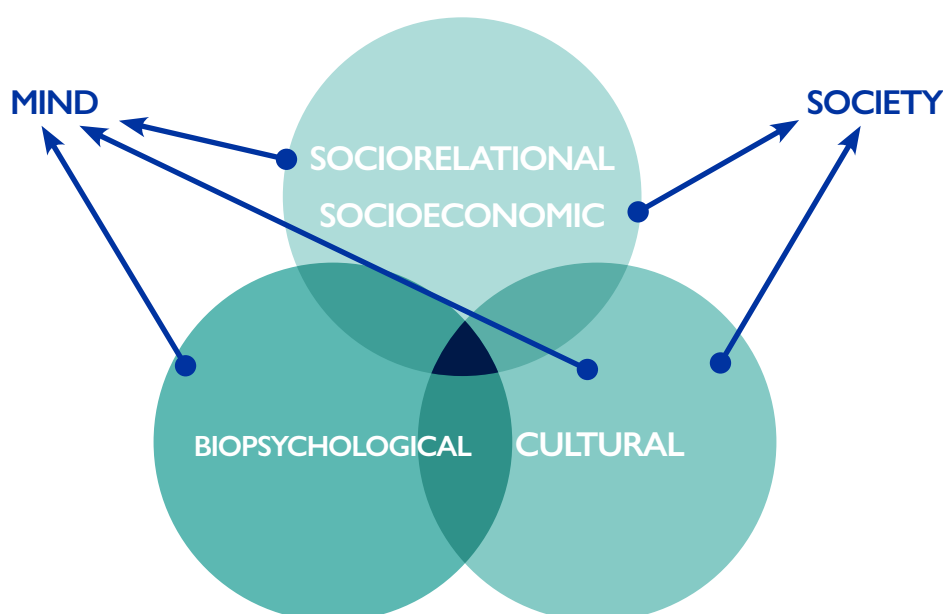
This Manual tries to operationalize this understanding within a model of work, derived and designed mainly for the MHPSS activities of IOM in humanitarian settings, but that could be applied to other programmes by other agencies. This work is based on the following models.

→ 1.3. MODELS

1.3.1 The model of a psychosocial approach to programming in emergency and displacement

This model lies in the fundamental interrelation of biopsychological, socioeconomic/sociorelational and cultural factors in defining the needs of migrants, displaced and crisis-affected populations, as well as the responses to these needs, as illustrated in Figure 3.

Figure 3:
The model of a psychosocial approach to programming in emergencies and displacement



Source: Schininà (2012).

The three spheres are equally important, interdependent and mutually influencing in defining psychosocial needs, resources and responses.

The **biopsychological** factor encompasses emotions, feelings, thoughts, behaviours, memories, stress and stress reactions. Psychological coping skills are related to this sphere. Body and mind are considered a unique system in this model.

The **sociorelational/socioeconomic** sphere focuses on the interactions and the interdependence between the individual and communities he/she belongs to. It consists of two complementary aspects: The **socioeconomic** aspect has to do with the availability of and access to resources, such as, for example, livelihood, health care or information technology. The **sociorelational** aspect brings up the quality of relations between an individual and their family, wider social systems and communities.

The **cultural** sphere regards, as already mentioned, a system of shared material and immaterial elements that members of a society use to signify their world and relate with one another, which are extremely important in how they make sense of adversities.

This scheme should inform the understanding of all humanitarian needs in a community in its interrelatedness. Therefore, biopsychological needs should be understood as being related to sociorelational and socioeconomic determinants, and their manifestations read based on culture. Likewise, socioeconomic and sociorelational needs should be understood as being interrelated to the biopsychological and cultural disruptions they derive from and generate.

Similarly, humanitarian responses should always be mindful of these interrelations. Needs must be prioritized, and agencies may respond to one set of needs rather than another. Yet, this interconnectedness should always be considered, for instance, by the following:

- Providing psychiatric support, one should be mindful of cultural explanatory systems and adapt culturally the diagnostic tools. One should also be mindful of how the provision of services can be understood by the community and how this can affect the well-being of the client and can't be detached from the consideration of the socioeconomic possibilities the family has to provide for the care.
- Distributing food, one should be mindful of the cultural elements of the distribution, such as which food is appropriate for that community and, for instance, how receiving in-kind charity can be perceived in the environment, to mitigate possible stigma. On the other side, one should also consider the emotions that the modality of the distribution can generate: such as shame and a sense of disempowerment, among others.

Keeping this interrelation in mind will make any humanitarian programme more psychosocially informed, and more community-based. A part of this Manual is about what the managers of an MHPSS programme should do to make sure that a psychosocial approach is used in humanitarian programmes organized by the same organization, or existing support mechanisms within the community that are not labelled as MHPSS programmes.

1.3.2 The model of CB MHPSS programming in emergency and displacement

To schematize the approach to dedicated CB MHPSS programming of the organization, IOM has for almost two decades used an adaptation of Renos Papadopoulos' grid of outcomes of disruptive events, applying it to programming. This model is in line with a socioecological model and with a community-based approach to MHPSS, as advocated by the relevant **IASC Guidance Note**.

To know more of the informing principles of the model, **here** is an original contribution Papadopoulos wrote specifically for this Manual. In the chapter, the model is called Framework for dedicated MHPSS programming, and is presented as it is used for IOM programming and therefore adapted from its original elaboration.



Figure 4: Framework for dedicated MHPSS programming

	Negative psychosocial responses	Neutral psychosocial responses and resilience factors	Positive psychosocial responses or adversity activated developments
INDIVIDUAL			
FAMILY			
SIGNIFICANT GROUPS			
COMMUNITIES			

Source: Adapted from Renos Papadopoulos (2007).

A CB MHPSS programme will assess and respond to needs with a systemic and comprehensive approach that attends to:

- The suffering and the negative psychosocial consequences that the emergency and the displacement have provoked at the individual, family, group and community levels, and how they interrelate: It will therefore devise activities that respond to these different levels of suffering, which can include:
 - Ordinary human suffering due to mental disorders at the individual level;
 - Family violence, separation and roles readaptations at the family level;
 - Disruptions or polarizations of significant groups;
 - Community fractures such as stigmatization, conflict, divides, lack of sense of trust in institutions, and a lack of sense of trust in others, among others.

The tendency of MHPSS in emergencies is to focus, almost exclusively, on the negative individual responses to adversity: In a CB MHPSS paradigm, these will instead be attended and responded to at all levels, always connecting the negative to the other two categories of responses.

- The neutral responses and resilience factors – that is, what makes people, groups and communities able to go on after a crisis counting on their pre-existing resources, qualities, skills, networks and coping mechanisms: A CB MHPSS programme will try to identify existing neutral responses and resilience factors, and strengthen them to mitigate the negative reactions. Resilience, as defined by Panter-Brick and Leckman (2013), “is the process of harnessing biological, psychosocial, structural and cultural resources to sustain well-being”.
 - An emphasis on strengths, resources and capacities, rather than deficits;
 - Anticipation of actions that reduce the impact of adversity;
 - Attention to multiple levels of influence, ranging from the structural and cultural through to the community and the individual;
 - Mapping influences within ecologically-nested systems (Ager et al., 2010). Resilience applies not only to individuals, but also to families, groups and communities. Thus, family resilience factors, for instance, can be used to respond to individual suffering, alone or in combination with tailored individual responses. Or, pre-existing support groups can be reactivated and trained to respond to the new challenges.
- The positive responses to adversity: In addition to the negative and unchanged responses to adversity, every person, family, group and community exposed to adversity also gains something to some degree from these experiences. There are endless examples of positive responses to adversity in real life: for example, altering previous individualistic style of life by appreciating the importance of

social networks, volunteerism, widening and deepening the scope of previous life goals, new community preparedness or learning new skills. A CB MHPSS will identify and give space for the presentation of these positive responses.

The original grid can be used in rapid assessments or any other form of assessment where the intention is to map out the entire range of effects following an **emergency**. Here it is presented as a model of the various components that should inform a community-based psychosocial programme, which includes:

- Mental health care for people with severe mental disorders, pre-existing or magnified by the circumstances of the crisis.
- Counselling to help individuals and groups to cope with their predicaments, focusing on their existing resilience.
- Family counselling, parental skills trainings and family mediation, to help families to overcome their predicaments.
- Support to marginalized and affected groups, including minorities, and specific categories of survivors, in the form of counselling and integrated protection services.
- Community messaging addressing the identified root causes of community suffering, as well as conflict mediation and transformation to respond to the chain of violence that can characterize these situations.
- Promotion of activities that are known to alleviate individual, family, group and community suffering in a given community, strengthening the social fabric, and promoting and mobilizing the agency of individuals and groups who have skills and prosocial attitudes in a community. This includes fostering the creation of self-support, creative and cultural groups, and sport and learning activities; and re-establishing livelihoods, as well as those rituals and celebrations that are part of the natural ways people respond to adversity.

- Identifying and empowering positive responses to adversity through skills-building, capacity-building, mentoring, in-kind support, mobilization and engagement, volunteerism, and fostering civic participation.

To do these, CB MHPSS programmes should have:

- A specific focus; and
- Core teams that reflect a variety of needed background and expertise.

1.3.2.1 The focus of a CB MHPSS programme

MHPSS in emergencies is defined as:

“any type of local or outside support that aims to protect and promote psychosocial well-being and/or prevent or treat mental disorders”.

Within this definition, in a CB MHPSS programme, the focus is on strengthening local supports, and on looking at psychosocial wellbeing from a relational perspective. The “client” of a community-based MHPSS programme is therefore the social system, and the focus is on strengths, resources, continuity and adaptation to changes. The activities supported by such an approach are often those that community members are already engaged in, but not solely. The focus is less on direct services, and more on offering a structure that promotes positive connection and social processes. Most often, this involves helping to reactivate old and build new connections between constituencies, and helping people recognize and enhance existing resources for recovery. On the other side, CB MHPSS programmes recognize the changes and difficulties that war, disasters and displacement bring to the social and symbolic fabric of a community, which create gaps in interactions and services that will need to be addressed.

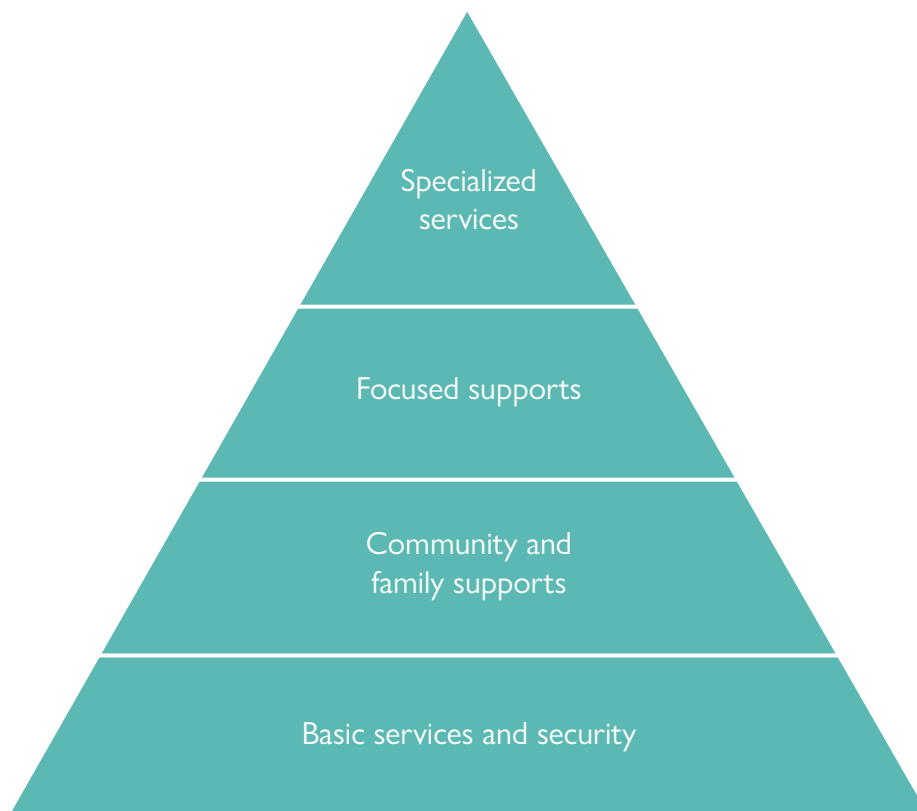
1.3.2.2 The background and expertise of the core team

The disciplines and competencies that a CB MHPSS programme should have include:

- Clinical psychology;
- Counselling psychology;
- Social psychology;
- Community psychology;
- Social work;
- Linguistics;
- Anthropology;
- Humanities;
- Sociology;
- Applied arts;
- Education.

Professional staff in the programme, experts and supervisors will possess a combination of those backgrounds, or competencies will be prioritized according to the specific MHPSS components the programme focuses on.

Figure 5. IASC pyramid of MHPSS in emergency (IASC, 2007)
(each layer is described in Box 8)



Source: IASC (2007).



Box 8

The IASC pyramid of MHPSS intervention

The Inter-Agency Standing Committee (IASC) *Guidelines on MHPSS in Emergency Settings* (IASC, 2007) structure MHPSS activities in a pyramid, which has become extremely popular in MHPSS interventions in emergencies around the globe. The pyramid calls for a layered system of complementary supports that meet the needs of different groups (see Figure 5). These include basic services and security, community and family supports, focused services and specialized services. These layers are not hierarchical and should ideally be implemented concurrently.

The first layer of the pyramid refers to the protection of the well-being of all people through ensuring psychosocial and/or social considerations in the (re)establishment of basic services and security are taken. Security, adequate governance, and services that address basic needs, such as “food, shelter, water, basic health care and control of communicable diseases”, should be provided in “participatory, safe and socially appropriate ways that protect local people’s dignity, strengthen local social supports and mobilise community networks.” MHPSS responses in this level could include advocating for these services to be “put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial well-being” (IASC, 2007).

The second layer refers to “Community and family supports”, and draws attention to the importance of the role community plays in enabling the maintenance and improvement of the affected persons’ mental health, specifying activities such as “family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women’s groups and youth” (IASC, 2007). More specifically, the Guidelines recommend the facilitation of “conditions for community mobilization, ownership and control of emergency response in all sectors... community self-help and social support... conditions for appropriate communal cultural, spiritual and religious healing practices”

The third layer, focused supports, refers to support provided to people who “require more focused individual, family or group interventions by trained and supervised workers” (IASC, 2007).

The fourth layer, specialized services, refers to services provided to people who experience significant difficulties in basic daily functioning due to intolerable suffering, and to those who have severe mental disorders (IASC, 2007). Assistance should include psychological or psychiatric supports, “referrals to specialised services if they exist, or the initiation of longer-term training and supervision of primary/general health care providers” (IASC, 2007).

Most of the activities identified by the Guidelines at the community and family support level will be presented in this Manual following a different framework. Yet, wherever possible, the Manual will signal at what level of the pyramid of psychosocial intervention a certain proposed activity should be categorized. This is done to allow programme managers to present results within the IASC groups and frameworks in a way that can be understood by partners. On the other side, as it will become evident in the Manual, often the various layers of the intervention pyramid are more interconnected than a rigid categorization would allow, which will be also highlighted.

→ 1.4. CHALLENGES AND CONSIDERATIONS

Although community is a system that comprises different subgroups, levels of individual interiorizations and counternarratives, and is constantly transforming, it risks in certain instances to be perceived and performed as atemporal, normative and prescriptive by its actors as well as by external observers. This brings several consequences:

- CB MHPSS activities might consolidate negative stereotypes and bring about harmful practices as a reaction to the emergency (for example, early marriages, segregation of girls and persons with mental disorders, and aggressive behaviours).
- Psychosocial managers may tend to generalize community characteristics to all assisted individuals and consider them immutable. By contrast, they should always understand the dynamic and evolving nature of community.
- Competing discourses inform most functions of communities: a *dominant* discourse, which is responsible for forming the main position of the system; and *subjugated* discourses, which are different if not contrary to the dominant one. The key dimension that distinguishes these two types of discourses is power. All discourses should be listened to and validated in a CB MHPSS programme, as necessary and appropriate.
- When community is identified with its dominant and hegemonic discourse, this risks exacerbating the marginalization/discrimination/stigmatization of subcultural and subjugated groups, reinforcing power imbalances or subverting existing power balances in a way that creates tensions and further oppression.
- Furthermore, communities are transformed due to emergencies. People might react and adapt to adversities in peculiar and different ways. Some of the community members might become more conservative, while others might become more explorative (or even negative) towards their cultural belonging than they were before the crisis. The same person might swing between these polarities at different stages of her/his journey-in-the-making. Therefore, community, in its cultural and identity aspects, needs to be contextualized in the present while an intervention is planned.
- Humanitarian workers can have an impact on the affected communities in terms of:
 - The human relationships that are developed between them and their clients;
 - The range of expectations and hopes that are raised;
 - The idealizations that emerge;
 - The identities that are formed as a result of the CB MHPSS programme;
 - The impact of the “beneficiary” identity;
 - The dependency that is created;
 - Focusing on a specific group of the population.

An MHPSS manager needs to be mindful of how all these impacts interact.

 FURTHER READING

Bateson, G.

1979 *Mind and Nature. A Necessary Unity*. E.P. Dutton, New York.

Erikson, K.

1991 Notes on Trauma and Community. *American Imago*, 48(4):455–472.

Papadopoulos, R.K.

2007 Refugees, trauma and adversity-activated development. *European Journal of Psychotherapy and Counselling*, 9(3):301–312.

For other references, find the full bibliography [here](#).



2. ENGAGING WITH COMMUNITIES



→ 2.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Community engagement is considered a cornerstone of all humanitarian responses, and can be summarized as an operational approach that involves the affected communities in the different phases of the programme and the provision of services, not only as users, clients or beneficiaries, but to varying extents as agents of their own individual and collective well-being.

Community engagement can therefore be considered as both a process and a result of an MHPSS programme in emergencies.

- In terms of process, *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007) guide humanitarians on how to facilitate the conditions for community engagement. In addition, the IASC Reference Group on MHPSS' *Community-Based Approaches to MHPSS Programmes: A Guidance Note* (IASC, 2019a) further emphasizes meaningful participation of communities in the provision of MHPSS in emergencies. As previously **mentioned**, communities are composite, and encompass different groups and social systems. All different components of a community, and all different communities coexisting in a territory, should be engaged, not only the mainstream one. For instance, in the case of IOM, the host community, various migrant communities and socially and culturally diverse subgroups should all be engaged. As a process, engaging communities:
 - Reduces conflicts and enhances trust: Engaging and informing communities helps to manage expectations, and avoid misunderstandings between the management of the programme and the affected communities.
 - Brings to more effective programming:

Builds on existing knowledge, resources, networks and concepts.

- Assures better access to the most vulnerable populations.
- In terms of results, engaging communities effectively brings a series of direct outcomes to well-being:
 - Facilitates recovery: Through engagement, organizations can support communities' long-term recovery rather than only providing for immediate needs.
 - Grants agency and protect resilience: The use of existing resources within the community is an element of stability and limits the negative effect of the non-participatory approach of many emergency humanitarian interventions and the creation of **victim identities**.
 - Increases local ownership and empowers people: Being a part of the decision-making process, affected communities are more likely to own the intervention, and to learn and be empowered by this process.
 - Strengthens social cohesion: Different components of a community, and all different communities coexisting in a territory, should be engaged. Sharing activities and decisions enhances social cohesion between these communities and groups. And social cohesion enhances well-being.
 - Helps mend the social fabric where disruptions have torn it.

This chapter covers the objectives and stages of community engagement in an MHPSS programme, and describes a process of engagement suitable for IOM MHPSS programmes.

2.1.1 The three main areas of engagement

Community engagement can have a lot of positive effects, and is an essential feature of the process of implementing a CB MHPSS

programme. Its objectives can be organized in three main clusters:

- a) Informing decisions: Providing opportunities to the community to contribute to decision-making processes. This is important but at times difficult to achieve in emergency MHPSS programming, where at times the main activities of a programme are decided even before meeting the communities. And yet, a certain level of contribution to decision-making can always be achieved.
- b) Building capacity: Enhancing MHPSS capacities and competencies in a community.
- c) Strengthening relationships: Improving relationships between the agency and the community, and between some components of the community.

The three objectives are interrelated and should be pursued at the same time, but the timing of the programme and the nature of the emergency may bring a prioritization of one objective over another. For example, building and strengthening relationships becomes the primary objective when the MHPSS intervention was designed without community engagement, to fit with the requests and timing of donors. Informing decisions is instead the primary objective of an agency that has money to spend but no preconceived ideas of existing needs and resources. Building capacity will be the primary objective of an agency that has a very technical profile (Capire Consulting Group, 2015). In an IOM CB MHPSS programme, for instance, engaging communities of concern is a way to build relationships with and between migrant and non-migrant communities. It is a way to inform decisions about the programme (objectives, indicators and priorities, among others), and it is mainly a way to create capacity in communities, as it will be explained in this Manual.

From a programmatic point of view, engaging communities in MHPSS happens in a continuum that invests all phases of the MHPSS programme cycle, from assessment to monitoring and evaluation, taking into account the three objectives

of community engagement in the process.

2.1.2 Gradations of community engagement

Community engagement can have different gradation and scales, as summarized below:

- Passive: Information is shared with communities, but they have no authority on decisions and actions taken.
- Information transfer: Information is gathered from communities, but they are not taking part in discussions leading to decision-making.
- Consultation: Communities are asked for their opinions, but they don't decide on what to do and the way to accomplish it.
- Functional: Communities are involved in the planning of one or more activities, but they have limited decision-making power.
- Interactive: Communities are completely involved in decision-making with the agency implementing the programme.
- Ownership: Communities control decision-making and agencies act only as facilitators (funders, supervisors and trainers).
- Empowerment: Communities are empowered in the provision of MHPSS, so that they can ultimately be able to respond to existing needs with limited external support.

The aim should always be to strive for as much community engagement as possible, putting the bar at the functional level, aspiring to reach ownership and empowerment levels. In IOM MHPSS programmes, different levels of engagement will be used with different actors within a community. For instance:

- Empowerment: Professional categories and practitioners active in various domains of MHPSS will be empowered through academic level trainings, designed with local academia and experts as partners (see chapter on **Training**).



- Functional and ownership: Psychosocial teams are fully a part of the decision-making process of MHPSS programmes. They come from both the host and the displaced communities, and they engage and interact with others in the community (see chapters on **Psychosocial mobile teams** and on **Technical Supervision**).
- Functional and interactive: The activities that are proposed by the teams are both service-oriented and mobilization-oriented, therefore granting a balance between responding to needs and allowing a meaningful participation of volunteers, professionals, survivors, stakeholders and other actors (see chapter on **Sociorelational and cultural activities** and on **Creative and art-based activities**).

All this will be explored in the following chapters.

→ 2.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

2.2.1 Whom to engage

Engaging communities means engaging people, social functions and institutions through a process, and specific actions that allow them to actively participate in decision-making, to the different degrees mentioned above. Whom to engage in an MHPSS programme is set in the objectives of the programme itself.

2.2.1.1 Individuals

The first point of contact for IOM MHPSS managers should be MHPSS professionals and resources. Even in complex emergencies, national and local MHPSS professionals can effectively contribute to informing and shaping psychosocial support programmes.

Secondarily, many social, administrative, political and religious structures that are relevant to

mental health care and psychosocial support might be still in place. Even before starting with a proper mapping, one can engage with the leaders of those structures already known by the organization, or the most relevant and visible.

Finally, it is important to identify community gatekeepers who are able to help the manager engage with the affected communities or their subgroups. Gatekeepers are people with social functions in their community, in particular leaders, due to their influence and access to the community. For instance, civic and local government leaders, religious and spiritual leaders, leaders of other community-based organizations, teachers, artists and intellectuals, members of relevant departments at local universities, youth activists, elderly and female leaders and many others can be engaged as gatekeepers.

Both the MHPSS professional community and the other gatekeepers can help the manager in **assessing needs; mapping resources** with a snowball approach; and learning about local concepts and idioms of distress and grief, frustration and fear, happiness and hope, as well as the local customs and beliefs important for the implementation of an MHPSS programme. The time taken to meet and listen will often pay off with appreciation and collaboration. However, in engaging with gatekeepers and members of different professional and administrative-political groups, managers should maintain a critical approach. Organizations, local governments and social groups have their own agendas and, without recognition of these strategies, wrong operational decisions are easily taken (**IASC, 2007**).

2.2.1.2 Families

Families are important social systems, and need to be engaged as such. In an emergency context, particularly in cases of displacement and forced migration, families are the cultural and social spaces where individuals express

their stress, fears and grievances, and receive basic care, emotional support and protection. Although families are usually part of larger social and territorial groups formally represented by cultural, administrative or political leaders (see above), it is important to establish direct operational engagement with extended families or clusters of families (camp's sections, neighbourhoods in urban settings, and villages in rural areas).

Families of primary concern for community engagement in MHPSS should be those whose members are:

- Affected by disabilities, including cognitive disabilities;
- Affected by pre-existing or crisis-generated mental, neurological and substance abuse disorders;
- Survivors of violence and/or witnesses of violence that occurred during the crisis;
- Single-headed families with a large number of dependants (children, elders, relatives);
- Associated with or from minority ethno-religious groups.

Box 9

Engaging with families

Engaging with families can include the establishment or an early warning system for cases of suicidal attempts, segregation of girls and persons with disabilities, early marriages, child abuse and domestic violence. For the purposes of such an informative system, youth and women are usually the best community members to engage with in monitoring family dynamics and hidden cases of abuse. Trust and confidentiality between community members and MHPSS staff are the core of this system, which can't be established at the very inception of the emergency response, but at a later stage.

During the assessment phase, samples of families should be interviewed as a whole (allowing for active participation of all members, not only the heads or the most vocal), to understand MHPSS needs, and coverage and quality of delivered services. According to local cultural norms and emergency settings, representatives of extended or clustered families can be supported to establish projects' or parents' committees in support of the programme.

2.2.1.3 Groups

Community engagement involves the inclusion of diverse groups in the community; men, youth, disability and women's associations, professional associations and clubs, activists and self-help groups, community-based organizations, groups of interest, and groups that gather around a specific activity or interest (sports, fan clubs, choirs). In an emergency situation, these groups might be weakened by conflict, displacement, or logistical or political restrictions. Financial and technical **resources should be earmarked to revitalize, strengthen or even re-establish these groups**. Particularly relevant is the creation of networks and digital platforms where local NGOs and community-based organizations can share best practices, information and coordination, and promote campaigns of mutual interest.



Box 10

Engaging with persons with disabilities

Accessible and inclusive MHPSS community-based activities ensure: people with disabilities are part of decision making and leadership processes; information on MHPSS is accessible and inclusive; MHPSS facilities are accessible; and MHPSS activities are designed in an accessible and inclusive way and encourage active participation. Furthermore, MHPSS programmes should specifically identify and invite people with diverse disabilities to attend MHPSS activities.

2.2.1.3.1 Religious groups

Working with religious groups retains strategic consideration during the engagement process, because religion plays a relevant role in the value set and emotional and social life of many in the communities. Endorsement from religious groups and their involvement in the programme are thus important factors of community legitimation and ownership of the project. In fact, during an emergency, it is likely that religious organizations would already be conducting CB MHPSS activities, in which case the possible engagement can be extended to partnership.

It is also important to look at inclusion through the lens of religion. Local faith communities are usually able to stand close to people in emergencies and offer an interpretation of the experience that might prove to be meaningful to many. Therefore, religious and spiritual leaders can have a positive influence in channelling negative psychosocial reactions and promoting peaceful coexistence and participation. However, the involvement of religious and spiritual groups must be carefully considered and balanced in contexts with more than one group, or when a specific religious, ethnic, or social subgroup might be subject to open or covert discrimination by religious groups. For additional guidance on integration of faith, faith groups and leaders in CB MHPSS programmes, see [here](#). For a more structural approach, please see the guidelines on *A Faith-Sensitive Approach in Humanitarian Response: Guidance on Mental Health and Psychosocial Programming* (IASC, 2018a).

A project committee can be created with people who are a true representation of the different facets of the community. Regular meetings can be organized with them, building trust in the programme and in the process. The committees will include MHPSS experts, community leaders, religious leaders, and representatives from the various communities and groups. Consistent with the objective of the engagement and the gradation of engagement required by the programme, the meetings can be:

- Information sharing on the update of the programme (passive);
- Sessions where new information is shared with and gathered from the committee based on technical and managerial needs (information transfer);
- Meetings where the opinion of the committee members on issues pre-identified by the manager is collected (consultation);
- Planning meetings where output indicators are evaluated together and important programme decisions are taken (functional–interactive) (**Capire Consulting Group, 2016**).



In addition:

- Psychosocial mobile team (PMT) members are a part of the community (see chapter on Psychosocial mobile teams).
- Each IOM PMT includes a community mobilizer (as above).
- Relevant local professionals are hired as consultants or in specific training and technical positions.
- Local experts and academics are part of the supervision team (see section 4.4 of this chapter).
- Artists, activists and promoters can be given in-kind support to organize activities for the community (see Figure 9).
- Existing networks, services and traditional practices can be supported in kind, or by training or network-building, to act as referrals or service providers.

2.2.2 How to engage

There are several ways to keep communities engaged during the various phases of a MHPSS programme. The engagement process requires transparency and accountability, accessible and timely information, and clarity about the structures, processes, policies, capacities and limitations in human and material resources.



- Structured forms of feedback collection from the project's affected populations, decision-makers and the rest of the communities are implemented. These should take into account the **Accountability to Affected Populations framework and Communication with Communities mechanisms**.
- The engagement of migrants' communities can additionally require cultural mediation, adequate interpretation, and cultural competence trainings for the members of the committees.
- Religious and cultural activities, such as fasting season and seasonal work, should always be considered – negatively, as they may affect participation; and positively, to be used in support of the communities' engagement with the programme.
- Capacity-building can be offered to community members.

Box 11

Engagement and partnership with local organizations

IOM has successfully implemented in Colombia, Lebanon, Libya, Turkey, Serbia and Iraq, just to mention a few, structured forms of engagement and partnership with local organizations providing MHPSS. These intensive training programmes (usually a weekly session over three to four months covering theoretical and operational topics) helped not only in capacitating the organizations but also in establishing coordination and consolidating civil society networks. This was usually followed up by the delivery of practical in-kind support, and supervision and mentoring, to develop small-scale MHPSS activities.

These organizations represent several ideologies, motivations, operational capacities and concerns, including faith-based, humanitarian, educational, women and children support, elderly, persons with disabilities, minorities, migrants, and gender-based violence (GBV) and torture survivors. IOM's initiative helped these organizations to increase their capacity to:

- Intervene and coordinate themselves during the acute phases of the crisis on the basis of territorial and operational proximity to the affected populations and host communities;
- Pool professional resources and share best practices to ensure compliance with community-based methodologies and quality standards of MHPSS;
- Lobby as a unified group for funding, capacity-building and administrative procedures towards local authorities, the private sector and public service providers;
- Advocate for recognition, protection and care of affected populations by international organizations, national governments and humanitarian systems (United Nations agencies, donors and embassies);
- Interact with IOM as an international partner in assessing and jointly implementing emergency MHPSS interventions.

The resulting community-based organization coordination groups and NGO networks proved to be crucial in the provision of CB MHPSS in **Libya** in the immediate aftermath of the resurgent civil war in the summer of 2014, and in **Iraq** after the military campaign to liberate the north-west governorates from ISIS, including Mosul, in 2017.



Box 12

Local committees

National staff members working for the organization could be in part biased by the fact of receiving salary or compensation, and could be preoccupied with adapting what they know about their cultures to the new organizational culture in which they are embedded. Local programme committees can be formed to steer MHPSS programmes and engage on regular basis (Sliep, 2011).

The local committees should be involved throughout the project cycle. They can help in prioritizing assessment questions and advising on the appropriateness of the means of verification used. In the planning phase, the committee decides how to prioritize the findings of the assessments and help in developing mutually agreed upon action plans that facilitate ownership and control by the communities involved (IASC, 2007). These plans should clarify how decisions will be made, define common values, and negotiate rights and responsibilities for each stage in the process (who, what, where, when, why and how). During implementation, the committee will provide regular feedback on the results of the programme and vet training plans. The committee will also validate the tools of and participate in the evaluation of the programme. The committee members can also act as focal points for their subgroups (academic, professional, ethno-religious, geographical, gender, age, subcommunities). They are the ones to inform their community or specific group, and are the ones who try to involve them in the programme. MHPSS managers should support the committee members and gatekeepers to their own strengths through specific training sessions and active involvement in the activities. **Local committees should include gatekeepers and experts for both the displaced and the host communities, as well as subcommunities.**



2.3. CASE STUDY

LINC Community Resilience based on Transitional Family Therapy (Landau, 2018)

A LINC Community Resilience Intervention involves an entire community or its representatives in assessing a situation and designing its own intervention (Landau, 2007). This type of intervention can be used within a community or by governments and organizations as a way to prepare for and/or resolve the consequences of mass disasters (Landau, 2004, 2007, 2012, 2018; Landau et al., 2008; Landau and Saul 2004; Landau and Weaver, 2006). The intervention uses a series of maps to assess demographics, attitudes, customs, family structures and important events in the community. Following this assessment, community forums are organized, each representing a comprehensive cross-section of the population. In larger communities (more than 6,000 people), LINC Community Resilience Interventions begin with consultants who train local professionals to assist in facilitating the interventions so that the entire community may be reached.

Following LINC guidelines, members of the community are divided into small discussion groups, each representing a cross-section of the community. The groups identify the strengths, themes, scripts and resources that are available within the community, and discuss what the concept of resilience means to them individually, as well as to their families and community. Each group then develops overarching goals for the future. Groups usually embrace the goals set by the collective, but they also usually add several of their own. They discuss ways in which their available resources can be applied to each small and easily achievable task that is derived from one of the goals. The groups then work as collaborative teams to select their community “Links”, or people from within their own group

whom they trust and with whom they can communicate easily. Links are identified as people who would make good leaders and who are able to bridge the gap between the community and outside professionals. Members of the collaborative teams then identify practical tasks from their goals and arrange work groups to achieve them. The number of Links depends in part on the size of the community. Medium-sized communities (populations of 6,000–50,000 people) select, on average, 3 to 5 Links; larger cities (50,000–1 million people) select 8 to 10 Links, each of whom coordinates multiple projects. This model has been applied in Argentina, Australia, Brazil, Finland, Japan, South Africa, the United States, Kosovo¹ and elsewhere.

2.4. CHALLENGES AND CONSIDERATIONS

Community engagement is not an easy process, especially not with refugees, or displaced and migrant communities. Displaced communities are often fragmented, scattered and pervaded by a generalized lack of trust due to their experiences. In addition, at times they cannot fulfil their cultural and social roles and traditions. The host community can feel threatened and not receptive.

There might be struggles between different community organizations and NGOs (including international NGOs), lack of funding, corruption, lack of well-functioning (governmental) institutions, exploitation and a challenging existing power structure, fed by a non-participatory humanitarian system (Saul, 2017).

Sometimes humanitarian organizations or workers are not engaging communities throughout their programmes' cycle for various reasons (**Health Communication Capacity Collective (HC3), 2017**; OCHA, 2017):

- Fear of the negative: Humanitarian workers might be afraid of negative feedback or that people see them as accountable for issues they have little or no control over.
- Lack of resources: Providing coherent and useful information and listening meaningfully to communities may be seen as tasks that require additional budget and dedicated human resources. As resources are strained in most emergencies around the world, community engagement often is not considered a priority investment.
- Competing priorities: In any emergency, time is always of the essence. Life-saving assistance needs to be provided quickly, and taking the time to consult with people may seem counterproductive. Food, water, shelter and health often are considered as the only or most pressing priorities in a crisis.
- Coordination: Organizations might also have conflicting or competing approaches or messages. Not all international organizations easily work with different local groups, such as the local media. Harmonizing this can be an ongoing challenge.
- Inclusion of different groups: It is often not easy to include all the different groups due to power relations and dominant sociocultural behaviour and narratives. In conflict situations, there is a risk that there is a mingling of perpetrators and victims. Because of cultural sensitivity, certain issues are not easily discussed by the various groups.
- Language barriers (see chapter on **Counselling**).

¹ References to Kosovo shall be understood to be in the context of United Nations Security Council resolution 1244 (1999).

2. ENGAGING WITH COMMUNITIES

Access to communities and the available methods for community engagement may be altered during health emergencies such as the COVID-19 pandemic. Although not exhaustive, conducting continuous assessments, awareness campaigns, and remote support can be **useful engagement strategies** during health crises.



Additionally, the IASC Thematic Group on Community-Based Approaches to MHPSS held an **online exchange discussing** challenges and ways forward for community engagement.



Cooking activity for Syrian and Turkish women, Turkey. © IOM 2020

3. ASSESSMENT AND MAPPING



→ 3.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Assessing the MHPSS needs and resources of people affected by an emergency, and mapping existing MHPSS services, or resources that could be easily reactivated, are essential parts of community-based MHPSS programmes. MHPSS assessments and mappings in emergencies should not only aim at listing problems, they should also help managers in analysing how individual, familial, cultural, social and political factors are intertwined in emergency responses, and how these connections affect the mental health and psychosocial well-being of crisis-affected populations and migrants. It therefore becomes essential that the MHPSS needs of affected populations are assessed in ways that involve **community members**. This is clearly defined in *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007:38–45 – Action Sheet 2.1, Conduct assessments of mental health and psychosocial issues).

If assessment is aimed, among other goals, to get insights into the collective tensions that lie behind individual and family psychosocial problems and the way to respond to these problems, communities need to be engaged to the extent possible in all the steps of the assessment, as illustrated in Figure 6.

Since literature on how to design and conduct an assessment is copious, this chapter does not present an assessment method or a specific tool, but rather focuses on how to engage communities in MHPSS assessment and mapping, and make them more community-based, referring to existing tools. This will include:

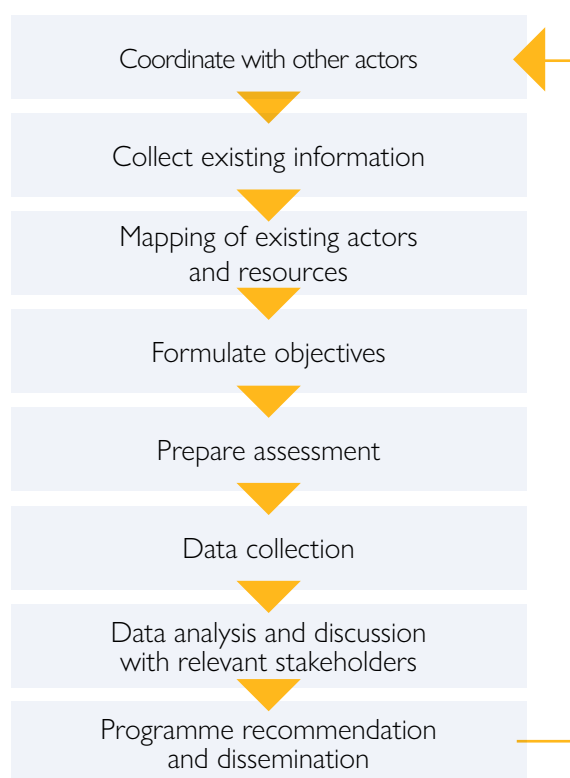
- How to include community members in the assessment team;
- How to validate and discuss the assessment's objectives, methods and priorities with key

community members;

- How to custom-design participatory assessments;
- How to select existing tools based on their participatory nature.

This chapter regards general initial MHPSS assessments. Once activities are set and the teams established, other assessments may be needed that are specific to the activities performed. For instance, (a) a livelihood programme that includes MHPSS components requires a market analysis; (b) the organization of creative activities requires a creative mapping of the community; and (c) in certain situations, a conflict analysis will be necessary to inform MHPSS activities in certain areas. These assessments are related to specific activities and are presented in the relevant chapters of this Manual.

Figure 6: Assessment steps



Source: adapted from WHO and UNHCR (2012).

The initial assessment should address three main questions:

- What are the existing resources and capacities in the communities (both affected and host communities) to cope with adversities and provide MHPSS services?
- What are the most urgent needs objectively identified by the project's staff and stakeholders, and subjectively perceived by the affected populations themselves?
- Who are the most vulnerable individuals, groups and subgroups in need of MHPSS in the affected community?

The answers to these questions will help the PMTs reach the aims of the assessment, listed in Box 13.

Box 13

Main aims of MHPSS assessments

- To learn about the MHPSS concerns created by the emergency and how they are being addressed, with special attention to those most vulnerable;
- To identify social, cultural and professional resources that exist in the affected community to address psychosocial issues and reactivate self-confidence, resilience and agency;
- To identify existing structures that could serve as referral, particularly for those affected by severe mental, neurological and substance use disorders;
- To identify and provide special protection to groups excluded from or stigmatized by the community;
- To obtain the baseline data against which the programme's strategies, activities, outputs and outcomes can be measured later.



3.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

3.2.1 Coordinate assessment with other actors

Assessment and mapping should be coordinated with other concerned agencies and actors in the field. This includes (a) other agencies involved in MHPSS activities; (b) other humanitarian actors, including the cluster system; (c) local authorities; and (d) communities:

- Other agencies involved in MHPSS activities in a given context can be contacted through the IASC field-based technical MHPSS group, if one exists (see Annex 1). To the extent possible, assessment and mapping efforts should be coordinated among different agencies to avoid overlapping and enhance complementarity.
- Other humanitarian actors shall be contacted, especially within the cluster system, to explore whether part of the information has been or is being collected through other assessments, and whether some items of the MHPSS assessment could be included in other ongoing humanitarian assessments. In addition, they can be contacted for facilitation, coordination and clearances. For IOM, MHPSS items could be included in Camp Coordination and Camp Management cluster mappings and in Displacement Tracking Matrix assessments (see Box 14), through coordination with the responsible officers.
- Local authorities should be informed about the plans and made aware of what exactly is meant by a participatory MHPSS community-based assessment and its implications.
- Communities should be engaged, not only as participants, but as decision-makers in the assessment. A way for engaging communities in the assessment is by establishing a

community committee when the assessment is being planned. The membership can be enlarged during the assessment based on the results of the mapping, with the task of providing inputs and feedback into the assessment's topic and methodology (and later, analysis and results). For the formation and dynamics of a community committee, see the chapter on **Engaging with communities**.

3.2.2 Collect existing information

A desk review can be done remotely and *in loco*, searching for, reading and analysing academic studies and grey literature, including scientific articles, field reports, books and materials produced by humanitarian agencies.

If resources allow, or if a strong partnership with relevant faculties exists, academic centres could support the desk review, mobilizing their students and experts. IOM, or the IASC MHPSS group, would identify and partner with a relevant academic institution and commission a review. A best practice of this approach was seen in Haiti, soon after the earthquake of 2010, when WHO commissioned a review by McGill University of existing information on mental health concepts and services in the country, which was ready within weeks after the catastrophe.

For the methodology used in such reviews, see this [article](#).

To read the report produced by McGill University on Haiti, see [here](#).

To read a similar report produced by IASC after the earthquake in Nepal [see here](#).

The desk review analyses existing information about cultural, social, political and religious background of the affected communities that

Box 14

MHPSS questions in the Displacement Tracking Matrix

Two questions pertaining only to the realm of MHPSS could be included in **Displacement Tracking Matrix** protocols:

- (a) Are there psychiatrists, psychologists or doctors able to treat people with mental disorders in your community?
- (b) Are there services or individuals that people in your community can refer to, when they do not feel psychologically well? In case psychology is not understood, local idioms or the formula “do not feel well at heart” can be used.

Focus group discussion in Bentiu, South Sudan. © IOM 2018



are relevant to an MHPSS intervention in the context. It helps in having precious information at the inception of programmes, and in focusing subsequent assessments and mappings.

3.2.3 Mapping of existing actors and resources

Mapping of existing services, capacities and resources, and needs assessments, are complementary exercises. Focusing on the presence or absence of services the humanitarian system deems necessary might give an idea on what is available or missing, but it might not clarify if what is available responds to what affected populations and community members perceive as the most needed, risking to underplay communities' perceptions of their own needs. On the contrary, an assessment without a mapping of services and resources might give an idea of what people perceive as needed, but it might not describe if these needs can be addressed with local resources, potentially overlooking the community's capacity to cope and respond to the situation.

3.2.3.1 Inter-agency mapping

The IASC Reference Group on MHPSS in emergencies has elaborated a “4Ws” mapping tool, which is a helpful matrix aimed at providing an overview of the existing MHPSS responses within the humanitarian system. The 4Ws mapping focuses on “Who is Where, When and doing What”, to get insight into the provision of related resources, capacities and services along the four tiers of the IASC MHPSS intervention pyramid (IASC, 2012).

The IASC 4Ws was designed to serve the humanitarian intervention. As such, it is a powerful tool to identify geographical and thematic gaps, avoid duplications and foster coordination among humanitarian actors involved in MHPSS. However, in some instances, it risks focusing primarily on what humanitarian agencies

are doing or plan to do, thus missing pre-existing community-based resources that are currently inactive (but could be easily reactivated), or active but unknown to the humanitarian system. Also, agencies that receive funding from the humanitarian system are the most motivated to participate in such mapping exercises, which may be unknown to community-based actors that receive their funding from other sources, or operate according to different paradigms (pre-existing governmental services, churches and traditional resources, spontaneous volunteer groups, professional groups, and so on). It is therefore important that IOM fully engages with the inter-agency 4Ws exercise, while also enlarging the scope of the mapping to community-based resources that may be unknown to the humanitarian system, and foster ways in which these resources can be included and represented in the mapping.

Box 15

Resources

Some hints on where to look for information:

- <https://publications.iom.int/> – bookstore;
- www.mhpss.net;
- www.reliefweb.org;
- www.who.int/hinari/en;
- www.academia.edu;
- www.apa.org/pubs/databases/psycinfo/index.aspx;
- www.ncbi.nlm.nih.gov/pubmed/;
- <https://scholar.google.com/>;
- www.humanitarianresponse.info/;
- www.interventionjournal.org;
- www.migrationhealthresearch.iom.int

In loco: In the field one could consult academic archives, repositories of theses of relevant faculties, local libraries, among others.



At the beginning of an emergency, mapping often happens through a snowball approach (an actor will refer the mapper to another, who will refer the mapper to a third, and so on). It is therefore important to consider the mapping as an ongoing exercise to expand throughout the life cycle of a programme. In addition, while in the flowchart mapping is presented as step 3, in practice it can also be conducted at the same time as the needs assessment or after the needs assessment.

Box 16

Assessment and mapping of specialized services for those with severe mental disorders

When designing and delivering interventions targeting those with mental disorders, mapping should focus on:

- Existing “informal” sources of care available for people with severe mental disorders at the community level;
- Knowledge around the different sources of available care;
- Attitudes towards the different sources of care;
- Health-seeking behaviour of people with severe mental disorders;
- Existing coping mechanisms, including social, cultural and spiritual outlets, which could be usefully strengthened;
- Any current or previous community plans to address the needs of people with severe mental disorders, including capacities, gaps and requests for additional support;
- Resource persons from different community subgroups (for example, women’s groups, youth organizations, cultural and religious associations) who could potentially be recruited and trained to support individuals with severe mental disorders.

This information should facilitate IOM MHPSS managers to identify:

- Services for immediate referral of those in need;
- Services IOM should partner with, with the objective to gradually build their capacity to receive referrals;
- Possible obstacles created by perceptions and health-seeking behaviour of affected individuals, families and communities.

However, this mapping should always be accompanied by quality control and human rights compliances of the mapped services (See Chapter on **Community-based support for people with severe mental disorders**).





3.2.4 Formulate objectives

The objectives of the assessment are highly dependent on the results of the desk review, the organizations' mandate and actual possibilities to respond to the current crisis, and the discussion and inputs received from the members of the project's committee, if already established, or the first community gatekeepers met during the process. In general, as identified in the *IASC Community-Based Approaches to MHPSS Programmes: A Guidance Note* (IASC, 2019a):

A CB MHPSS assessment should identify mental health and psychosocial problems as well as safe and quality resources and strengths; including individual, family, community, traditional, religious and cultural coping mechanisms, social support mechanisms, community action and government and NGOs capacities.

An important distinction is whether the primary aim of the assessment is of advocacy or to plan a direct intervention. Another important factor is the nature of the programme. If the programme can respond to different emerging needs with a flexible approach, the goal can be broader. If the scope of the programme is limited – for instance, it can only provide urgent clinical services to people with severe mental disorders – then the goal should be restricted in identifying issues around this subject. Doing otherwise would not only be ineffective, but also tiring for the community, risking assessment fatigue and raising false expectations.

For IOM, typically, the first MHPSS assessment is broader, aiming at understanding people's psychological reactions – their own perception of what causes these reactions, and people's existing coping strategies, at the individual, family and community levels – and their understanding of needed services.

For agencies or IOM missions whose programmes are limited in scope, the objective of the assessment should be as specific as possible; realistically considering a minimum amount of information needed, timing and resources available (staff, logistics, access) to

achieve the required output (ICRC and IFRC, 2008:25–39).

3.2.5 Prepare

In this phase, several decisions and actions related to the assessment must be taken. They are addressed briefly below.

3.2.5.1 Select methodology and tools

The methodology should be based on:

- Objectives;
- Scope of the programme;
- Availability of time;
- Availability of financial resources;
- Availability of human resources;
- Informing logic of the intervention.

In general, assessment methodology determines the degree to which participants and therefore communities can freely express ideas, which is an essential aspect of community-based and participatory approaches. The existing tools vary in the way they allow the expression of and/or emergence of participants' opinions. In this regard, a distinction needs to be made between at least four methodological approaches:

- A nomothetic approach based on types or categories: A nomothetic approach brings an assessment constructed around categories that are predefined. For instance, how many people fit in a certain category or need that the assessment aims to identify?
- An ideographic approach that aims at understanding meaning and perceptions of cultural or subjective phenomena: This approach lets participants express what matters most to them and then places these inputs in a coherent structure. Results can be categorized, but categories are not predetermined. They emerge from the assessment.
- Quantitative methodology that will result in prevalence data, number of people in need of a certain service, among others.

- Qualitative methodology that will result in insights on the issues at stake, a grasp of participants' perceptions of various issues, among others.

Checklists and closed-ended questions with binary answers (yes or no) are quantitative measures, part of a nomothetic approach. Semi-structured interviews with open-ended questions, case studies, group discussions and art-based assessments are all qualitative measures, part of an ideographic approach. While a qualitative and ideographic approach could be considered more community-based, in that it lets participants express more freely their concerns, and grasp what is more accessible in their narratives, it may bring data that are more difficult to analyse or whose analyses are more dependent on the researcher's point of view. It may also bring results that are not strictly related to the sort of programme the organization has the capacity to run. Table 1 presents a series of complementary information addressed by different methodological perspectives.

A quantitative, nomothetic approach is more likely to bring valid and precise results, but also to be based on categories of needs that may not be what matter the most for communities, grasping what is available in participants' cognition but not necessarily what is most accessible and therefore relevant for them, and to limit the scope of the assessment to narrow, predetermined elements.

In any approach chosen, questions should be limited to collect exclusively the information needed to plan a successful project. The focus should be on the quality of the information, not the quantity, to avoid exposing communities to lengthy assessments and maximize resources.

WHO and UNHCR have developed a toolkit that includes several MHPSS assessment methods and tools that can be used in an emergency, which are for the most part quantitative and nomothetic, but with notable exceptions, such as the last three, tools 10, 11 and 12 (**WHO and UNHCR, 2012:63–77**).



Another relevant source of useful procedures and tools for MHPSS assessments is the *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide* (IASC, 2013).

Relevant for the aims of this Manual on CB MHPSS are the two annexes on participatory assessments (ibid.:15–26).



A useful compendium of assessment tools to be used in a community engagement perspective (see also Chapter on Engaging with Communities) is proposed by the Capire Consulting Group in the *Inclusive Community Engagement Toolkit* (**Capire Consulting Group, 2016**).



Figure 7, retrieved from the Capire Consulting Group's *The Engagement Triangle* (**Capire Consulting Group, 2015**), presents different assessment tools that can be used in humanitarian emergencies: interviews, intercept surveys, vox pop, briefings, meetings, focus groups, consultative groups, citizen juries, kitchen table discussions, workshops, field trips and deliberative forums. It details which tools are recommended (✓) or highly recommended (★) for each assessment purpose.



Figure 7: Capire Consulting Group's scheme of selection of tools per assessment objective

A range of tools and techniques have been mapped on the Engagement Triangle, based on the intent of the community engagement.

These tools and techniques are just mediums to facilitate the community engagement. The content and delivery needs to be tailored on a project by project basis.

Note: This sample of tools and techniques are drawn from Capire's recent projects and experiences.

A range of tools and techniques have been mapped on the Engagement Triangle, based on the intent of the community engagement.

These tools and techniques are just mediums to facilitate the community engagement. The content and delivery needs to be tailored on a project by project basis.

Note: This sample of tools and techniques are drawn from Capire's recent projects and experiences.

					Small group							
	One-to-one								Large group			
	Interviews	Intercept Survey	Vox pop	Briefing	Meeting	Focus group	Consultative group	Citizen jury	Kitchen table discussion	Workshop	Field trip	Deliberative Forum
1 To inform decisions	★	✓	✓		✓	★	✓	★		✓		★
2 To primarily inform decisions and secondly build capacity	✓		✓	✓	✓	✓	✓	✓	✓	★		✓
3 To primarily inform decisions and secondly strengthen relationships	✓		★	★	✓	✓	✓	✓	★	✓	✓	✓
4 To build capacity				✓							✓	
5 To primarily build capacity and secondly inform decisions	✓		✓		✓	✓	✓	✓	✓	✓		✓
6 To primarily build capacity and secondly develop relationships				★								
7 To strengthen relationships									✓		✓	
8 To primarily strengthen relationships and secondly build capacity				✓	✓				★		★	
9 To primarily strengthen relationships and secondly inform decisions	✓		✓		★		★	✓		★		✓
10 To inform decisions, build capacity and strengthen relationships	✓				✓	✓	✓	✓	✓	✓		✓

Source: adapted from Capire Consulting Group (2015).



Table 1: Nomothetic/ideographic – Practical differences

NOMOTHETIC – QUANTITATIVE	IDEOGRAPHIC - QUALITATIVE
Topic: Incidence of people who define themselves as psychologically stressed or very stressed and rank “anger” as the most recurrent feeling in the last 2 weeks. Key Question: How much would you define yourself psychologically stressed on a scale from 1 to 5, and how many times have you felt anger as the most relevant emotion in the last two weeks?	Topic: Identification by affected populations of the main emotions and states of mind felt during the crisis, risky journey, forced movement, displacement and confinement (if any). Key Question: Can you describe your prevalent feelings and emotions over the different periods: when the crisis started, during the journey to the camp/centre, now that you are settled in a safer space?
Topic: List of mental health and psychosocial support resources (practitioners, clinics, hospitals) available in the camps, centres and host communities. Key Question: Who are the available psychologists and psychiatrists and which health posts can you refer to if you need medical care?	Topic: Identification by affected populations of the main providers of affective support, emotional and spiritual care, medical and religious services in the communities. Key Question: To whom in your family and neighbourhood do you refer when you need emotional support, you want to share your bad feelings and you are searching for medical treatments?
Topic: Number of individuals who show mild to moderate symptoms of depression related to displacement situation and irregular migration. Key Question: How many persons have developed symptoms of depression (ideas, attitudes and behaviours) due to crisis, journey or displacement in this service?	Topic: Description of the occurrences that make people living in camps and transit centres feel sad, melancholic, apathetic or hopeless. Key Question: Could you recall situations, places, people or discourses that make you feel bad, sad or concerned about your emotional balance in the camp/centre?
Topic: Number of survivors of torture, GBV and domestic violence living in the camps and host communities. Key Question: How many persons are survivors of violence or (actual and potential) survivors of abuse in their families in the camp/centre	Topic: Identification by affected populations of vulnerability factors, aggressive communication and negative social codes that affect survivors, women and children in displacement. Key Question: Which do you think are the most offensive behaviours, words and attitudes for persons who have been survivors of abuse and violence, and might threaten their sense of safety and protection?
Topic: Number of families who have one or more members with disabilities who experience barriers in participating in their family and community life. Key Questions: How many families have one or more members with a disability? What barriers do members with a disability experience?	Topic: Description of barriers and enablers experienced by people with disabilities to accessing support services. Key Questions: What are the support services available to you? What are the challenges and enablers you experience to accessing these services?
Topic: List of the most important religious rituals, civic celebrations and family activities usually performed by affected communities and/or their subgroups. Key Question: What are the most relevant religious festivals and public ceremonies for the affected community or for specific subgroups/families?	Topic: Identification by affected populations of collective and family practices that offer a sense of belonging and homeness to people who share cultural practices such as spiritual beliefs, aesthetics, arts and crafts, and cooking. Key Question: Which kind of religious festivals and rituals, public ceremonies or social meetings, creative activities or domestic chores do you most like to attend and perform, and why?

In emergencies, IOM normally uses an **MHPSS Rapid Appraisal Procedure toolkit** that contains quantitative elements (surveys), qualitative elements (interviews) and observations. The protocol and methodology can be:

- Very simple, in case of assessments taking place in the immediate aftermath of a disruptive event or a displacement in under-resourced realities (**see, for example, IOM, 2014**).
- More elaborate, for instance in situations of protracted displacement, or situations where expert interviewers can be identified (**see, for example, IOM, 2010c**).

All in all, the best way to proceed is for an MHPSS manager and their team to tailor context-specific assessment methods and tools that take into consideration the above-mentioned resources, or others, and pick those that are suitable for the context, more community-based, doable in the time and with the resources available, and pertinent to the scope and the kind of programme the agency can actually run. In addition, the tools, especially the ones that are ideographic, can be transformed, adding or deleting certain items. For instance, each of the tools of the IOM MHPSS assessment toolkit is not to be considered as final, but as a list of questions and items that can be reduced, expanded or prioritized upon need. In addition, whatever method and tools are used, they should be contextualized and adapted to the specific languages of participants, cultural context and stage of the emergency. This should be a collaborative process between the IOM international team, the IOM national team involved in the assessment, and the project committee or community anchors identified at that stage. A context analysis can be planned to better understand social, political, cultural and economic aspects of the changing environment in which the affected population lives.

Box 17

Assessing prevalence of mental disorders: Cautions

Differentiating between what is abnormal “pathology” and what is a normal emotional response to an abnormal event is a global challenge. Large-scale epidemiological surveys, especially those that have not been culturally validated, may not be able to differentiate between the two – for example, sleeping poorly can be a “symptom” or an expected response to an adversity or stressor. This can mean rates of disorders could be overestimated when local expressions of adaptive distress reactions are confused with psychopathology. Any study into the prevalence of mental disorders needs to begin with ethnographic understanding of people’s lived experiences and different social and cultural expressions of distress in order to find holistic and accurate descriptions. These include:

- Cultural frameworks for mental disorders and associated belief systems;
- Community attitudes towards mental disorders and their impact;
- Relevant information on social, cultural, religious, economic and political structures and dynamics (for example, conflict issues, ethnic/class divisions, individualistic/collectivistic);
- Ethnographic information on relevant sociocultural norms and practices;
- Understanding the impact of the emergency context on the above.

In addition, diagnostic (mental health) questionnaires need to be validated, and clinical interviews are better predictors than checklists and self-reports. In fact, if surveys are just translated but not validated and administered by interviewers who are not (mental health) professionals, results could be misleading. It should be noted that assessments are not the same as epidemiological research, and the collection of prevalence data on mental disorders is rarely feasible or useful as part of an initial assessment.

3.2.5.2 Select target groups and interviewees

Participatory assessments are conducted with different members of the population to understand specific needs, resources, capacities and proposals, and to test the validity of the existing set of information.

The IOM toolkit includes specific batteries of questions for national stakeholders, international stakeholders, local/community stakeholders and affected families. Other tools in the WHO–UNHCR toolkit (WHO and UNHCR, 2012) can be addressed to affected individuals only, or to groups. In any situation, participants can be randomly selected and, depending on the objective, there should be relevant participation of men and women, and people of different ages, ethno-religious, socioeconomic and culturally diverse groups, including different migrant groups, if relevant. In order to have relevant communities and subgroups represented, purposive sampling can also be adopted (see Box 18). A mixed approach that remains random in the selection of participants but fixes minimum and maximum quotas of people to interview for each representative group is always preferred.

Box 18

Purposive sampling

“Purposive sampling (also known as judgment, selective or subjective sampling) is a sampling technique in which a researcher relies on his or her own judgment when choosing members of a population to participate in the study... The purposive sampling method may prove to be effective when only limited numbers of people can serve as primary data sources due to the nature of research design and aims and objectives. For example, for research analysing effects of personal tragedy such as family bereavement on performance of senior level managers, the researcher may use their own judgment in order to choose senior level managers who could participate in in-depth interviews.”

Definition taken from the website Research Methodology, available [here](#).



Language and culture should be considered. There may be a need to develop a lexicon of words, phrases and expressions according to affected populations' understanding, cultural practices and belief systems. For instance, when talking about feelings without knowing that “feeling” in a language means only physical sensations, there is a risk to misjudge the collected information, generating far-reaching effects on the intervention.

MHPSS assessment in Cox's Bazar, Bangladesh. © IOM 2020



3.2.5.3 Selection of interviewers

A team that will carry out the assessments needs to be selected. The size of the team should be decided upon in relation to the number and distance of the sites, the sample to be interviewed, their location, and the time frame and budget. The following points should be considered when identifying staff for assessments:

- **Technical expertise:** Ensure that the team or individuals engaged in the assessment have the appropriate or the most relatable expertise and capacities.
- **Personal qualities:** Good communication, compassionate ability of good listening, basic reporting skills.
- **Context:** Ideally, the assessment team is comprised of members of both the host and the displaced communities, or at least by professionals familiar with the local context and the language used in the area where the assessment will take place. If this is not possible, at least a cultural mediator or translator should accompany the interviews.
- **Communities' involvement:** Make sure to involve and engage communities and include members in the assessment team. Further information about team selection can be found in the **Psychosocial mobile teams chapter**.

Depending on the context, one could expect each member of the team to conduct 3 to 4 individual interviews, or 2 to 3 focus groups per day, plus reporting.

3.2.5.4 Training of interviewers

Before the assessment starts, all interviewers need to be trained in:

- Interviewing and communication skills;
- Documentation skills;
- Analytic and problem-solving skills;
- Understanding of basic mental health and

psychosocial issues;

- Ethical principles, confidentiality and informed consent;
- Psychological first aid (PFA) to support the interviewees if needed;
- Administering the specific tools that will be used for the assessment including using Washington Group Questions to disaggregate data by disability. See **How to ask the Washington Group Questions**.

In emergency situations, where the protocols are prepared in a hurry, the training can contain a workshop to discuss and transform the assessment protocols based on feedback received by the trainees in terms of suitability, lexicon, cultural elements and possibly stigmatizing elements of the protocol. At times, some items will need to be deleted because they may not be comprehended by the team.

An important element of the training is ongoing supervision and support during data collection (see chapter on **Technical supervision**). The training should ideally take no less than three and no more than five days.

3.2.6 Data collection

The methodology for carrying on a good data collection exercise should include the following points when possible:

- Reading situational analyses from at least three viewpoints, including external and community ones (triangulation of information), while interviewing key informants and direct observations on the ground;
- Meetings with community and religious leaders, stakeholders, teachers, health workers, focusing group discussions with members of the community affected by mental, neurological and substance use disorders, persons with disabilities, their family members and relatives;
- Using different visual (photos, drawings, emoticons) and interactive (participatory ranking, voting, walks) exercises to also allow

3. ASSESSMENT AND MAPPING

children and individuals with low levels of formal education to actively contribute;

- Community consultations, which should be carried out by means of semi-structured interviews that allow for a full range of qualitative data;
- Participatory mapping exercises aimed at identifying existing MHPSS services for referral and human resources (displaced health workers, teachers, trainers), which should be carried on at this stage, as well as social networks diagrams, which should be drawn in camps, transit centres and neighbourhoods hosting internally displaced persons, refugees and migrants;

It is important to inform discussants and leaders that data collection is part of a learning exercise, and might be repeated at later stages. Data collection will vary according to the methodology adopted. It is important to consider that data collection will first

and foremost follow ethical principles and participatory standards based on *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007:8). In this regard, it is mandatory to ensure that data collection would be confidential, grant anonymity and be based on voluntary participation and informed consent. It will be condensed in a short period of time, given the high volatility of the environment of an emergency and in order to inform programming in a timely manner.



Interviewers will usually be divided by camp sector or neighbourhood, and each team will comprise of different genders, allowing participants to choose the gender of the assessor.

Interpretation and cultural mediation should be provided, if needed.

Given the fact that participants may have conflicting needs, lengthy interviews should be avoided. In some context, it is preferable to have

Clinical assessment, IDP centre, Sana'a, Yemen. @ IOM 2014



multiple interview sessions, rather than a very long one-off one.

Especially when an assessment includes clinical components, a referral system should be put in place before the assessment takes place.

In addition, data collection should be conflict-sensitive and limited to the minimum disruption to the community fabric that may derive from the ways in which data are collected. Those modalities are best assessed and reviewed with the project committee and the project team, as well as camp managers and other local authorities.

Key points to be considered in terms of community-based approaches include:

- Cultural sensitivity, gender diversity and inclusiveness: For example, discussing sexual violence with a woman in a mixed group can cause punishment or exclusion for the women afterwards. On a different level, if the tool is addressed to families as a group, the male head of household may have a prominent role and focus groups with women and younger people may become necessary to balance information.
- Power relations: People with power can exercise control on what is being publicly said, or participants might exercise self-censorship in their presence.
- All the actors involved in the assessment retain a degree of preconceived knowledge, which might marginalize alternative views of a specific group. Therefore, constant attention for stigma and biases about and within certain groups, including the humanitarian community, should be exercised.
- A focus group is not always representative of the most compelling needs of the whole affected population, as some individuals might monopolize focus group discussions, particularly related to sensitive topics. It might be helpful to take that person out of the group dynamic and proceed with an individual

interview because they have such clear information and opinions.

Box 19

Power structure

Working in a community-based approach, the acknowledgement of the role that power structures play in a community is vital, so parallel interviews or focus groups with individuals or small groups should be promoted, because it may be inappropriate to talk about certain issues in a larger group. It is essential to create a space in which people can openly talk. Dividing groups according to gender and age can be useful for the assessment, but a consideration of the social, religious and cultural dynamics of the specific emergency context ensures that all voices are heard and that everyone can identify their needs, problems and resources, which can lead to richer results, such as in this example:

Ask the young men what they see as the most important issue to the women in their community. The women are, at the same time, in a small group discussing what is important to them. When everyone comes together again, the men are given the opportunity to share their thoughts on what women consider important at this moment and time in their lives, with the group. They usually get it wrong and this creates a lot of laughter. The roles are then reversed, so that everyone has a chance to get it wrong, and to laugh, so we feel that we laugh with the people and not at the people (Sliep, 2009:16).

Such a reflective exercise should only be done early in a meeting and by workers who have experience. It may be totally inappropriate or ineffective in communities where women are not allowed or used to judging **men**.



3.2.7 Data analysis and discussion with relevant stakeholders

The procedures of data analysis will also largely depend on the methodology adopted to engage communities and collect information. Ideographic and qualitative tools are typically more difficult to read than nomothetic quantitative tools. The procedures through which data are going to be analysed and the needed capacity should be considered from the very beginning of designing the assessment (see figure 8).

Figure 8: Data analysis

Data analysis of a quantitative nomothetic tool:	Social network analysis, cluster analysis, trend analysis, descriptive statistical analysis, incidence and prevalence analysis, regressions and correlations analysis.
Data analysis of a qualitative ideographic tool:	Discourse analysis, narrative analysis, content analysis, grounded analysis (themes, categories and codes), framework analysis.
Data analysis of a mixed method tool:	Complementary analysis, comparative analysis, context analysis, inferential analysis.

Preliminary analysis and clustered findings should be shared and discussed with community representatives, to the extent possible and using visual representations such as graphics, diagrams, drawings and pictures. These meetings can include:

- The assessment team, which includes experts or activists from the affected communities;
- The project committee or relevant stakeholders (including at least those who were interviewed);
- Local leaders and representatives of affected populations, including representatives of the most vulnerable categories.

This ensures that interpretations are made more in line with community perceptions and avoid misunderstandings. This analytical process in a community engagement perspective is also aimed at identifying local resources to be mobilized during the implementation phase and monitoring and evaluation exercises.

In IOM rapid MHPSS assessments, results are presented based on Renos Papadopoulos' systemic grid of outcome of consequences. See [here](#).

For contextualization, see the full study [here](#). For a more recent study, using a similar but simplified model, see a MHPSS assessment conducted in South Sudan in 2014, [here](#).



3.2.8 Discussion and dissemination

Findings and data analysis should be discussed with all involved: NGOs, government, community and subcommunity representatives. After this discussion, findings and data analysis should clarify needs and available resources, and bring actual programmatic recommendations, including an evaluation of obstacles, misperceptions or any issues of credibility related to the assessment. Findings (for example, report, summary and/or presentation) should be shared in the local language and in culturally appropriate ways, when possible. For the purpose of this Manual, the assessment findings and recommendations need to be shared with the IASC system, especially if there are recommendations for other sectors to mainstream MHPSS, and the academic partners, and through the identified gatekeepers and members of the project committee. Gatekeepers and members of the project committee can describe findings and recommendations to their specific communities and subgroups in the perspective to (re)activate individual and collective resources, reducing the risk of “learned helplessness” generated by the range of problems detected by the assessment.

→ 3.3. CHALLENGES AND CONSIDERATIONS

There are multiple challenges associated with the assessment phase in emergencies:

- It can be problematic to reach remote areas that are heavily affected by the emergency, ensuring that all community subgroups (social

status, ethno-religious, political) are represented on the assessment team, as well as in the interviewed populations (including the elderly, women, men, youths, children and persons with mental problems and/or disabilities). Community engagement and working with partners can help alleviate this concern.

- Assessments can raise false expectations in the communities. It is important to inform them on the objectives of the assessment in advance, and be honest about goals.
- It can be challenging to train people from the community to ensure high-quality, safe, culturally sensitive and ethical data collection, as there are also time limits.
- Analysis of data is often challenging because of the lack of statistical expertise in the MHPSS teams. It is important to choose assessment objectives as well as methodology based on the existing capacity of analysis; otherwise, a lot of efforts will be nullified by the impossibility to meaningfully analyse the gathered data.
- It can be challenging to gather sensitive data, such as human rights violations, and make sure the data collection is confidential (**UNFPA, 2014**).
- Tools have limitations, as described throughout the chapter.



Reasons for not doing an assessment include:

- When conducting a needs assessment will put data collectors or interviewees in danger or are harmful;
- When a population feels over-assessed and possibly hostile to additional needs assessments.



Table 2: Dos and don'ts

Dos	Don'ts
Respect ethical principles and heed protection concerns	Don't do harm
Only collect information that will be used to design interventions	Don't collect information that will not influence programme decisions
Coordinate assessments with all relevant stakeholders	Don't collect information without involving others
Include the affected communities in the design, analysis and decision-making	Don't neglect the perspectives of those affected by humanitarian crisis
Assess problems and resources	Don't focus on the problems only
Ensure that the assessment tools are culturally appropriate	Don't use assessment methods across cultures blindly
Tailor each assessment to the particular situation and phase of the crisis	Don't employ a standardized assessment package
Check beforehand what is already known in the area	Don't immediately start collecting new information
Include different sections, age groups, gender, ethnic and religious groups	Don't forget the "silent" groups
Be attentive for conflict and tensions	Don't put people at risk by asking questions
Ensure that assessment teams are trained and knowledgeable of the local context, balanced in terms of gender, and include members of the populations	
Make sure that the assessment is timely and tailored to the phase of the humanitarian crisis	

Source: Based on Ventevogel and Schininà (2009).

The IASC Thematic Group on Community-Based Approaches to MHPSS held an online exchange discussing challenges to assessment, monitoring and evaluation, of which a video can be found [here](#).

→ FURTHER READING

International Medical Corps (IMC)

2016 *Rapid Mental Health and Psychosocial Support Assessment: Needs, Services, and Recommendations for Support to Individuals Affected by the Mosul Emergency*. IMC, Erbil, Iraq.

2017 *Ethnographic Assessment of Psychosocial Needs of Children at Vasilika Camp*. IMC, Athens.

International Organization for Migration (IOM)

2011 *Who am I? Assessment of Psychosocial Needs and Suicide Risk Factors Among Bhutanese Refugees in Nepal and After the Third Country Resettlement*. IOM, Kathmandu, Nepal.

For other references see the full bibliography [here](#).



4. PSYCHOSOCIAL MOBILE TEAMS





4.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

IOM CB MHPSS programmes in the aftermath of an emergency usually make use of a standardized approach: the psychosocial mobile teams (PMTs). PMTs are multidisciplinary psychosocial support teams that offer services not in a facility-based but in a community-based fashion, which is why they are called mobile. They have been engaged by IOM to respond to the MHPSS needs of displaced populations in many emergency situations over two decades, including in Chad, Haiti, Lebanon, Libya, Nepal, Nigeria, Serbia, South Sudan, Sri Lanka, Kosovo¹ and many others. While many elements of the work of the teams depend on the dimension, quality, characteristics, cultural context and existing MHPSS capacities of each emergency, a series of common standards and suggested processes have been identified.

The key strengths of PMTs have proved to be:

- Their multidisciplinary composition: The combined expertise of a range of team members is used to deliver community-based comprehensive care to individuals, families and groups (IOM, 2016).
- Their participatory approach: Teams include members of the concerned communities with various types of educational backgrounds, cultural competencies and professional skills.
- They allow for flexibility of programming (sites, responses, timing), which is an essential factor when dealing with emergencies.
- Their mobile nature allows outreach and proximity to the communities over time and displacement phases.
- They render services more accessible for women, persons with disabilities, older people, large families and others who may experience limitations in travelling to facilities.

This chapter of the Manual illustrates the process of establishing and maintaining a PMT, more in terms of teamwork than taskwork. The actual activities and services offered by the teams are in fact described in subsequent parts of the Manual. This chapter mainly illustrates the experiences of IOM's PMTs, but its overarching principles and recruitment methods can be applied to any MHPSS team.

4.1.1 The composition of IOM PMTs and what the team members do

Each PMT is composed by up to six team members with the following qualifications/roles:

- A team leader, coordinating the activities of the teams, linking the necessities of the teams with those of the project management, identifying training gaps, supporting the teams in designing activities based on assessed needs, and attending to output-level monitoring (see chapter on **Monitoring and evaluation**) and reporting: If properly trained, team leaders can also act as supervisors for the teams (see chapter on **Technical supervision**). 
- A member tasked with directly attending or organizing provision of individual and group psychological counselling and support: Ideally, this team member would be a clinical or counselling psychologist or a counsellor. In situations in which this profile is not available, the functions can be carried out by a social worker, or a health counsellor, a pastoral counsellor, a midwife or a traditional resource, who will be supervised and trained for the **scope** of the team's activities. 
- A member tasked with social support, including referral to additional services and social support organizations, as well as family mediation and case management: Ideally, this will be a social worker. If social workers are not available, the function can be performed by a counsellor, or a social activist, and **training and supervision will be adapted accordingly**. 

¹ References to Kosovo shall be understood to be in the context of United Nations Security Council resolution 1244 (1999).

- A member tasked with the organization of sensitization sessions, psychoeducation sessions, awareness sessions and informal educational activities for the community: This professional will be an educator or a trainer.
- A member tasked with the organization and promotion of cultural, socializing, sport and recreational activities, both in terms of structured activities that they facilitate directly; and mobilizing, supporting, framing and putting in a network already existing activities: This professional will usually be an artist, an anthropologist, a sports coach or a cultural and social mobilizer (activist, journalist, animator), who is named an artist-animator.
- A community mobilizer, who understands the community very well and assists in the mobilization of its various sectors: This can be either part of the core team, or someone who acts as a community focal point for the teams. The community focal point differs from the mobilizer because their function is mainly of support and does not require full-time engagement. Moreover, the focal point is not mobile but is bound to a specific camp sector or neighbourhood.

Other team members may include:

- A member tasked with small-scale conflict mediation (see chapter on **Integration of MHPSS in conflict transformation and mediation**).
- A health worker (typically a nurse) in case no one else is providing medical services, and just for the time necessary to cover the gap.

See relevant terms of reference [here](#).

Box 20

Selection of PMTs

In some contexts, one or more of these profiles may not exist or are not represented in the sites of displacement. In these cases, based on mapping of capacities, teams are selected among the most relatable professionals or activists. The frequency and scope of supervision, as well as training, are therefore strictly connected to the existing capacities within the teams, the nature of the needs that the team respond to, and the type/context of the emergency (see chapters on **Training and Technical supervision**).

The PMTs start their engagement with communities by assessing the needs of specific sites and/or groups, based on IOM and other assessment and mapping tools (see chapter 3 on Assessment and Mapping).

They then provide psychosocial support based on the multitiered approach suggested by the pyramid of MHPSS **intervention** covering tier one (basic services and security, mainly in terms of information, field coordination, advocacy and referral to services); tier two (community and family support); and tier three (focused services), establishing referrals to the teams in charge of clinical referral and **follow-up**, or the services or agencies providing clinical care for people with mental disorders. See **box 24**.



Their approach is twofold. Most often the mobile teams provide support through:

- Direct provisions of services and activities; and
- Mobilization of and support to community-based resources.

In general, each one of the team members has his or her own function, but they all collaborate on needs assessment and the design of the interventions. They refer clients (individuals and groups) to each other, and when they think their internal support is not sufficient, they seek help and supervision from international or senior national experts within the programme (manager and supervisor).

Each of them is able to provide psychological first aid (**PFA**).

The educators produce and disseminate messages related to psychosocial well-being and health promotion. They provide or organize the provision of informal education to children and adolescents, and organize safe spaces and child-friendly spaces. They additionally organize adult non-formal education classes and support the educational and awareness activities organized by other members of the teams.

The social workers attend to vulnerable social cases and make referrals to service providers that are previously mapped and mobilized. Moreover, they support the rejuvenation of community support and safety networks, and attend to family mediations.

The artist or community animators engage the communities in some of their traditional, cultural and religious activities, which help them maintain a sense of identity. This includes traditional arts and crafts workshops that are used as income-generating activities as well as a form of psychosocial support (Babcock et al., 2016). They can also organize and propose specific structured cultural and artistic activities in forms of workshops and or events that promote

expression through artistic means, either directly or by mobilizing existing creative resources.

The counsellors in the team offer (lay) individual or group counselling to people they directly identify, who seek assistance or who are referred by other members of the teams and train other key people in the community in buddy-to-buddy **systems** and **PFA**.

Conflict mediators intervene to mediate small-scale family and community conflicts, while nurses or other health professionals attend to the referral to health services and help the educators to design health awareness inductions.

The community mobilizer or community focal point supports the team, sharing with them relevant information about the security and social situation in the sites on a daily basis, as well as linking with local authorities and actors, and keeping the community informed and reminded of the activities of the teams.

The specificities of all sectors of involvement of the teams are explained in more details in the forthcoming chapters.

Box 21

Local partners

In some contexts, IOM might be unable to directly recruit people to set up a mobile team, or similar multifunctional community structures already exist. In these situations, the manager should work through identified local partners. A mapping analysis (see chapter on **Assessment and mapping**) helps to identify local stakeholders and available resources, and IOM will provide complementary programmes such as trainings, technical supervision and other capacity-building initiatives (see chapter on **Technical supervision and Training**).

→ 4.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

4.2.1 How PMT members are selected

IOM, like any other agency, considers a well-established set of practices, from recruitment to deployment, that will need to be administratively followed in those cases. This chapter does not dwell on administrative procedures and types of contracts, but the general scope of the selection. PMTs, in IOM and other agencies, are built through active mobilization of communities, in order to reach people in camps, transit centres, and urban and rural areas. How teams are selected therefore becomes of paramount importance. Applying a community-based approach to team selection and composition requires a good understanding and engagement of:

- Communities and subgroups and their **dynamics**;
- Economic, social and political contexts and their actors (stakeholders, leaders, influential individuals);
- **Conflict and conflict sensitivity**;
- MHPSS concepts and needs.

Ideally, after the adoption of terms of reference, the various positions will be advertised through ministries, local authorities, relevant faculties of local universities, interest groups, professional and civil society organizations, websites and social media. The PMTs will then be composed taking into consideration their language skills, expertise, references, ethnicity, nationality, gender balance and educational backgrounds and, ideally, balance between members of both host and displaced migrant communities, noting that this may not be always the case due to bureaucratic impediments, work permits, and other obstacles.

Considering the necessary emergency development nexus, the fact that often professional resources are few in emergency situations, and the fact

that the PMTs receive extensive supervision and training, members of the teams can also be appointed from the staffs of university faculties, ministries, and existing professional and civil society groups. These engagements can take the form of secondments, extra-time volunteer work, or part-time engagements, through agreement with the respective employers. This will allow the concerned institutions, universities and civil society organizations to acquire knowledge and trained staff over the longer term, ensuring sustainability. In addition to the core team, other members can be attached to the teams and included in the trainings based on identified needs, or for determined periods of time, with a capacity-building objective in mind. Starting the programme with advocacy and sensitization actions can give the programme higher chances to be successful. The community should be informed on the roles and functions of the teams before MHPSS activities begin to be better accepted.

Box 22

Care for people with severe mental disorders

PMTs do not deal directly with clinical support to people with severe mental disorders. Usually, their work is complemented by dedicated smaller referral teams, comprised of health counsellors and, when possible, psychiatric nurses. They usually receive referrals by the PMT and other actors after informed consent is signed, and arrange, after consultation with the manager or the supervisor, the appointment and transportation of the person in need to the nearest mental health care or health care facility; attend to the psychoeducation and support of the family; and provide follow-up care, including making sure that the prescription is followed, and inclusion of the clients and their families in the activities promoted by the PMTs. For more information, see chapter on **Community-based supports to people with severe mental disorders**.

Box 23

Engaging academia

An example of engagement of university students come from post-earthquake Haiti, where the entire university's infrastructures were destroyed and fourth-year psychology students were able to achieve their last year, supporting the IOM's PMT and being involved in their trainings and supervision sessions, which were recognized by the university as part of their curriculum for the year. This brought to an entire generation of psychology students the experience of being exposed to post-disaster practical provision of psychosocial support, and helped the university to adapt its psychology curriculum based on trainings they received.

4.2.2 How the PMTs are trained and supervised

Supervision and training of PMTs are crucial, and they receive continuous training through different modalities:

- Induction training predeployment, covering basic MHPSS topics: This includes an introduction to the IASC Guidelines, community-based MHPSS, PFA, communication skills, ethical considerations, self-care and other relevant topics.
- Monthly training sessions, which address more specialized topics: The supervisor and manager decide on the topics to be presented, based on emerging needs identified in the field: for instance, peer-to-peer support, case management, counselling, **GBV**, work with children, work with people with disabilities, art-based interventions, conflict mediation, and the subjects of the chapters of this Manual.
- On-the-job training and supervision: Team members receive on-the-job training and supervision through regular meetings or field visits. The manager and supervisor may also organize on-the-job training delivered by external experts, based on specific identified training needs.

Induction and core training modules must be standardized and institutionalized as much as possible. For more information, see chapter on **Training**.



4.2.3 The role of hubs as anchors of the work of the teams

Hubs are temporary structures run by the PMT that can vary in form and size according to needs, but they are usually constructed with the same material used for the other units in the camps or displacement site (tents, caravans, prefabricates, shadings structures), or created in existing rooms or flats in neighbourhoods. They ideally comprise a small office for management and counselling purposes, a big room for larger events, and two rooms for workshops and classes, one of which can also be used for counselling. Hubs are better located close to schools and sports grounds if available, or they might include:

- Playgrounds for children (also to support caregivers to attend courses and psychosocial sessions);
- Volleyball/mini-soccer grounds to facilitate sports activities for youths, particularly girls, in safe and protected spaces.

They should be safe and protected spaces (choose the location and eventual protective measures in coordination with the security unit), and close to latrines for males and females, water points or hand-washing stations.

Hub structures are usually decorated internally, and externally if appropriate, in order to create a welcoming atmosphere for affected populations. PMTs are mobile by definition, in the sense that they cover different camps and neighbourhoods, and adapt to the movements of the populations they serve, with an aim to grant continuity to the intervention. In some situations, however, it has proved useful to create these hubs in different sections of camps, transit or community centres, hosting neighbourhoods that can be used by the



Community mobilization in IDPs sites. Psychosocial Mobile Teams, Ethiopia. © IOM 2018

teams to organize and implement activities. The hubs can be used to host activities organized by the teams, and also activities organized by members of the communities mobilized by the teams, including meetings, workshops, classes and events. Activities should always follow a schedule (daily, weekly) and should be well communicated through boards and visual/verbal announcements (for those who cannot read). The schedule will be up to the team leader, and the daily operations of the centre could be included within the functions of the community mobilizer, as appropriate.

The hubs are not long-term centres, but temporary facilities that help the logistical part of the work of the teams, and provide suitable spaces for activities that require higher confidentiality (counselling, group discussions on sensitive topics), and in ritualizing the work done by attaching it to a physical space. The work of the team, however, remains highly mobile, with regular outreach activities.

4.2.4 What is next

Usually, the PMTs, or at least their members that come from the displaced communities, follow the populations in their movements. For example, in Haiti, two years after the earthquake, MHPSS teams were fully engaged in the return process of returning from camps to communities, offering MHPSS, referral, and supporting persons with disabilities and other

vulnerable individuals, who were returning home or returning to transitional shelters.

When the population stabilizes in one place due to relocation, return or because the displacement becomes protracted, the work of the teams consolidates in two ways:

- From the one side, if the affected population and authorities consider that there is still a need for regular MHPSS, recreational and counselling centres for families are established. These centres expand their functions over emergency interventions and thus are not included in this Manual.
- On the other side, the training provided to the teams is evaluated and consolidated in a national curriculum, which can take the form of a master programme, an academic diploma, creating preparedness in the country for the next emergency to come, as it is better explained in the chapter on **Training**.



→ 4.3 CASE STUDY

For an example of the work of the PMTs, see this **video** on how PMTs were utilized in north-east Nigeria. Since then the project has expanded and some teams have accompanied the displaced populations in their return home.



→ 4.4. CHALLENGES AND CONSIDERATIONS

There are also challenges associated with a community-based approach to team selection:

- Different languages spoken by the host and displaced communities can create challenges in recruiting and training the most adequate staff. In these cases, consider adding cultural mediators to the teams (see chapter on Counselling).
- In some countries, it is challenging to recruit both females and males within the same team with the same level of education, skills and professional levels, because of cultural considerations on gender. In those situations, the number of team members could be expanded, to allow gender balance.
- Balance in ethnicity of the team members with the same level of education and skills might also be difficult to achieve in some contexts. Expanding the number of members to include different ethnicities can also be considered.
- The competition among relief agencies during a humanitarian operation can sometimes interfere with the recruitment of candidates or the retention of team members after training is provided to them. This can be mitigated by establishing inter-agency agreements and including actors from other agencies in the trainings provided to the teams.
- While different contracts are offered to different team members based on their level of expertise and prior engagements, teams may allow volunteers to join them to achieve flexibility and sustainability. The different contracts among team members can create dissatisfaction and tensions within the team, which need to be addressed in a participatory way, through supervision and clearly set and transparent differentiations.
- Likewise, when teams operate with a

mobilization approach, the difference between the team member, who is paid, and the mobilized community resource who conducts an activity usually for free, can create a grey area. In these cases, it is important to find forms of gratification for the community resource (training, in-kind compensation, public recognition), and identify time and engagement limits between volunteer and paid functions.

- Finally, conflicts might occur within and between teams or between the teams and other providers or some community members, due to different reasons, including personalities, cultural and political attitudes, and stressful working conditions, which tend to exacerbate over time. These can be addressed in **supervision**, and time and resources should be dedicated for **staff care**.



Box 24

How many teams for how many services?

There is not a unique formula to calculate how many teams are necessary to serve a certain number of people. This ratio is highly dependent on the service the teams are providing, their expertise, the size of the problems, the other services and support networks available, and the general population to serve. In general, a team of 5 should be able to provide around 4,000 services per month. This figure includes individuals participating in one-off events and psychoeducation sessions, several sessions of a workshop with multiple affected populations, sporting events and others, both facilitated by the team members (500 to 800 max.) or by other facilitators or community members mobilized and supervised by the team members (up to 3,500), and should not be considered as the total number of individuals receiving counselling or case management, which cannot be more than 30 per month per dedicated team member.



FURTHER READING

Bjerneld, M.

2009 Images, Motives and Challenges for Western Health Workers in Humanitarian Aid. *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine* (453).



Kutash, K. et al.

2014 Quality Indicators for Multidisciplinary Team Functioning in Community-Based Children's Mental Health Services. *Administration and Policy in Mental Health and Mental Health Services Research*, 41(1):55–68.



Schininà, G., M. Aboul Hosn, A. Ataya, G. Dieuveut and M. Salem

2010 Psychosocial Response to the Haiti Earthquake: The Experiences of International Organization for Migration. *Intervention*, 8(2):158–164.



Schininà, G., N. Nunes, P. Birot, L. Giardinelli and G. Kios

2016 Mainstreaming Mental Health and Psychosocial Support in Camp Coordination and Camp Management. The Experience of the International Organization for Migration in the North East of Nigeria and South Sudan. *Intervention*, 14(3), 232–244.



Yeboah-Antwi, K., G. Snetro-Plewman, K.Z. Waltensperger, D.H. Hamer, C. Kambikambi, W. MacLeod, S. Filumba, B. Sichamba and D. Marsh

2013 Measuring Teamwork and Taskwork of Community-Based Teams Delivering Life-Saving Health Intervention in Rural Zambia: The Qualitative Study. *BMC Medical Research Methodology*, 13:84.



For other references, see the full bibliography [here](#).



5. SOCIORELATIONAL AND CULTURAL ACTIVITIES



→ 5.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Box 25

Chapter Video

The following chapter is explained in **this video** which was developed as a complement to the Manual. For a visual explanation of the information presented in this chapter, please watch before or after reading the material.

In the first chapter, a series of MHPSS operational models were presented. The first model gives centrality to sociorelational, cultural and biopsychological factors and how they influence each other, both in determining psychosocial well-being and in the provision of effective **MHPSS**. The section of the Manual encompassing chapters on **Sociorelational and cultural activities, Creative and art-based activities, Rituals and celebrations, Sport and play** and **Non-formal education and informal learning** describes activities that work mainly at the cultural and sociorelational levels, and that can have a profound impact on the biopsychological well-being of crisis-affected individuals. These activities can help bridge tradition with the necessity to change, and in turn, transform what individuals and communities face after a crisis, helping them maintain a sense of **identity**. Considering the model of MHPSS **programming**, these activities respond to the suffering of individuals and groups, focusing on enhancing resilience factors and activities that traditionally mitigate distress, while giving evidence to the positive outcomes of the emergency in terms of skills, creativity and reflections. Culture has a significant impact on an individual's well-being because it strengthens the social fabric, and provides individuals and communities with a sense of belonging and of being **supported**.

Sociorelational and cultural dimensions regard

the full spectrum of a community-based mental health and psychosocial support programme in emergencies, including specialized mental health care and focused counselling services. The sociorelational and cultural aspects of those services are discussed in the respective chapters (**Counseling** and **Community-based support for people with severe mental disorders**). The following chapters present dedicated sociorelational and cultural activities that can be mainly included in MHPSS programming at the second and third layer of the **pyramid of MHPSS in emergencies**.

The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007), point out the relevance of cultural, spiritual and religious practices, both as forms of community engagement and in the provision of mental health-care services, respectively, in **Action Sheets 5.3 and 6.4**. These paragraphs are concise and comprehensive, and they should be considered for complementary reading.

Specific to children and families, the UNICEF *Operational Guidelines: Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families* (UNICEF, 2018), and the **UNICEF Compendium of Community Based MHPSS Resources** (UNICEF, 2021) provides guidance on activating or restoring community structures that strengthen social networks and protect and support children and families, and should be used as reference.

Box 26

Safeguards for children

As soon as children are involved, safeguards against abuse should be put into place. They include behavioural protocols for the staff, training and complaint systems. This regards not only sociorelational and cultural activities, but also Creative and art-based interventions, Sport and play, Non formal education and informal learning. For advices on the practical implementation of the principles **see here**.



Games for youth with and without disabilities. Recreational and Social Centre for Families, Moultakana-Abu Sliem, Tripoli, Lybia. © IOM 2013/Stefano SPESSA

Box 27

Selection of activities

The selection of the activities described in this and the following chapters is embedded in the IOM operational framework and past experiences and is, in this sense, partial. In particular, the sociorelational and cultural relevance of social media and other web-based tools should not be underestimated in how it shapes bodies and their perceptions, minds, values, sense of community, value of memories, group building and socialization practices, as well as reactions to the emergency. Affected communities, particularly youth and those on the move, are usually connected among themselves and to external networks through smartphones and computers, searching for information, entertainment and guidance. How and when these connections have an impact on their mental health and psychosocial well-being should also be taken into consideration by programmes. While some examples of best practices are presented, this version of the Manual won't provide a complete overview and reflection on these possibilities.

Apart from the activities that will be presented in the following chapters, which are based on specific mediums, MHPSS programmes should support a series of spontaneous or induced groupings of affected populations, with an aim to

foster social cohesion and social supports.

These activities very often build on existing practices. In any community and in any group, people have their ways to relate to and support each other. In some cultures, men may meet to play chess or backgammon at the end of the working day in the main square; in others, women may meet to cook together. These sociorelational and cultural activities and groupings, after emergencies, should be restored, facilitated and supported. For instance, during the Balkan wars, it was noted that traditionally women, especially those who were married and in rural areas, would gather at certain hours of the afternoon to crochet and knit together. This was an occasion for them to share resources and skills, to relate and socialize, and to receive social support. During and after the various Balkan wars, many organizations started supporting women to re-establish these practices in camps, refugee centres and affected neighbourhoods. The support varied from context to context, and could include outreach, provision of a safe space, provision of materials and tools, provision of access to markets and fairs, and in some cases facilitators, animators and even psychologists, who could help the women use these venues to discuss in more structured and non-stigmatizing ways their psychosocial problems and negative feelings, or could provide **psychoeducation**. Another example is the coffee ceremony in Ethiopia. Coffee ceremonies



– such as gatherings in which women usually roast, grind and brew coffee beans for family, friends and neighbours – play a strong social support role and provide an occasion for positive socialization. After displacement, the affected population could no longer participate in such ceremonies and reported that this was affecting their coping capacity. The MHPSS programme thus provided material support (cups, coffee, pots, among others) to enable the resuming of such ceremonies. Not only were the coffee ceremonies strengthening the social fabric and support network, they also became an easy avenue for MHPSS team members to engage with the community.

These kinds of activities are socializing, not entirely structured, and possibly non-validated. They sit between discussion groups, livelihood support, group psychological intervention and counselling, without following entirely the standards of any of these activities. Yet, in a community-based MHPSS approach, they are a fundamental tool to support communities, starting from their resilience and traditions. Another difficulty with these activities is that they are very context-specific, while humanitarian interventions tend to favour interventions that are duplicable and scalable.

IOM MHPSS programmes have found, intuitively, ways to support groups to hold spontaneous and traditional social gatherings, with specific MHPSS objectives in mind.

These groups can largely be categorized by:

- Interest group: A group that gathers around a specific interest, a preoccupation, or an affiliation. IOM Iraq works with displaced people in urban settings, who want to be active members of their new communities. Neighbour groups gather regularly to discuss issues of concern for the neighbours around hygiene, decorations and others, and propose initiatives for improvement, such as launching cleaning campaigns.
- Activity group: A group that gathers around an activity, for instance watching television, playing chess, crocheting, preparing the church or the shrine for the weekly or daily celebrations. In South Sudan, for instance, women's groups were supported that gathered each week for tailoring and crocheting the decorations and textiles for the Sunday mass.
- Problem-based group: A group that gathers around a problem, for instance female heads of household, men who can't find a job. In both Iraq and South Sudan, IOM facilitated support groups for women who lost their husbands due to conflict. They gather regularly to do social activities, such as knitting, sewing or sweets baking, and connect with other women in the same situation. The PMTs supported these groups with complementary sessions on loss, grief, life skills or parenting skills.
- Traditional Group: elderly, congregation meetings, traditional spontaneous dance groups, religious/inter-faith groups, among others. Healing ceremonies were facilitated in Cox's Bazar in Bangladesh with Rohingya community members, who were able to reconnect with different aspects of their culture. The ceremonies consisted of three parts: music, to express emotions and experiences; art and paintings, to preserve culture, history, and share individual and collective stories; and the third part consisted of each participant choosing a symbol of strength, that represented their culture, unity and resilience. These three ceremony elements had a strong inter-generational component, in that older generations were able to pass down aspects of their history and culture to the younger generation. The healing ceremonies allowed participants to engage with their historical narratives, cultural and community identities, and promoted positive coping mechanisms and a sense of social support.
- Structured group: Scout groups, organized youth groups, students' associations.

Often, groups can fall under more than one category. For instance, in Cox's Bazar, Bangladesh, IOM organized communal kitchens where refugee women from different parts of a camp could gather to cook together. This has created a group that is at the same time an interest group, based on the preoccupation of being able to feed the family; an activity group, revolving around cooking; and a problem-based group, because these are mainly vulnerable women.

Regardless of their nature, all of them can function as peer-support groups, if empowered to do so. For instance, the communal kitchens groups helped to identify women particularly at need and refer them, and to provide basic forms of MHPSS, since IOM psychologists spend time with the groups of women while cooking.



5.2 WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

Managers should envisage and design programmes that allow for supporting spontaneous and traditional forms of gatherings that can have specific MHPSS objectives and outcomes. While they are not going to run these activities directly, they should be aware of the process that needs to be involved in supporting them:

- (a) Assess which traditional ways of gathering exist in a community, with a gender and age differential approach, as in the example of crocheting groups in the Balkans.
- (b) Identify what kind of support may be needed to reactivate or maintain these groups. This can include in-kind support, transportation, or the establishment of a space where people can meet as they are used to.
- (c) Identify the value that these groups and ways of gathering can have for the objectives of the programme, for instance:
 - (i) Facilitating entry points to communities, and the organization of assessments and focus groups
- (d) Foster the creation of additional groups that are not spontaneous but project-generated. These can be useful in supporting particularly vulnerable individuals or to respond to identified problems: for instance, the communal cooking groups in Cox's Bazar, or the men's groups in South Sudan.
- (e) If the group can have a specific MHPSS outcome, or is designed to have an MHPSS objective, it is important to:
 - (i) Identify a leader or facilitator for the group, and train him or her in peer support and mentoring techniques (see 5.2.1); or
 - (ii) Provide a skilful facilitator to the group, from the MHPSS programme team.
- (f) Create a network between relatable groups, through exchanges and events, or mobilizing the groups for support in the organizations of rituals and celebrations, sporting activities, and so on. In South Sudan, an IOM-supported cultural dance group became well known and was often called in to participate in important community ceremonies: weddings, birth celebrations and memorials. While the group was important for the participants' own coping strategies, it also had an impact at the community level. In Iraq, participants in hairdressing, baking, sewing and makeup courses would often support community activities with their skills: for example, offering free haircuts before important celebrations, baking sweets for the community, making toys for children, offering hairdressing and makeup services for weddings, among others.
- (g) Monitor and evaluate how the activities of the group have helped to achieve the intended MHPSS outcome.

5.2.1 How to identify and support the group facilitators towards MHPSS objectives

Mentoring and peer support is based on a supportive relationship between peers with similar experiences. They are empowering lay forms of psychosocial support learned through organized training activities.

The mentor is a volunteer, the spontaneous leader of a sociocultural group, who is available to support their group, but is not a counsellor. The mentor's role is to help their peers in the group through identifying problems, and giving information about services, networks and resources. The mentor should be sensitive, empathic and available.

The mentor should receive a training, covering aspects such as:

- The types of activities that they can do with the group;
- How to listen effectively;
- How to manage and adapt expectations;
- How to encourage equal and respectful relationships;
- How to refer others to services;
- How to provide PFA;
- How to end the group;
- The specific needs of children and families (see here for more information and guidance on resources for **training**).

The programme can set up an effective mentoring system by:

- Identifying mentors;
- Organizing formal trainings, covering the above described topics, which usually should entail a five-day initial training and refreshers;
- Organizing regular technical supervisions (see chapter 15 on Technical Supervision and Training);

- Supporting them in their emotional needs;
- Evaluating the system on a regular basis.

5.2.2 Informal groups as peer-support groups

In some cases, the gatherings of these groups can become forms of group peer support, in which individuals having similar life experiences interact and form helping connections. In this sense, peer support groups provide social, emotional, physical and tangible support, and can help the participants to overcome feelings of social isolation and build a bridge towards the community. A structured peer support group would consist of:

- (a) One initial meeting.
- (b) Ideally 8 to 20 participants: Newcomers should not be included in existing groups, but form new ones. This can be kept flexible due to geographical distances, and pre-existing bonds considerations.
- (c) A trained facilitator: For instance, the mentor.
- (d) During the first meeting, explanation of the purposes, agreement on the calendar, and choosing the topics to discuss: Participants learn how important it is to listen to each other's story, without forcing a disclosure and without being intrusive. They learn how beneficial from an emotional point of view it is to find out that not only predicaments but also resources are common among them.
- (e) Follow-up sessions organized based on the interest and availability of the group.

This **guide** shows more about how to organize these groups.

To finalize plans and organize trainings for the facilitators, one can refer to IOM's MHPSS Section at contactpss@iom.int.



→ 5.3. CASE STUDIES

5.3.1 South Sudan

An example comes from South Sudan, where spontaneous groups have been supported by the programme through a process of facilitation of conditions for the groups to meet, and training for their leaders and facilitators.

In this video can be found the genesis and evolution of a gathering of female-headed households (problem-based group) which started as a support group, and which quickly became a peer-support group, an activity group, and finally, a livelihood

activity.

This publication highlights the voices of the group facilitators who provided peer-support to the other members of the same interest and problem groups.

5.3.2 Ethiopia

Another example comes from Ethiopia, where a youth group was formed over an activity, and which facilitated social cohesion amongst youths from different backgrounds. The youth came from both IDP and host communities, its members were both male and female, and was supported by two MHPSS team members who varied in age. Wanting to engage in an activity that would benefit the group and the greater community, the youths decided to engage in honey farming, and with the support of IOM who provided material support, built traditional beehive spaces. This process allowed the group to interact with others in the community, broke down negative stereotypes community members had about youth and eventually led to other initiatives, in which members of the group began volunteering in the community to build shelters and help run errands for others. The group's impact went beyond its direct activities and promoted positive social interaction between communities differing in age and migration background.

→ 5.4. CHALLENGES AND CONSIDERATIONS

One of the main challenges is establishing who is part of the group. Some groups may be spontaneously established, which can create challenges. For instance, the group composition could create difficult dynamics if all group members are from the same ethnicity (in a context with ethnic tensions). Groups including several members of the same family may affect participants' ability to share in a confidential manner. However, spontaneous groups can also prove very useful: they are rooted in the community's own support structures system and have a good understanding on how to navigate those. Group members may feel more comfortable, as they know each other and trust each other's motivations.

Establishing groups may make it easier to influence group dynamics: members can be selected to ensure a helpful balance.

Yet how to select group members can also be challenging. It must be decided if the group is heterogeneous or homogenous. Membership will be influenced by the objectives of the group. For instance, if the group aims to provide a safe forum of socialization to women-headed households, the group may wish to exclude men from this specific group. Factors to consider when establishing membership criteria could include: age, sex, clan/tribe, interest, commitments, areas of origin, social status, IDPs/host community members and religious affiliation, among others. This is not say that there should be segregation based on those factors, but rather that it is important to recognize that these factors will have an impact on the group dynamics internally and also on how the group will be perceived by the rest of the community, which in turn can also affect the groups' own self-perception.

Another consideration to take into account is whether the group will be open, welcoming newcomers, or closed. In order to address this, it is

important to look at different criteria:

- The size of the group: If the group gets too big, it may be more challenging to ensure it reaches its objectives.
- The structure of the group: If it is a more informal group focusing on social activities, or a more structured group with defined roles for its members and a psychosocial objective. In the latter case, it may be more difficult to incorporate newcomers.
- The journey of the group: As the group evolves, and members have gone through the life cycle of the group, newcomers may find it complicated to fit in.

Handling of difficult support group members and their unintended impact of activities must be taken into account. MHPSS teams should be aware of any potential negative effects of difficult group members in social and cultural activities, and adopt mitigation measures. For instance:

- People with mental health issues may feel worse and become more withdrawn if they try something that is too challenging for them, affecting the group environment.
- Highly disruptive individuals can interfere in the participation of other group members.
- There can be negative health impacts for some people with health issues while taking part in certain activities.
- The possibility of violent behaviour and fights must be prevented.
- Members who attend and don't participate, or experience communication problems, might affect the group environment.
- More dominant group members might try to impose their values.
- It is important to create boundaries and manage expectations so that people will know what is appropriate and what they can expect. If people have a bad experience, it can prevent them from engaging in activities in the future.

It is also important to evaluate the use of cost-effective ideas vs. having a variety of activities, prioritizing which option is appropriate depending on the situation. The most popular activities will reach a wider sector of the affected population but might risk leaving individuals out of the programme or leave specific needs unmet.

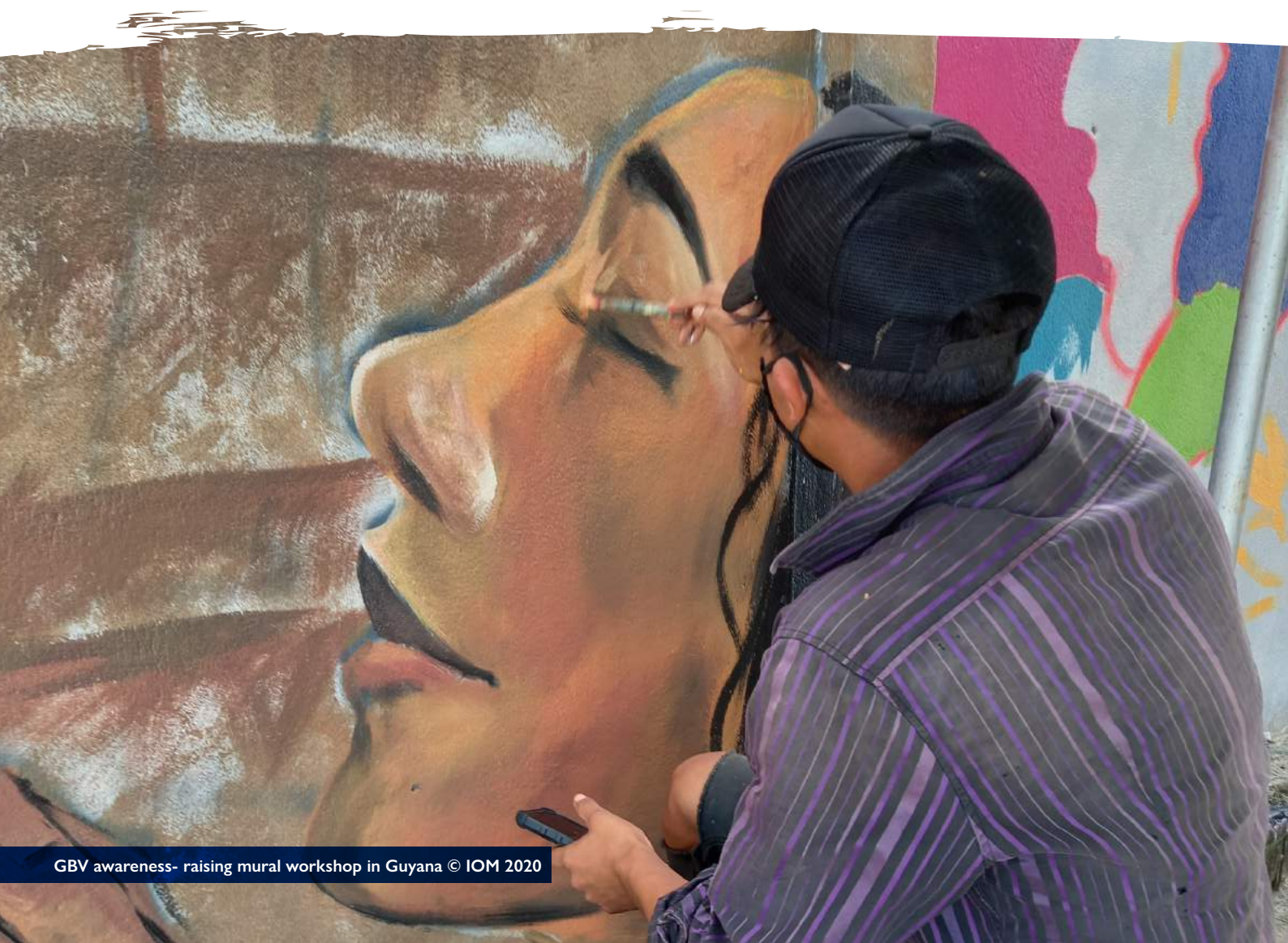
Keeping the groups going can be challenging, especially in protracted displacement situations. The dynamics of a group may change over time: for example, it could change focus in terms of topic and membership. Groups can also give birth to new groups or subgroups, depending on the need to recognize new “groups” as they arise. For example, mothers’ support groups were organized in the Primary Health Care Clinics in Wau, South Sudan, as part of a nutrition programme. Teenage and young mothers were usually quiet during the meetings. When asked why by the facilitator, they shared that they were not comfortable discussing or speaking about certain issues related to their status in front of older women, including relatives. Eventually, this led to the formation of a new subgroup within the mothers’ group.

Groups can also eventually end, and may end for different reasons: members may choose to end the group as they have achieved their objectives, or are displaced again by the conflict. As the group evolves, and especially as emotional investments are made by its members, it becomes more crucial to prepare for such a possibility. The possible ending of the group could also influence how groups are formed: for instance, in Nigeria, some groups created themselves with members who came from the same locations so that in the event of return, they could continue the group at their location of origin.

For references, see full bibliography [here](#).



6. CREATIVE AND ART-BASED ACTIVITIES





6.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Box 28

Chapter Video

The following chapter is explained in **this video** which was developed as a complement to the Manual. For a visual explanation of the information presented in this chapter, please watch before or after reading the material.



This chapter will introduce the use of expressive art-based and creative activities, such as music, theatre and drama, storytelling, poetry and creative writing, dance, painting, sculpting, photography and video-making within MHPSS programmes. The aim is to inform MHPSS managers on how to design and monitor MHPSS programmes that include these fundamental cultural components, facilitating expression, relaxation, symbolic re-elaboration and transformation of painful predicaments, agency, relationships, problem-solving and peaceful discussions through metaphors, social communication and documentation. These activities can activate processes that are at the same time healing, educational, social and cultural, and that are rooted in structured and recognizable (and therefore safe) forms, but allow for individual, subcultural and collective changes and transformations.

Art-based and creative activities are strictly connected with the paradigms presented in the chapter on **Models of work**. Artistic interventions work on the connection between the three spheres of **the model of a psychosocial approach to programming in emergency and displacement**, since they link body and mind in a creative action that is relational, rooted in culture, and creates cultural “objects”, such as songs, sculptures, paintings, plays, videos, etc.



They are central to the model of CB MHPSS programming, since:

- The arts, with their capacity to transform suffering, negative experiences and collective wounds in artistic production of aesthetic, social and cultural significance, work at the interconnection of the individual, collective and societal dimensions, and the intersection between suffering, resilience capacities and practices, and the positive outcomes of the adversity.
- They also connect individuals with their families, subgroups and larger segments of society, possibly including new narratives in the public discourse.
- With their metaphorical yet recognizable language, they can at times voice the unspeakable, and link the unlinkable.

They represent an important dimension of identities in that they are a fundamental feature of collective identities and can also give a voice to subcultural identities, while promoting individual agency.

Box 29

Effects of art-based and creative activities

Art-based and creative activities can have a positive effect on social and cultural determinants of health, such as social capital, literacy, life skills and auto-efficacy. Furthermore, recent neuroscientific and psychological, neuroendocrine and immunological studies have claimed that participation in cultural and artistic activities can have a positive impact at the organic level, containing the negative outcomes of protracted distress and empowering the immune responses. According to the most recent studies of neuroaesthetics, the vision and creation of artistic forms solicit the mirror neurons and stimulate empathy and “atunement”.



Theater activity for children's day in Izmir, Turkey. © IOM 2019

The relations of these activities with the IASC MHPSS pyramid of intervention will be explained in the following section.

First, the chapter will look at common programmatic indications to consider when including creative activities within an MHPSS programme. Then it will describe programmatic steps that should allow this integration. Finally, it will describe in more detail some processes and models of work that regard only one of the arts, such as theatre and drama. Theatre and drama are specifically used as an example for reasons that will be better explained later in the chapter.

6.1.1 Programmatic indications

Art-based and creative activities are rooted in the agency of populations and exist in any community. An MHPSS programme should provide so that these practices can be protected or reactivated after the emergency and/or the displacement, allowing theatre ensembles, dance troupes, music groups, individual artists, among others, to continue producing their artistic creations. This can include in-kind support and distributions of materials, or equip a psychosocial hub or a community centre with musical instruments, for example. These are called community-generated activities.

Since these activities create social capital, occasions for collective discussions and making

of meaning, the psychosocial programme should purposely create occasions to link these experiences between them and, in the case of displacement, to link similar artistic experiences between the host and displaced communities. This means creating or supporting spaces, such as festivals, events, contests and art exhibitions on a given theme. It also includes common productions and dedicated multidisciplinary spaces, where integration is easier than other domains, being based on agency and a common artistic language, rather than vulnerability and services. These activities are defined as programme-facilitated.

In addition, and most inherently to its objectives, an MHPSS programme should try to mobilize and capacitate artists and people who like using various forms of arts in the facilitation of workshops and processes with more precise MHPSS (relaxation, self-esteem, social cohesion, community development, peaceful discussion, documentation) focus for more vulnerable populations. This is not only about supporting existing practices, but engaging with different artistic communities and individual artists, proposing that they put their wisdom and skills at the service of others in need in their communities, with a more direct healing and reparative objective. Most of these artistic forms have indeed been used with different social and psychological aims in developed countries, as well as in the psychosocial domain in humanitarian

6. CREATIVE AND ART-BASED ACTIVITIES



action for decades ([Schininà, 2009](#)), and best practices have been identified throughout the years. These workshops and activities are defined as programme-generated.

Finally, creative and art-based interventions can be used as an entry point to the community and also as an assessment tool to inform programme design.

- Peaceful discussion and identification of problems within the group (for example, theatre forums, setting the programme for a concert, among others);
- Social communication from the group to the community (for example, theatre plays, concerts, exhibitions, videos).

Box 30

Three categories of activities

- Community-generated activities protect, support and reactivate existing creative and art-based resources;
- Programme-facilitated activities build on existing creative and art-based activities, creating occasions for networking, mobilization and sound communication;
- Programme-generated activities mobilize art-based and creative resources in specific activities and workshops with a clear psychosocial support aim, targeting specific problems or vulnerable groups.

Art-based and creative activities act simultaneously on various levels:

- Individual expression (for example, painting, singing, dancing);
- Group building (for example, choirs, music ensembles and groups, dance and drama groups);

Notable differences exist between different forms of art in the prominence they give to these levels. For instance, figurative art activates the level of individual artistic expression, and of social communication through the “objects” it produces. Theatre and dance give more importance to the relational aspects and group building because they are often ensemble works and need an audience, which is a relation with an out-group, to take place. Video documentary productions and art exhibits of photos usually focus on social communication. An MHPSS programme will mainly engage with existing resources and practices, but it should consider the pertinence of the used medium when assigning psychosocial support-related objectives to the activity.

Art-based and creative activities encompass a series of practices that act at the four levels of the pyramid of psychosocial interventions, with most practices positioned at **levels 2 and 3**. The scheme in Figure 9 categorizes a few of the possible activities, without aiming at being exhaustive.

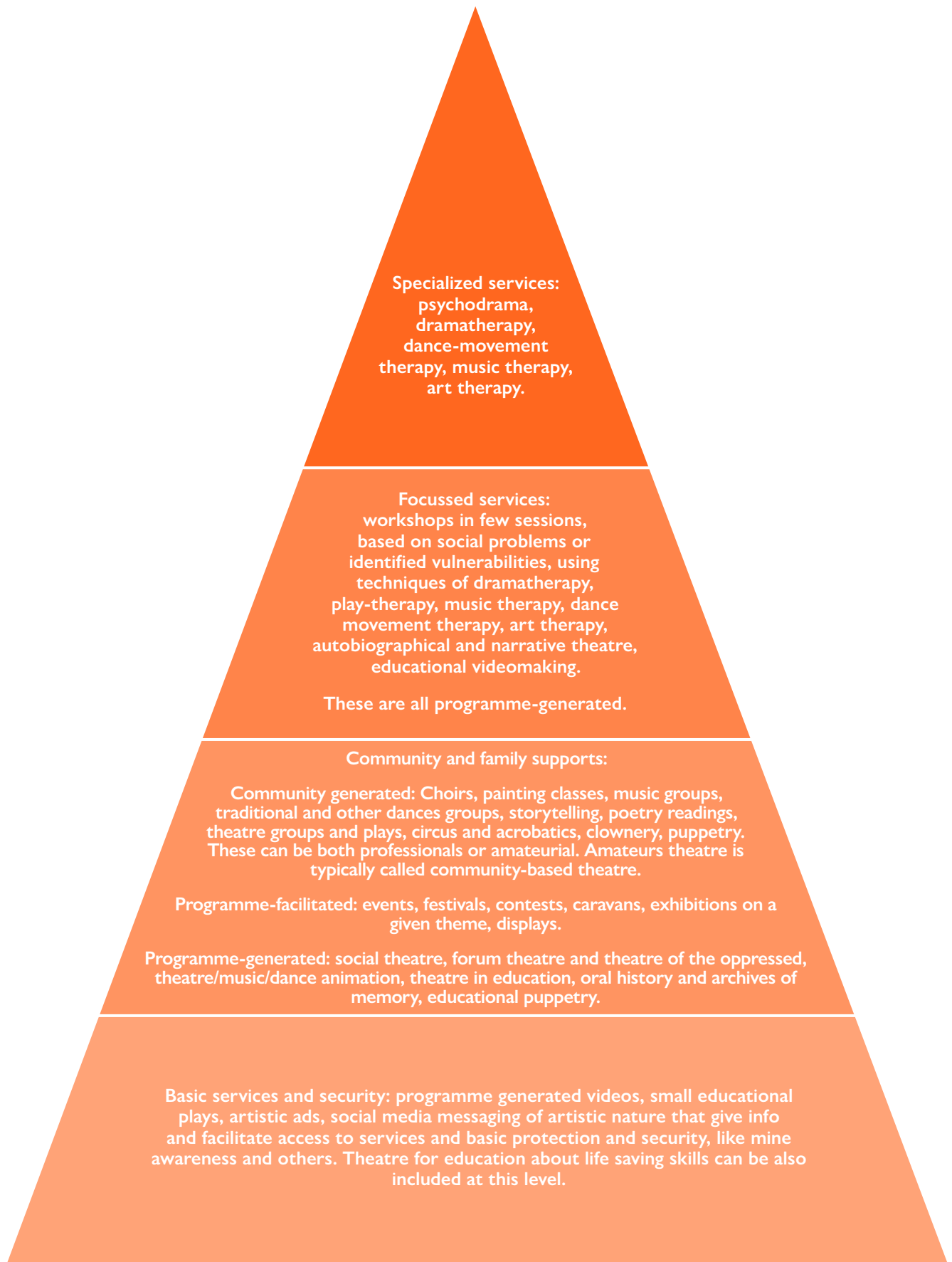


Group painting. Dohuk, Iraq. © IOM 2018



6. CREATIVE AND ART-BASED ACTIVITIES

Figure 9: Creative activities along the MHPSS pyramid



However, in an emergency context:

- Art-based therapies as a form of treatment of mental disorders (fourth level) will be used only if certified experts exist in the given context; otherwise, the programme should not engage in creating such an expertise.
- Application of these practices for problem-based focused support (third level) can be a part of the MHPSS programme, and training can be provided to artists and activists in this respect, but it should always be accompanied by supervision of the facilitators or be conducted and facilitated by mixed teams of artists and psychologists/counsellors.
- Community-based uses of art and creativity can be performed and facilitated by anyone who has a skill in the specific art medium. These can be divided in two: those that are generated by the community and that the programme just mobilizes or supports, and those that are generated by the project to respond to specific socialization needs of a community. They include the recreational use of arts.
- At the basic services level, arts are engaged to inform people creatively about existing services and life-saving measures through performances, simulations, radio ads or songs with this specific purpose.

The categorization of these practices for levels of intervention may be fluid, yet it is important, since very often in humanitarian MHPSS programmes, terms and concepts related to the psychosocial application of artistic disciplines are not used consistently. In many cases, games with an educational purpose offered at the community support level are labelled psychodrama, which creates both the wrong impression that these are a possible treatment for mental disorders, and a bias that they can harm. The same often happens with the definitions of dramatherapy, art therapy and others that are erroneously used to define

activities that are in fact not what they are called, but just the use of creative tools in an MHPSS programme. However, when actual art-based therapies are used, they need to be accompanied by technical supervision, safeguards and methodologies that these disciplines adhere to.



6.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

MHPSS programme managers most likely won't conduct art-based and creative activities by themselves, but they should make sure their programmes allow for the use of such methodologies and practices as follows:

- (a) Mapping of existing and pre-existing arts-based and creative practices and resources, and assessing perceptions in the community, including:
 - (i) Individual artists or amateurs;
 - (ii) Teachers of related disciplines;
 - (iii) Ensembles, groups and companies, both formal and informal;
 - (iv) Spaces and venues where these activities take place, if any;
 - (v) Art-based and creative activities more recognized by the communities at large, including the traditions linked to the cultural and artistic heritage of that culture.
- (b) Reactivating and protecting the existing or pre-existing practices and resources: These can happen in many ways and need to be contextualized. Support can be material or immaterial, in network or in training, and include barter. For instance, the project could provide in-kind support to individual artists and groups using arts, as materials, instruments, equipment and safe venues. This support can be subject to a barter (see (d) mobilizing the arts, below) and is better provided to:
 - (i) Collective rather than individual initiatives (for example, a choir rather than a singer);

6. CREATIVE AND ART-BASED ACTIVITIES

- (ii) Initiatives addressed to vulnerable groups, if already existing (for example, a theatre class in a disadvantaged school or neighbourhood, or minority cultural centres);
- (iii) Artistic processes with a wider social impact (for example, traditional dance groups involved in Sunday masses or other civic celebrations, radio shows);
- (iv) Dedicated spaces, such as psychosocial support hubs (see chapter on Psychosocial mobile teams), or collective centres.

Since these practices have strong subcultural values, understanding that practices and perceptions can differ for different groups in the same community is necessary. Conflict and context sensitivity should be adopted in selecting activities to support, as well as the “do no harm” principle.

- (c) Catalysing these initiatives and bringing them in a network: This is usually programme-facilitated and is done by:
 - (i) Reactivating past festivals, contests and celebrations;
 - (ii) Finding ways to foster the inclusion of displaced people’s artistic production in events, exhibitions and festivals happening in the host community;
 - (iii) Calling for contests, festivals, events and campaigns with a given theme, exhibitions, readings, regular or mobile cinema caravans and tours, in order to facilitate a network;
 - (iv) These can be based on specific media (for example, a film or video festival, a day of theatre shows, dance contests), or making them neighbourhood-based (see a possible model in Box 31);
 - (v) Informing local authorities and linking with them.
- (d) Mobilizing the arts: These capacities and energies should be mobilized to respond to specific problems the communities are facing or to facilitate the inclusion of specific groups or to create social cohesion, attributing direct

or specific psychosocial support functions. This can be prompted in different ways, which include:

- (i) Campaigns calling people who have an artistic skill that they want to put to the services of their communities to come out (see, for example, Box 32).
- (ii) Organizing trainings in using arts as a form of social action, like in social theatre, art in education, adaptation of art and drama therapies adapted to social mobilization, and problem-based groups (see, for example, Box 33).
- (iii) Offering incentives or grants for small-scale interventions involving vulnerable communities in artistic activities with a social aim: These may be linked to training.
- (iv) Barter, which are related with the support given: For instance, if the programme equips one of the psychosocial hubs with instruments for a musical band and gives access to the instruments to the bands in the neighbourhood in shifts, the bands can be requested to give back to the community. The giving back can take different forms:
 - o A concert, either stand-alone or during an event or a celebration.
 - o A course in playing a particular instrument for displaced youth.
 - o If artists wish to be trained and feel such a drive and/or have the right attitude, a workshop in the use of music and rhythm as a form of expression and relaxation can be given.
 - o What is important is not to force anyone to perform psychosocial support functions that they are not ready or willing to perform because of the barter, but to find the best barter that can fit anyone’s attitudes and engagements with an MHPSS programme.

This is just one example, and similar options can be given to painters, performers, poets and writers, among others.



Art workshop in Gubio IDP camp, Maiduguri, Nigeria.
© IOM 2018

The mobilization can bring a series of activities involving specific groups of community members in theatre, dance, music, video and creative writing workshops, among others, which involve the group in a creative process where the dynamic and the well-being of participants are more important than the aesthetics of an artistic product. In case there is a product and it is displayed, the relevant show, exhibition, projection, etc., will be opened only to the proximal community, such as friends, family and caregivers.

Box 31

Mobilization of artistic and creative resources

The social and community-based theatre research group attached to the University of Turin has adopted a model to mobilize artistic and creative resources in marginalized neighbourhoods and camps. They create moments of artistic barter, in the form of community events, where the most creative part of the population is invited to perform and the other to attend. These should happen in locations that are safe, ample enough and yet can have a symbolic value for that community, including IOM's psychosocial support hubs and centres. They include parades, concerts, readings, and displaying of arts and crafts, and can become a ritual/repeatable event.

- (e) Including in the plan of support groups, community-based interventions for people with severe mental health disorders and focused support with art-based workshops and processes: These activities, due to their psychosocial objectives, which can be diverse (from relaxation and stress management to social cohesion), are usually structured with a series of safeguards and boundaries. The MHPSS programme manager is not supposed to be an expert in all these applied forms of the arts, and should rely on national, regional and international capacity in the design phase. However, most techniques and processes have a few elements in common:

6. CREATIVE AND ART-BASED ACTIVITIES

- (i) Graduality: There is no rush towards a product, but time is allowed for individual expression, relationship-building, creation of a safe space, trust-building, explorations, contracting and feedback.
- (ii) Resource-based: The work focuses on resources. People may be grouped, based on their needs, but within the group of work, their resources (relative to the media of the workshop) are the focus of the work.
- (iii) Agency-based: Art-based psychosocial support activities are neither top-down nor didactic, but are facilitation and valuing processes built with the participants. Activities ownership is a condition and an objective of the activities themselves.
- (iv) Diversity-focused: Activities allow each participant to express his or her own personal and cultural identity, and to pacifically and respectfully find an encounter with others' identities, through the development of inclusive behaviours. Socialization of differences is allowed by the fact that, in creative processes, more diversity leads to more interesting creative outcomes.
- (v) Group-building: Participants are stimulated through training exercises, games and artistic processes to discover their diversities, similarities and communalities at the physical, psychological and cultural levels. Theatre expression and artistic creation help in developing group communication and group cooperation, often without the use of words, which especially in conflict situations can be the most divisive.
- (vi) Metaphor-based: Most of these activities, especially those engaging theatre, art and music, are metaphorical in nature. The problems and the expression of personal feelings and experiences are mediated by a so-called transitional object – a song, a character, a puppet or a sculpture – that allows one to express, but at the same time, take a distance from the expression of personal issues.
- (vii) Quality of processes and products: Activities stimulate participants not only to express

themselves, but also to search together the most effective ways to communicate. The research of quality in the relationships, and in the realization of the products, allow participants to activate self-efficacy strategies and resources, and to develop an aesthetic satisfaction, important for the development of well-being.

- (viii) Multidisciplinarity: Usually, the workshops will be jointly facilitated by artists and a psychologist or counsellor.

Typically, these workshops engage in a process that starts with individual empowerment, then creates trust and a safe space for people to express freely and enter into a relation through their expressions. When the group is consolidated enough, it can start tackling problems through metaphoric and artistic means, and finally goes on to produce an artistic object for an audience that is usually preselected and consists of proximity groups (families, friends, neighbours, caregivers and stakeholders with decision-making powers on the issues at stake). Engaging artists in these forms of support should come with a solid training programme for them, which will be specific to the technique and the medium involved.

Box 32

“I can do”

In the Bekaa Valley, one of the Lebanese regions most affected by the war with Israel of 2006, after the war was over and people returned home, IOM and UNICEF launched a campaign called “I can do”, to mobilize individuals and groups with artistic and creative skills to create interventions of social utility for the most affected communities. (See the English version of the [campaign materials](#).) The campaign attracted a large number of people who proposed activities that were implemented to start up the IOM-run recreational and counselling centre for families. Twelve years on, the centre is still running, operated by a local NGO, and some of the people who responded to the call at the time are still among its facilitators.



➔ **6.3. EXAMPLES OF THEATRE AND DRAMA ACTIVITIES THAT ARE PROGRAMME-GENERATED**

The artistic techniques and processes that can be used for programme-generated MHPSS activities are various and can't be exhausted in this chapter. As an example, a series of techniques linked to theatre and drama are presented in the following paragraphs. Theatre and performance art are indeed the arts that have enjoyed more declinations in the community development, psychosocial support and mental health fields. This may be due to the fact that theatre and drama are usually based on physical and emotional expression and their interrelation, improvisation, and relations with a team. Their products are relational in nature because they need the co-presence of at least two persons, the performer and the spectator, to exist, and can work on catharsis (emotional release thanks to the identification with the experience lived by the character), or metaxis (the ability to understand a problem in its fundamental points thanks to the staged action).

(a) **Dramatherapy:** This is a certified form of therapy based on the links between body and mind, memories and expression, emotional

regulation and physical expression of emotions, role-play and creative discussions. It works on re-elaborating personal experiences, in a safe fashion, thanks to the use of transitional objects (puppets, stories, characters) and metaphors. There are two main non-exclusive practices in dramatherapy: one that brings participants to work on existing plays, characters, stories, myths and legends that can resonate with experiences of their own lives; and one that stages the lived traumatic experiences from participants' pasts. Dramatherapy could be used in IOM MHPSS programmes in emergencies with people with severe mental disorders only if the practice is pre-existing in the context and dramatherapists are trained. Otherwise, some dramatherapy practices can be taught and used as focused, problem-based support activities, especially those using pre-existing creative materials. For applications of dramatherapy practices in focused support activities, see Jennings (2005, 2009, 2017, 2018).

(b) **Psychodrama:** Similar to dramatherapy, psychodrama is a certified therapy that entails a process bringing the restaging of a traumatic event from the past with a group of peers, which will allow the protagonist to change elements of their own behaviour in the situation, or ask others to do the same, to reach catharsis. It can be used only when certified



6. CREATIVE AND ART-BASED ACTIVITIES

psychodramatists are already present in the context. It is otherwise not recommended due to skills, time, setting required. See Moreno (1987) and [here](#), and [also here](#).

- (c) Playback theatre: Similar to psychodrama, but less emotionally charged, Playback theatre implies a group of actors or trained individuals who are able to stage impromptu the storytelling of someone from the group or the audience, giving it a visible form. It is widely used in situations of human rights violations. See Dennis (2004) and [here](#).

Box 33

IOM training in the Syrian Arab Republic

In Damascus, in 2014/2015, IOM organized a one-year ongoing training course for artists and activists who were facilitating artistic workshops in the context of psychosocial support programmes for displaced and crisis-affected women, youths and children in the country. Participants included painters, actors, musicians and animators working for 20 different organizations, volunteer groups and churches, and the training consisted of 5 residential modules of 24 hours each plus distant supervision. The modules included dramatherapy and art-therapeutic techniques, social theatre, puppetry for social intervention, and Theatre of the Oppressed. These techniques were found particularly useful in the context, because they allowed practitioners to express their issues through metaphors, granting privacy and safety that were missing in other more talk-based interventions, due to the specific nature of the crisis. An 18-month evaluation showed that participants benefited greatly from the trainings, both in terms of professional skills and through the personal empowerment that came from the interactive and experiential parts of the modules. Modules can be obtained from contactpss@iom.int.

- (d) Social theatre (applied theatre): At the beginning of the 1990s, a new form of theatre – taking inspiration and methodologies from theatre animation and community-based theatre, new theatre and art and theatre therapy – found its way into direct interaction with the problems of individuals and groups in specific areas. It was a theatre based upon the body and relationships, but distanced from purely therapeutic approaches, and without solely aesthetic and artistic goals. It was, in fact, less self-centred and was ready to become an instrument of social action through laboratories, workshops and performances, with a goal of healing and of heightening the quality of social interactions. It was a theatre that linked the experience within the group to the sociocultural, economic, and historical context the group emerged from and remained a part of. This was and is called social theatre. As Bernardi stresses, social theatre is part of the current involvement of anthropology in society and facilitates: the social construction of the individual; the dynamization of interpersonal relations and inter-subjective comprehension; and the structuring of the entire community and of the smaller social institutions of which the community is compromised, such as schools, hospitals, villages. See Schininà (2004c) in further reading, and Pitruzzella (2006). For practices and examples on the differential use of dramatherapy and social theatre, see Jennings (2009), [here](#). For practices and examples of the use of social theatre, in refugee settings, see Balfour (2013) in [further reading](#).

- (e) Theatre of the Oppressed: This encompasses a series of techniques and practices of the theatre to use for social, political and well-being purposes. The most famous techniques are its games, Image Theatre and Forum Theater, which are both described in annexes to this chapter. [See Boal](#) (1995, 2002, 2008).

- (f) Theatre in education/theatre for development:

6. CREATIVE AND ART-BASED ACTIVITIES

Theatre in education consists of the preparation of theatre play with educational goals, which are designed to be interactive and accompanied by a series of warm-up games. The play is presented in front of an audience (typically of students), twice. The second time, the play is interrupted at different significant points and a discussion is solicited with the students on emerged topics.

[See here.](#)

Republic of the Congo. This model explores the effects of disruptive events or situations on community life and grassroots, theatrical means of responding. This approach has been influenced by the ideas and practices of Narrative Therapy and Forum Theatre (Sleip, 2005, 2009). This can be used at the community support and focused levels.

- (c) Theatre Forum: Another example of staging stories can be inspired by the Theatre Forum, a technique created by Augusto Boal (Sullivan and Lloyd, 2006), whose characteristic is the active engagement of spectators with the performance. A problem that oppresses an individual is presented unsolved in a theatre scene. The scene is repeated twice and, during the replay, which is facilitated by a presenter or joker, who is also expert in moderating the interactions, each member of the audience can stop the scene at any given moment, step forward and take the place of the oppressed character, showing how he/she could change the situation to allow a different outcome. Breaking the barriers between the performers and the audience, the dynamic engagement on stage is powerful and has transformative effects on all the spectators. In addition, practical and shared solutions to general problems are sought in the process. Usually, the scene is the result of a workshop of a few days with a group of people sharing similar situations. Find an example on how IOM has used Forum Theatre in post-earthquake Haiti, with a process illustrated in the attached article ([Schininà et al., 2011](#)). While the Forum is a community support activity, depending on its process, it can also be a focused support one.

- (d) Circus arts: This can be used as a way of expression with different age groups. Clowns' organizations have been involved in emergency settings in different countries, working especially with children and families. For instance, Clown Science Dreams, in

→ 6.4. CASE STUDIES OF ART-BASED AND CREATIVE ACTIVITIES IN PROGRAMMES

Examples include:

- (a) Art-based workshops with a group: The objectives and subobjectives are based on the typology of participants, needs assessed and media used. It has a variable duration (minimum five meetings of two hours each) and can host from 5 to 30 participants. The document in hyperlink is the report of a [training module](#) Guglielmo Schininà conducted with the students of one generation of the Summer School Psychosocial Interventions in Migration, Emergency and Displacement on social theatre workshops of this kind whose structural elements can be applied to other media. These are typically community support or focused activities, depending on the composition of the group or the objective.
- (b) Narrative theatre: This is a narrative approach to working with communities affected by trauma, conflict and war. The approach was initially tried in villages within rural Malawi in relation to issues of HIV/AIDS. It has been developed further over the last 10 years in different parts of the world, and is currently being engaged with in Uganda, Burundi and eastern Democratic

6. CREATIVE AND ART-BASED ACTIVITIES

collaboration with Jesuit Refugee Services, worked on enhancing resilience, self-development skills and self-confidence through art-based interventions, **theatre and clown activities** in Iraq.

- (e) Community events with narration or other artistic activities (music, dance, among others): These events are properly structured and developed based on artists', professionals' or dilettantes' competencies. They can be developed with a small group of stakeholders and community members, can involve traditional arts, and can consist of a single performance or concerts, or storytelling, or require the active participation of those attending. These are full community support activities. **See** the example on the use of choirs.

- (f) Collective narrative practice, honouring and building on local skills, stories and knowledge: In many cultural contexts, talking in the first person about hardships is not culturally resonant. Collective narrative methodologies such as the **Tree of Life** and **Team of Life** approaches enable meaning to be conveyed through metaphor in culturally diverse and resonant ways. These folk cultural methodologies can be engaged with, not only by highly trained professionals, but also by key community and family leaders, who may not have had the privilege of extensive schooling or education (Denborough, 2008, 2012, 2014; and Ncube, 2006). These are both community support and focused

support, based on scope and objectives.

- (g) Visual arts: In various settings, visual arts have been used in the provision of MHPSS at the community level, from communal mural painting to representing people's daily lives and experiences through images. It is a valuable tool to express realities and ideas without words, frequently used with children and youth. It can include painting, drawing, ceramics, textile art, photography, video and other expressions, depending on the cultural context. Visual arts can be combined with other interventions. For instance, IOM Nigeria uses **portrait painting and storytelling** as tools to facilitate self-empowerment among affected populations. IOM South Sudan used theatre and moviemaking, working with youths affected by conflict.

- (h) Storytelling events: Storytelling is an effective tool for mobilizing communities and promoting social cohesion towards integration and healing. **Stories that relate experiences** can create understanding, and have the power to unite people while they are being told. They play on a deep emotional level, benefiting all participants: it is not only the listener who learns, but also the teller who becomes aware of the value of their own unique experiences and background, and the solidarity that can come from a recognition of mutual or similar feelings and experiences. Storytelling can be verbal, in the form of a video or a reading. A facilitator can help the



6. CREATIVE AND ART-BASED ACTIVITIES

returnees to combine their stories in different narratives to share in public.

A new form of storytelling is possible with the help of technology. Digital media have been playing an increasingly influential role in shaping both the perceptions and outcomes of emergencies. The combination of words and images can magnify the impact of stories. An example of audience engagement with visual storytelling is given [here](#) by IOM. These are community support activities that can derive from focused interventions.

(j) Youth workshops: An example of a youth workshop is titled “Piece of Art to Arts for Peace”. This was an interactive intervention designed to facilitate increased connections among group members in South Sudan. It intended to bring together multiethnic groups of displaced children and young people who met regularly in the psychosocial support resource centres, either during sports, craft activities or group discussions. In this workshop series, they learned about growing and fostering relationships, without relying on sophisticated verbal abilities. Specific techniques encouraged the expression of feelings and thoughts and interpersonal dynamics that cannot be easily translated into words. The interactive nature of the art projects creates a context where interpersonal disconnections can be explored and understood, and connections can be celebrated, both by talking and by making art.

(i) Archives of Memory: In many places, from Kosovo¹ to Colombia, IOM has used an approach that links creative activities, rituals, oral history and documentation. Facilitating communities in creating Archives of Memory, which are physical and/or digital archives collecting personal, creative, photographic, diarist memories of the experience of displacement, they can then be used as a cultural testimony and a living memorial for generations to come. The booklet based on the experiences in Kosovo¹ is in further reading. The development of new media, which allow storage and dissemination of memories that are not bound to a physical space, has changed the way archives are conceived. In 2017, IOM Indonesia organized a digital storytelling room for refugees and stranded migrants hosted in a migrant centre. This consisted of a room equipped to create short autobiographical videos using pictures and voice-overs, and a short tutorial for the interested migrants on how to create these videos. In 2010, IOM Jordan, in coordination with the River Jordan Foundation, created an online Archive of Memories of Iraqi refugee children enrolled in Jordanian schools. A profile was created for each child, in which were included photos, drawings and memories under the supervision of an expert facilitator. The archive was online for five years.

(k) Often programmes and workshops mix various practices and objectives. By instance, in Lebanon, in 2013 a group of Syrian displaced female teenagers that was already involved in various activities at one of IOM recreational and counselling centres, subscribed for a workshop aiming at developing a video animation. The workshop was run by a psychologist and an artist-videomaker and mixed artistic, technical and autobiographical elements. After an initial period, the participants decided to focus the workshop to the autobiographical element, maintaining only a small animation component. This brought to the video *Letter from a Refugee* that went on to win human rights awards at video competitions and to be translated in several languages, in order to be used as educational and antistigmatization tool, including in countries where Syrians were about to be resettled. See the video [here](#).

¹ References to Kosovo shall be understood to be in the context of United Nations Security Council resolution 1244 (1999).

Box 34

Art-based interventions in academic programmes

IOM includes components of art-based interventions and culture in its Master and other academic programmes on MHPSS in emergency and post-emergency settings, and includes artists among those who can attend those trainings. See, for instance, the special section of the Journal Intervention, containing the fieldwork of some of the students to the IOM Diploma in Psychosocial Support and Conflict Transformation, organized in collaboration with the University of **Ankara**.

supporting the reactivation of existing cultural and artistic practices, for which conflict sensitivity and inclusion always need to be taken into account. The other is to initiate specific psychosocial support activities with well-being objectives based on artistic practices. This will require dedicated expertise in the MHPSS team or in the supervisory team, and trainings for the facilitators, who may be skilful artists but lack the necessary psychosocial skills or be psychosocial workers with no specific skills on the media and the arts engaged, which are equally important.

Continuity is key for these interventions to be successful. One-off recreational sessions can be entertaining, but can hardly reach the intended psychosocial objectives. Yet timing and continuity, due to volatility of the security situation, are often a challenge in these contexts.



6.5. CHALLENGES AND CONSIDERATIONS

The most validated adaptations of arts-based practices into healing and social support programmes – such as, for example, dramatherapy, art therapy, playback theatre and the Theatre of the Oppressed – are largely based on Western artistic practices and traditions. Their adaptation to each and every culture can't be taken for granted, and should be attentively discussed with local practitioners and communities.

Activities should always be tailored to the needs and preferences of the target population, knowing that creativity expresses in different form in different cultures, but is present in all cultures. Adult males may not meaningfully engage in ludic activities and performances in some cultures. However, other artistic media – such as singing, playing music, and oral and written poetry – can be considered a fit. Likewise, while in the West bodily training is the first step of theatre-based workshops and practices, women in certain cultures find it difficult to engage in bodily expression.

MHPSS programmes can have two roles in engaging with art-based practices. One is

➔ FURTHER READING

Armaghanyan, S.

2018 *Theatre as Psychosocial Approach in Humanitarian Settings*. (Unpublished masters' thesis).

Balfour, M. (ed.)

2013 *Refugee Performance, Practical Encounters*. Intellect, Bristol, United Kingdom.

International Organization for Migration (IOM)

2001 *Archives of Memory: Supporting Traumatized Communities Through Narration and Remembrance*.

Schininà, G.

2004 Here we are. Social Theatre and Some Open Question on its Development. *The Drama Review*, 48(3):17–31.

For references see the full bibliography [here](#).



7. RITUALS AND CELEBRATIONS





7.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Box 35

Chapter Video

The following chapter is explained in **this video** which was developed as a complement to the Manual. For a visual explanation of the information presented in this chapter, please watch before or after reading the material.

This chapter concerns the inclusion and promotion of collective rituals and celebrations in a CB MHPSS programme. After a brief introduction to the functions rituals and celebrations can have in a CB MHPSS programme, the chapter will provide practical information to MHPSS programme managers on how to include rituals and celebrations in MHPSS programming. While the restoration of individual and family rituals has an important role to play in terms of self-care and psychosocial well-being, this chapter concerns collective and community-based rituals and celebrations only.

Box 36

Complementary information

The UNICEF *Operational Guidelines: Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families* (UNICEF, 2018) provides guidance on support to communities to re-establish rituals or cultural events (for example, commemoration events to foster communal healing, cultural festivals or religious celebrations), along with traditional healers or leaders as **appropriate**. The information contained in this chapter complements the information contained in the UNICEF Guidelines from a programmatic point of view.

In the aftermath of an emergency, rituals and celebrations can perform several functions. Through codified rules and scenarios, ritualized movements, learned narratives and symbolic images and practices:

- They offer occasions for codified expression of individual negative emotions and positive emotional reactions.
- They help to overcome isolation, and help people to socialize and share.
- Making use of metaphors, images, characters rooted in traditions, they allow people to communicate negative experiences in a safer, indirect way.
- Being learned and repeated for generations, they help in contextualizing the current suffering in history and heritage, providing continuity and a perspective.
- They can provide interpretative frameworks to personal and collective predicaments. Tales, legends, staged ritual dramas, songs, proverbs and scriptures all contain elements of reflection on the human condition that can also shed light on the current problems.
- They help people to feel reconnected with themselves, their families, communities of origin and host communities.
- Rituals can represent, validate and accompany transformations. The transformative function is inherent to rituals, which often are rituals of passage – such as marriages, seasonal celebrations, initiations and funerals – which all reflect the social recognition of the change in a personal state.
- In addition, in situations characterized by disruptions that have fractured communities, they can ritualize the experiences of violence, displacement and relocation, and celebrate the resilience of communities. Celebrating arrivals in the camps, and their closure, new intercultural rituals – along with the host communities – can all contribute to the well-being of affected populations.

Box 37
Example from the Yazidi community in Iraq

In 2015–2016, the Yazidi community in the northern part of Iraq welcomed back those Yazidi women who had been kidnapped into sexual slavery by ISIS, using traditional cleansing rituals, which allowed them to be fully reintegrated into their families, using a traditional form. This is an example of collective ritual of transition used to respond to war-related adversity (for more information, click [here](#) and [here](#)).



7.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

Psychosocial programme managers are not going to perform or organize rituals and celebrations themselves. Yet they should design and implement programmes that allow for support to rituals and celebrations in various forms, which will be described below.

7.2.1 Facilitate existing or reactivate interrupted practices

7.2.1.1 Map types of rituals and celebrations with community leaders and informants

Rituals and celebrations can be religious or non-religious. Both religious and non-religious rituals and celebrations can be daily (for example, Muslim daily prayers or flag-raising), weekly (for example, Sunday masses or elderly gatherings), yearly (for example, Eid, Christmas, Labour Day, Independence Day), occasional (for example, weddings, funerals), periodic (for example, initiations, coming-of-age processes). It is important, at the very beginning of a psychosocial support programme, to create a calendar of the rituals and celebrations that can be calendarized, to understand the scope of the necessary financial and manpower commitments. To note:

- Movements (but in some cases, also public gatherings) of refugees, IDPs and migrants outside camps and centres require authorizations and coordination with security forces that might take time and efforts to be obtained.
- Rituals and celebrations should be reviewed with community leaders, in order to identify potential human rights violations and be clear about what the programme can support or not and why.

Table 3: Examples of rituals

Examples of rituals	
Personal rituals	• Coffee in the morning. • Bedtime routines, like storytelling or prayers. • Personal religious practices. • Comfort rituals/stress management.
Social rituals	• Hospitality: Coffee ceremonies, meals, “good manners”, greetings and farewells, relations with guests. • Activities with friends: Tea and chess, bar hopping, dancing, sports. • Celebration of holidays, birthdays, name days. • Memorialization of events. • Presentation of “self” such as attitude, posture, approach to others. • Family relationships and activities.
Religious rituals	• Prayers and preparation for prayer. • Rituals of devotion: Fasting, abstaining from X, seclusion, paying alms, worship, special food. • Celebration of holy days, festivals. • Memorialization. • Preaching/worship. • Creation of shrines/altars/places of devotion. • Elevation of persons having certain gifts or training to be leaders for others.
Cultural rituals	• Initiation/membership rituals. • Group membership rituals: Political groups, gang behaviour. • Symbolic behaviour. • Clothing/hairstyle as reflective of group identification. • Citizenship or ethnic membership. • Development of arts, including song, dance, visual, crafts. • Sharing of history/narratives of group. • Passing of traditions across generations.
Rites/rituals of life events (cultural, traditional or religious)	• Recognition that a person has changed, therefore social position/relationships change. • Rites of passage from one state to another. Sometimes include survivorship or disaster recovery. • Births and naming. • Puberty and initiation to adulthood. • Marriage.
Rituals of grief, loss, disasters	• Gathering of people to mourn. • Support for friends and family of the bereaved. • Public ceremony, public demonstration of feeling, processions. • Prayers. • Lighting of candles, bringing of flowers. • Food, communal meals. • Rituals of honouring ancestors.

Box 38

Religious rituals

At the early stages of an emergency, religious rituals, such as public prayers and rituals connected with the life cycle – coming of age, marriages and, most importantly, grieving rituals – should take place. Click [here](#) for more information, and see [this video](#) highlighting ways MHPSS programmes adapted to the COVID-19 pandemic when working with communities processing grief and loss.

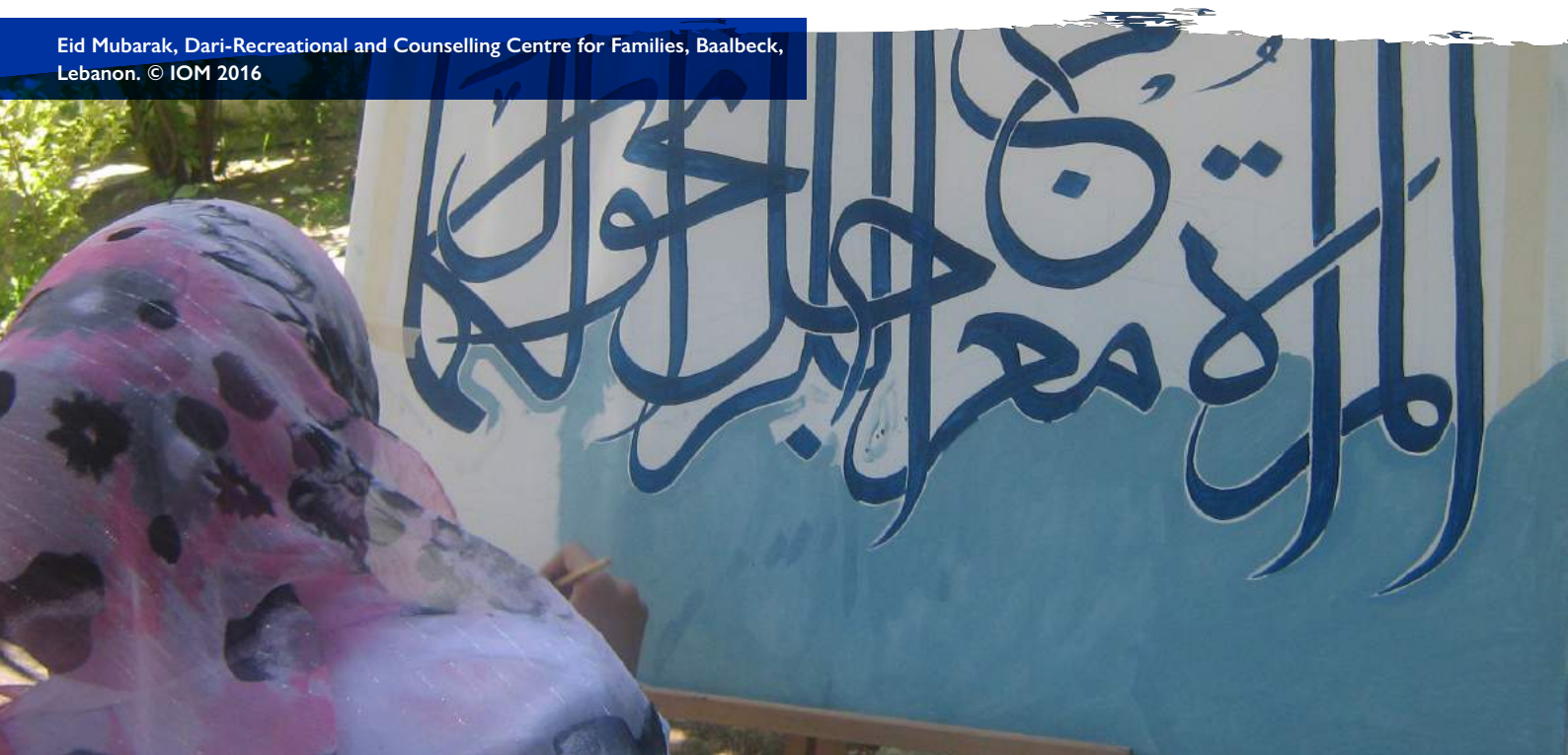
traditional instruments, stationery, chairs or necessary seating arrangements, lights and candles – might greatly support the execution of religious rituals and public gatherings in a warm and conducive atmosphere. It is important that all religious and ethnic/cultural groups present in a camp or a community be represented, always using a conflict-sensitive approach (see chapter on [Integration of mental health and psychosocial support in conflict transformation and mediation](#)).

7.2.1.2 Identify and refurbish (or prepare new) sites and locations

This includes, for example, mosques, churches, temples, meeting rooms, town halls, schools, museums, cinemas and theatres, where religious rituals and civic collective gatherings can be held in safe and welcoming premises. If such locations are not available in a close range, the project might consider the establishment of temporary dedicated spaces (rub halls, tents, caravans, shadings) or renting/rehabilitating available structures for the purpose. It is important to recreate a symbolic enclosure to these spaces, even with simple objects such as fences, pathways, boards, images, plants and decorations. Usually, provision of ad hoc equipment – such as data projectors, screens, sound systems,

7.2.1.3 Mapping and involving faith-based, civic and cultural organizations and their leaders

Religious leaders, artists and cultural activists, within and outside the groups of concern, who are willing to collaborate with the psychosocial project in organizing rituals and gatherings, and promoting participation, based on agreed procedures and aims, should be identified. If available, programme managers should actively search for collaboration with religious congregations, cultural centres, and faith-based and civic-based organizations to provide training on MHPSS to their staff and volunteers. These include both among the displaced and the host communities. If deemed appropriate, partnerships should be established with them to jointly carry out these activities.



7.2.1.4 Facilitate inclusion

Programme managers should facilitate inclusion of individuals and families who might experience difficulties accessing public gatherings and religious places. Examples include:

- Providing or subsidising transportation;
- Arranging translators (and sign interpreters if required);
- Using accessible venues;
- Enabling participants to attend with a support person;
- Explicitly inviting marginalised groups of people to attend.

On the occasion of civic commemorations, public campaigns or ceremonial exchanges of gifts, a mixed attendance and inclusion of different subgroups should always be pursued.

Rituals and celebrations can also be used to divide and exclude, and this needs to be evaluated at the inception of the **programme**.

Box 39

Safety and protection

Participants may need to be reassured of their safety and protection, vis-à-vis the risk of internal and external provocations. Not only should safety and security be provided, but participants should be made aware that these measures are in place.

7.2.1.6 Engage staff appropriately

Ideally among the multidisciplinary PMTs, there is a member that is tasked to learn from communities' religious and spiritual beliefs, traditional narratives and iconography, ritual and civic calendars (for example, cultural and media activists, teachers, scholars and artists). PMTs are likely to be composed of professionals with different ethno-religious backgrounds and social status, along with gender, age and political differences. Therefore, it is important as a preliminary to discuss modalities of their engagement in rituals and celebrations. Particularly for religious rituals and public gatherings, which might require the full mobilization of the team, it is important to coordinate roles and functions according to professional skills, social attitudes and cultural proximity to the affected populations. Staff members who do not feel comfortable, or perceive their presence as potentially obstructive to the smooth implementation of the activity, should be left free not to facilitate or attend. Discussions with and within the teams after the implementation of rituals and celebration activities should be encouraged by psychosocial supervisors as a good managerial practice and lessons learned exercise.

7.2.1.5 Mobilize stakeholders and partners

Local authorities, camp managers, section leaders, teachers, journalists, artists and media activists should be involved from the inception of the activity. Appropriateness of the activities, designing and implementing steps, available financial and material resources, logistics support and authorizations should be discussed and coordinated with them. If deemed necessary, ad hoc committees can be established for the organization of both civic and religious rituals, but religious ones may have to follow their established procedures, particularly on the subject of inclusion. It is good practice to mobilize groups and individuals in the organization of these events (for example, youths, scouts, heads of families, women's leaders and religious actors).



Healing Ceremony with Rohingya women in Cox' Bazar, Bangladesh. © IOM 2018

7.2.2 Promoting additional activities and new rituals and celebrations

7.2.2.1 Promoting the reactivation of rituals and celebrations

After a preliminary assessment on the most appropriate religious rituals and civic celebrations recognized by the community, according to the specific goals, stages of the emergency and target groups, different sets of activities should be identified (for example, public prayers, candlelit march, pilgrimages and visits to symbolical places, funerals, weddings, annual celebrations and commemoration, storytelling and poetry contests, radio talks and social media events) that the project aims to support directly, either because they are missing, or because they are deemed particularly important. Special attention should be paid to testing some of the assumptions on the positive effects of the specific activity on the well-being of participants through discussions with religious leaders, cultural activists and selected members of communities.



See example on community-led Iftar dinners in Turkey.

7.2.2.2 Promoting new celebrations

In strict dialogue with religious leaders and civic activists, new ritual celebrations could be promoted by the MHPSS programme, including:

- The anniversary of the day of displacement;
- The opening, anniversary or closing of a camp or transit area;
- A day celebrating the relations between the displaced and the host community;
- Interfaith celebrations based on the religious composition of the camp, displaced community and host community.

7.2.3 Links with sports, cultural creative activities and informal education

Preparation of the main celebrations and rituals can be linked to sporting events or activities, such as tournaments and contests. The ritual and the celebration can be linked to the other creative activities supported or connected to the programme. For example, one can organize seminars, drama, music, traditional and other dances shows, poem readings and storytelling, and photo and art exhibitions, during or around the celebrations. Moreover, the rituals and celebrations can be used to promote support groups and other programme activities.

7.2.4 Documentation

Many of these events might assume historical relevance and should be properly documented by the project. It is important to archive:

- Photos and videos produced by participants, PMT members and media;
- Printed materials such as brochures and posters;
- Professional documentaries.

Some of these documents will properly fill

Archives of Memory.



7.4. CHALLENGES AND CONSIDERATIONS

When public celebrations and religious rituals are associated with painful memories, deep resentment and contested meanings, their inclusion in a psychosocial support programme should be carefully planned, to prevent their close association with psychosocial interventions to antagonistic, partisan and politicized stances. Particularly sensitive in emergencies can be martyrs and veterans' celebrations, as well as commemorations of battles, exoduses and genocides.

Religious rituals and celebrations can be a source of conflict in some context, and this risk must be evaluated. The engagement of traditional healers and ritualists should also be done with utmost caution.

Participants might not feel comfortable having their rituals documented. As in any activity, they should be consulted before taking pictures or recording the event.

Often, rituals are used to divide and exclude, especially in conflict situations. A careful evaluation of the possible instrumental use of rituals for exacerbating conflict and exclusion needs to be carried out within an MHPSS programme before engaging with these specific celebrations. For further guidance, see [here](#).

Assessing the impact of rituals and celebrations can be challenging. Evaluation and feedback mechanisms can be used to ensure that the activity has a positive impact on the well-being of people of concern.



7.3. CASE STUDY

In the aftermath of the 2010 earthquake in Haiti, during masses, some Christian priests were blaming the earthquake on the prior behaviour of their faithfuls, characterized by a non-strict adherence to the prescriptions of the religion. By contrast, the cosmological vision of the world connected with Voodoo helped individuals and communities give a transcendental value to the earthquake, making it easier for them to attribute a meaning to its consequences. Many families believing in Voodoo were quite distressed about the impossibility to bury the roughly 80,000 corpses that could not be found, since in Voodoo, funerary rituals are extremely important in determining the well-being of the person in the afterlife, but also his or her possibility to still relate to the world of the living. For this reason, IOM, first alone and then under the umbrella of the IASC Working Group on MHPSS, promoted an interconfessional forum of religious leaders. The forum brought sensitization on the psychological consequences of blame towards priests in the country, the creation and dissemination of common supportive messaging and especially the elaboration of a guide, agreed by all, to perform funerary rituals in the absence of corpses, and to the organization of such collective rituals in several camps.



→ FURTHER READING

International Organization for Migration (IOM)

2018c *Psychosocial Support and Dialogue in the Syrian Arab Republic and Lebanon*. IOM, Geneva.

Schininà, G.

2004a Cursed Communities, Rituals of Separation and Communication as Vengeance. A Redefinition of Artistic Interventions in War and War-Torn Societies. In: *War Theatres and Actions for Peace* (C. Bernardi, M. Dragone and G. Schininà, eds.). Euresis, Milan.

University of Oxford Refugee Studies Centre

2013 Local faith communities and the promotion of resilience in humanitarian situations: A scoping study (E. Fiddian-Qasmiyeh and A. Ager, eds.). Working Paper No. 90.

For other references see the full bibliography [here](#).



8. SPORT AND PLAY



→ 8.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Sport and play are fully part of the cultural and relational experience of a community, and can contribute to protecting and promoting the mental health and psychosocial well-being of individuals and groups, across genders, ages and social statuses.

Sport can be defined as an organized and usually competitive form of physical activity, while play can be described as engaging in a recreational activity for the purpose of enjoying oneself. Play can be both physically passive or active, and within the context of this chapter, play will be referred to in its active form. It is important to distinguish between sport, play, physical activity and exercise. Physical activity can be described as any bodily movement, while exercise is a subset of physical activity which is structured and deliberate. Sport, play and exercise can thus all be forms of physical activity. For further information and recommendations on physical activity and health outcomes, please see [here](#).

The importance of physical activity on mental health and psychosocial wellbeing can be seen in the **bi-directional** and causative relationship between physical and mental health and through the **preventative and protective** effects physical activity can have on psychosocial distress. Additionally, people experiencing poor mental health are at a significantly increased risk of cardiometabolic disease and can experience higher than average **premature mortality rates**.

Sport and play are deeply rooted activities that are always present, in some form, in any community. As they are a part of learned interactions and behaviours, and easy to reproduce, they are often spontaneously reproduced even in emergency and displacement settings. They are therefore a powerful means to support interactions among community members in emergencies, as well as an entry to engage communities and their subgroups in **MHPSS programmes**.

Sport and play are essential for the physical and psychological development of children since, through playing, children express and externalize in a safe environment, learn how to connect and cooperate with others, and can give a symbolic structure to their experiences. Games are also spaces for exploration and problem-solving, and educational tools for adults. In this sense, sport and play can help individuals to develop their resilience. More information can be found [here](#).





Outdoor games. Dari Recreational and Social Centre, Misrata, Libya. © IOM 2013/Stefano SPESSA

Box 40

Children's well-being and resilience

Well-being describes the positive state of being when a person thrives. In children, it results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence a child's ability to grow, learn and develop to their full potential. In MHPSS work, well-being is commonly understood in terms of three domains:

- Personal well-being: Positive thoughts and emotions, such as hopefulness, calmness, self-esteem and self-confidence;
- Interpersonal well-being: Nurturing relationships, a sense of belonging, the ability to be close to others;
- Skills and knowledge: Skills to effectively interact with others, cope with distress and seek information.

Source: Children's Resilience Programme (IFRC and [Save the Children](#)).

For additional information on child development, well-being and resilience, not only in relation to sport activities, please see [here](#) and [here](#).



At the community level, in the humanitarian domain, evidence shows that sport and play, and other recreational and structured activities, can be powerful tools for social inclusion, social cohesion, conflict transformation and creating a strong sense of community and **togetherness**. They can also contribute to restoring a sense of normalcy, helping to maintain the developmental process.

From a psychosocial point of view, sport and play are able to work organically on several components of mental health and psychosocial well-being, since they engage the physical, psychological, social and cultural dimensions in the same actions.

In the IASC **pyramid** of MHPSS interventions in emergencies, sport and play are usually considered at the second level of intervention (family and community support). Most spontaneous and generic sport and play activities will in fact be offered to all community members. Yet, sport and play can also be focused activities at the third level of intervention by, for instance, problem-focused play therapy workshops centred on psychological problems, or by conducting sport activities which aim

to facilitate physical and psychological rehabilitation of vulnerable categories, for instance of people with amputations, among others. In some cases, sport and play can be used as a part or a complement of different forms of psychotherapy at the fourth level of intervention (which is true for mindfulness, as well as cognitive behavioural therapy, art therapy and others).

Box 41

Attention points

To increase the possibility of reaching MHPSS and protection outcomes, it is essential to have in mind, from the initial stage, several attention points, such as:

- How are sport and play perceived by the community? By children and youth? By women and men?
- Which activities used to be implemented in the past? Were these activities gender-, age- and disability-inclusive?
- Who were the main actors involved in promoting and supporting sport and playing activities (NGOs, schools, youth clubs, mosques, churches, sport and cultural centres, private institutions and/or sport federations)?
- Are there potential risks linked with supporting and stimulating games and sports (such as cultural divisions, human rights violations, gender issues, among others)?
- Are there social norms prohibiting certain groups from participating?
- Can sport and games be a possible answer to a specific community's needs?
- What are the existing resources?
- How is the emergency impacting the set-up and implementation of the planned activity (for example, see chapter on **Integration of mental health and psychosocial support in conflict transformation and mediation**)?

For more information, see [here](#).



Sport and play are strictly interconnected with rituals and cultural activities, since:

- Sport and play can be used to celebrate rituals.
- Rituals have their codified protocols that usually include play and games or representations.
- Sporting events can become rituals in their own capacity.

They are also interconnected with informal education, since:

- Informal education can regard psychomotricity and different forms of sport.
- Games and play can reinforce life skills.
- Games and play can be used as a learning method.

Finally, the relation between sport and play, and theatre and other arts-based activities, is clear-cut, since they all refer to the action of playing, of which they represent different forms and manifestations. Additional information, including the definition and operational framework for the use of sports in post-disaster settings, can be found [here](#).



8.1.1 Basic principles in organizing sport and play activities

In the design and implementation of sport activities that are structured and have specific psychosocial objectives, the MHPSS manager should embed principles found in Table 4.

Table 4: Sport and play in MHPSS principles

Meaningful participation	From a psychosocial perspective, to make participation in sport and play even more meaningful, it is important to organize before and after discussions about the changes activities have promoted at the level of the individual (self-esteem, sense of power, frustrations) and of the community (sense of playing together, exploring new rules and meanings to antagonism and cooperation). Non-meaningful participation, especially in emergency situations, would be the one that derives from focusing on antagonism.
Capacity development	Skills to facilitate sport processes, in a psychosocial programme include: • Personal skills; • Social skills (communication, listening; negotiation, conflict management; teamwork, empathy; motivational approaches); • Methodological skills, which encompass: - Knowledge of specific sport techniques; - MHPSS skills; - Pedagogical skills. In emergency situations, these skills may need to be refreshed or taught, since the challenges of the emergency context bring the need for new personal, social and technical capacities, as well as new sport practices.
Context sensitivity	Sport activities should be sensitive to the cultural and spiritual dimensions of individuals and families, the socioeconomic and political contexts of the emergency, and to subcultural and conflict dynamics.
Inclusion	In sports, inclusion is programmatically translated in a series of practices aiming at “increasing access to, participation within, and reducing exclusion from, any arena that provides sport and physical activity”. Therefore, proactive initiatives should be taken to ensure the participation of marginalized or segregated individuals to participate alongside their peers. Groups at risk of being left out include adults and children of all populations of disabilities, including cognitive disabilities, women and girls; and elders and youths belonging to different subgroups. A viable methodology to grant inclusion in sport activities can be found here .
Sustainability	This is mainly measured by the degree to which the MHPSS understanding and skills have been embedded in the sport practices of a community.



8.1.2 Categories of sport and play

There are different ways to classify sport and play activities, including structured versus unstructured activities. Regardless of how one chooses to classify them, it is critical that sports and activities aim to support psychosocial well-being, and are selected and implemented in ways that consider all ranges of

motions and abilities, and include considerations of age, gender, economic situation and culture, among other factors.

Games and sport training need to be organized in a programme and sessions. A suggested plan is the one that envisages a main goal for each session. In each session, the goal is discussed and agreed, then there will be a warm-up, core exercises and trainings, a cool-down, and a debate/discussion.

Activities may be:

- Individual/group;
- Outdoor/indoor;
- Aerobic/non-aerobic;
- Technology-based.

Which sports activities to select should be primarily based on what is already existing within the community. However, sport and play should also be seen as an opportunity to innovate and listen to the needs and requests coming from the community. For example, skateboarding in Afghanistan has been used in a particularly innovative programme for girls' **empowerment**.

and adding links to relevant tools.

As for creative and art-based activities, sport activities supported and promoted by an MHPSS programme can be divided into “community-generated”, “programme-facilitated” and “programme-generated”. For an explanation of these terms, click [here](#).

Practical steps to include sport and play activities in a MHPSS programme will include:

- (a) Mapping existing sport and play activities among the displaced and affected community, including activities they used to do but are currently unable to do due to the emergency displacement.
- (b) Mapping existing sport and play activities among the host community, including those that could easily involve the displaced, emergency-affected communities.
- (c) Identifying and selecting sport and play activities to support and engage people of concern in the programme: Support to community-generated sport and play activities can include:
 - (i) Sport materials;
 - (ii) Sport equipment;
 - (iii) Other in-kind support;
 - (iv) Training;
 - (v) Securing facilities and their access;
 - (vi) Including the sport activity in a referral mechanism;
 - (vii) Creating occasions for networking between sport activities, such as leagues, common trainings and forums.
- (d) Disseminate information on the physical and mental health impacts of sedentary behaviour. Sedentary behaviour can be associated with negative mental health outcomes, and informing communities of the consequences of sedentary behaviour can lead to improvements.
- (e) Implementing additional programme-facilitated sport activities within the programme, enhancing the capacity of existing realities, with the specific objective to respond to identified psychosocial needs (high levels of distress, lack



8.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

MHPSS managers are not going to directly conduct sport activities, but rather design, supervise and manage programmes that should create a space for the use of sport and play to reach psychosocially-related objectives at various levels of intervention. The activities will be mainly implemented by the PMT. The UNICEF *Operational Guidelines: Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families* (UNICEF, 2018) envisages practices for inclusion and participation of children and their families in sport activities and events. The suggestions below aim at complementing the information from a programmatic point of view

of social cohesion): In this case, clearly defined programme objectives will be influenced by, and will in turn influence, the type of sport/ interventions selected.

- (f) Group sport activities that are not part of the usual sport and play activities used in a community, but that respond to specific psychosocial objectives or emergency generated needs: In this case, objectives should reflect and be reflected in the type of sport, the local context, the stage of emergency, and the psychosocial needs that have been identified and prioritized through the assessments. They should be determined with a participatory approach.
- (g) Taking barriers experienced by persons with disabilities into consideration when planning sport and play activities to make them inclusive.
- (h) Including people of concern in the selection of activities and development of a schedule.

8.2.1 Capacity-building

Designing and organizing capacity-building for the identified coaches, organizers and volunteers are key steps for managers that should be implemented to support the setting up of activities, and also to maintain quality of activities, by providing ongoing support to trainees. These can be introductory or specialized, based on needs and pre-existing capacity. Training should always be accompanied by ongoing support and supervision. Table 5 is a reinterpretation of the one that can be found [here](#).

Coaches' technical skills should be developed in parallel with their MHPSS skills. The latter represent a prerequisite to reinforce the skills of others. In addition, training can vary for levels of complexity, according to the existing capacity.



Table 5: Key steps for managers to support the setting up of activities

Enrolment	- Make a list of existing and required skills for coaches and facilitators. - Develop a recruitment strategy for staff involving the community. - Select coaches from the local community whenever possible. - Engage equal numbers of female and male coaches where possible.
Training/ongoing support	- Train all coaches/facilitators on basic MHPSS (for instance, using this tool), PFA, motivational approaches and small-scale conflict mediation (see chapter Integration of mental health and psychosocial support in conflict transformation and mediation). - Complement with sports-skills and game-skills training. - Facilitate coach/volunteers/organizers exchange platforms. - Provide mentoring and psychosocial support for coaches, volunteers and organizers during training and throughout implementation, by the dedicated resource in the PMT. - Conduct on-the-job trainings with frequent follow-up rather than one-off longer trainings. - Provide training on how to include persons with disabilities in mainstream sport activities. - As part of training and ongoing support, ensure there is a functional referral mechanism in place for children who need other types of support, including non-MHPSS services and specialized MHPSS.
Retention	- Increase coaches' and facilitators' motivation and volunteerism by providing recognized training and certification in specific coaching/animation competencies and appropriate coaching kits. - Encourage coaches and facilitators to form peer-to-peer groups as part of ongoing support to the coaches and the activities they are implementing with the community.



→ 8.3. CASE STUDY

Egypt is home to many refugees from the Syrian Arab Republic, Sudan, Eritrea and Iraq. These refugees live in precarious conditions, and their children suffer the effects of forced displacement. Tensions between refugees and host communities are common.

In years past, Terre des Hommes developed and implemented a methodology called **“Movement, Games and Sports”**, which aims at improving young people’s well-being and protection. Since October 2017, a new project called “Sport for community-based protection and social inclusion” has been implemented and aims at providing sustainable sport as well as psychosocial and life skills activities that increase social inclusion and community-based protection for vulnerable children and youth.



8.3.1 Helping young people get back on their feet

Animators use football as a tool to support the children. “When they lose, refugees in particular feel as if they’ve lost everything. In their real lives, they feel they may never recover. We use activities to show them that they can get back on their feet and still make something of the situation. This applies to football and real life”, explains Pasant Aly Mokhtar, who is in charge of those running the activities.

8.3.2 Teaching key skills

One of the coaches explains: “I don’t want the children just to play. I’d like them to learn something new every day. I’d like to teach them new life skills and encourage social integration.”

8.3.3 Promoting integration

Noor, a Sudanese mother, came alone with her children to Cairo five years ago. She is afraid of making friends with strangers. To ease life for children in this situation, they can create their teams in advance for each training, but are not allowed to separate them by nationality. This promotes integration.

8.3.4 Building self-confidence

Some individuals suffer the consequences of war or the loss of a family member. Some no longer remember their homes, but still have trouble adjusting to their new culture. The first time they take part in the activities, they’re shy. It’s the coaches’ goal to support individuals to regain elements of positive self-recognition and strengths to promote self-confidence and resilience.

Sport is a tool to reach a variety of objectives but, as a stand-alone practice, its MHPSS potential has its limitations.

While sports are important, it is essential to consider food and other basic needs of participants. If food insecurity is a grave issue, one should consider delaying the start of sport programmes and partnering with those who are able to engage in mitigating food insecurity.

Coaches are in a unique position to be role models and mentors for young participants, but there are also stories of coaches misusing their influence and power, harassing, bullying, manipulating and neglecting participants’ safety. It is widely recognized that safeguards are necessary, and this includes putting into place safeguard **policies**.



Sport and play do not always nor automatically have a positive impact. Careful consideration should be given to potential negative effects of the intervention:

- Creating risks by empowering women or vulnerable categories in highly conservative cultures.
- Fostering negative and aggressive competition, which can validate or reactivate community tensions: Sport can be associated with political divides in conflict areas, and used as a divisive element. It is therefore important to associate planning of sport activity with a conflict-sensitive approach.
- Potentially creating new emotional stressors due to competition associated with the physical activities, and in turn having an **adverse impact** on mental health outcomes.
- Fostering women, girls and child abuse and intimidation.
- As sport and play are tools to reach psychosocial and protection outcomes, they should not be conceived as isolated activities but integrated into larger programmes.
- In specific cultures, participation of women can be very hard to encourage.



→ 8.4. CHALLENGES AND CONSIDERATIONS

Gender and disability inclusion should be mainstreamed. Activities should be culturally appropriate and respect non-discriminatory principles. For instance, girls may be at risk of bullying by taking part in a certain activity or sports that imply force and physical confrontation. It is important to offer different kinds of sports and to adapt rules and practices to make games and sports, even highly physical ones, accessible.

Communicating the objectives of the programmes to the community is essential, and illusions or disproportionate expectations should not be created to stay realistic.

→ FURTHER READING

Alexandria University Theories and Applications the International Edition (TAIE)

2011 *Sport as an Instrument for People Development and Peace Promotion*. TAIE. Faculty of Physical Education, Abu Qir, Alexandria University, Alexandria.

Clemens Ley, C. and M. Rato Barrio

2010 Movement, Games and Sport in Psychosocial Intervention: A Critical Discussion of its Potential and Limitations within Cooperation for Development. *Intervention*, 8(2):106–120.

Harknett, S.

2013 *Sport and Play for All: A Manual on Including Children and Youth with Disabilities*. Handicap International, Colombo, Sri Lanka. Available from www.sportanddev.org/sites/default/files/downloads/sport_and_play_for_all.pdf (accessed 16 April 2019).

Huizinga, J.

1949 *Homo Ludens*. Routledge, London.

PYKKA and United Nations Children's Fund (UNICEF)

2010 *Changing Life Through the Power of Sports*. PYKKA and UNICEF, New Delhi.

Sport Inclusion Network

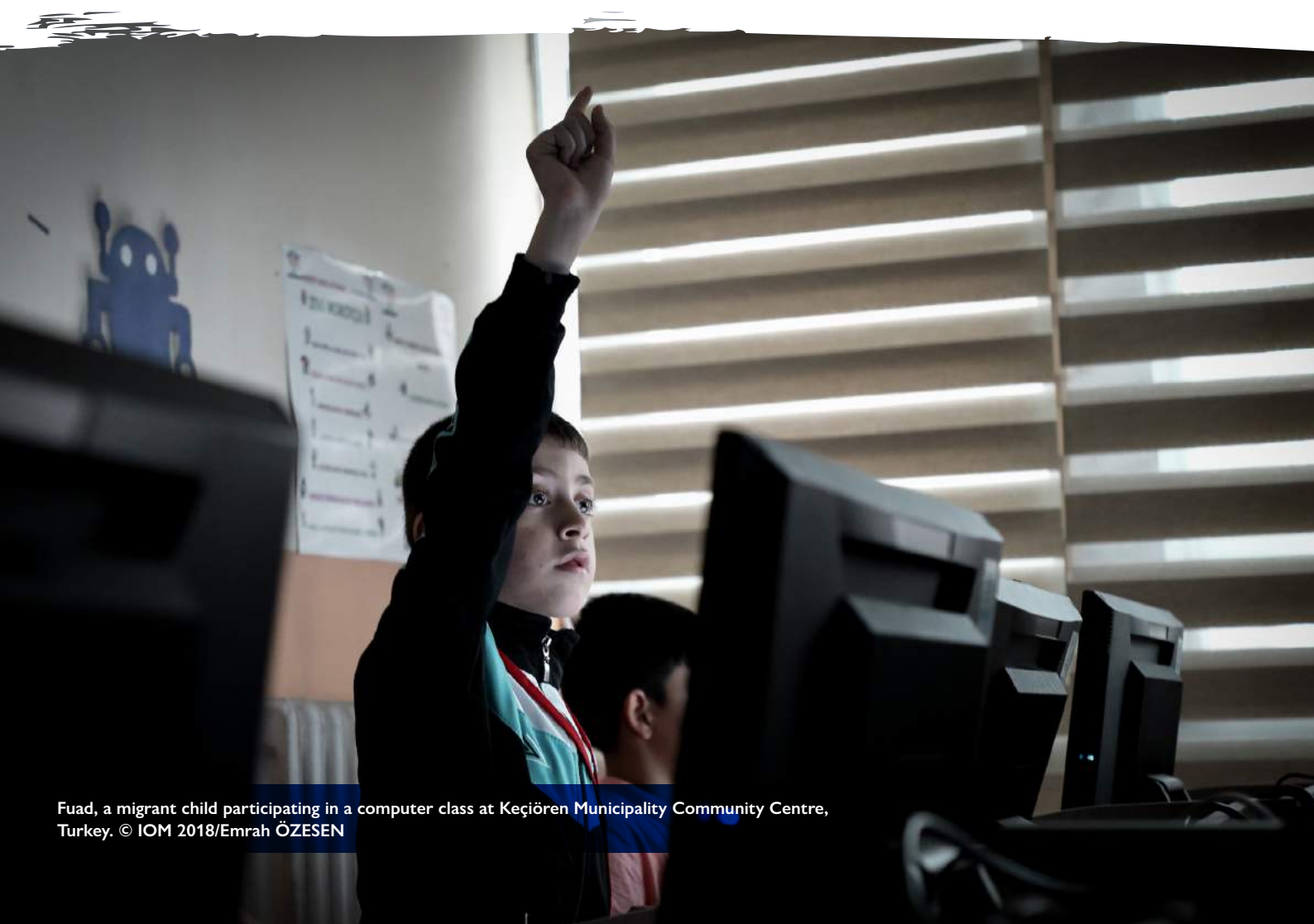
2012 *Inclusion of Migrants in and through Sports: A Guide to Good Practice*. Sport Inclusion Network, Vienna.

sportanddev.org

N.D. Sport as a Psychosocial Intervention.

For other references see the full bibliography [here](#).

9. NON-FORMAL EDUCATION AND INFORMAL LEARNING



Fuad, a migrant child participating in a computer class at Keçiören Municipality Community Centre, Turkey. © IOM 2018/Emrah ÖZESEN

→ 9.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

In the immediate aftermath of a crisis, restoring the functioning of formal educational institutions can be difficult for both local governments and humanitarian actors. In situations of forced or mass displacement, the integration of newly arrived communities in the formal education system of the country of destination can be hampered by logistical and administrative constraints. Moreover, in displacement and migration, students, even if integrated in the education system of the host country, can struggle in adapting to different curricula and pedagogical models from the ones they were used to. Therefore, such contexts call for programmes facilitating either non-formal education and/or informal learning responses as a bridge towards, or as a complement to, formal education. Formal education, non-formal education and informal learning are all fundamental cultural activities which contribute to organic community integration. They are also an important venue to create relations and to learn how to relate to others.

It is important to understand the various definitions and differences. The Inter-Agency Network for Education in Emergencies (INEE), provides a common framework to refer to (see Table 6).

Table 6: Common framework for education in emergencies

Education in emergencies	- Quality of learning opportunities for all ages in situations of crisis, including early childhood development, primary, secondary, non-formal, technical, vocational, higher and adult education. - Provides physical, psychosocial and cognitive protection that can sustain and save lives.
Formal education	- Usually refers to educational institutions that follow a specific curriculum developed and approved by a government with one or more final graded examination(s).
Non-formal education	- Takes place both within and outside educational institutions, and caters to people of all ages. - Does not always lead to certification. - Non-formal education programmes are characterized by their variety, flexibility and ability to respond quickly to new educational needs of children or adults. - Often designed for specific groups of learners, such as those who are too old for their grade level, those who do not attend formal school, or adults. - Curricula may be based on formal education or on new approaches. - Examples include accelerated “catch-up” learning, after-school programmes, literacy and numeracy. - Non-formal education may lead to late entry into formal education programmes, which are sometimes called “second-chance education”.
Informal learning	- “Forms of learning that are intentional or deliberate but are not institutionalized are known as informal learning. It is consequently less organized and structured than either formal or non-formal education. Informal learning may include learning activities that occur in the family, workplace, local community, and daily life, on a self-directed, family-directed, or socially-directed basis” (United Nations Educational, Scientific and Cultural Organization (UNESCO)).



Non-formal education can target different populations, and can be implemented in a specific space or not. Curricula are more or less formalized, but with no certification process nor diploma at the end. These can include language classes, uncertified literacy and numeracy courses for adults, computer literacy and psychoeducation sessions.

Informal learning is less structured than formal and non-formal education, but what differentiates it the most from other forms of education in an emergency is not the structure, but the objective. A structured sport session, for example, has objectives. A specific set of games and exercises solicits brain/muscles and is categorized as informal learning, even though it is a very structured activity. In basketball training, one has to learn how to play, and to practice a lot in order to do so. He/she will engage mind–body circuits through learning positions, targets, how to throw the ball, how to collaborate with others and how to follow rules, for example. Yet the final objective is not the learning but the actual playing. The same happens during cultural, creative, artistic and theatrical activities illustrated in this Manual, which are not aimed specifically at education, but can have objectives related to learning (skills, attitudes, processes). The non-formal learning potential of several activities can be spontaneous or well thought out, in the sense that activities can be redesigned and structured to reach their full potential.

Non-formal education and informal learning contributes to MHPSS outcomes for different reasons (see Table 7).

Table 7: Non-formal education and informal learning as they contribute to MHPSS

MHPSS	- Safe schools and non-formal learning spaces are some of the most beneficial environments for children and youths during a period of uncertainty. - Intentional investment in education-based psychosocial support has proven to protect children and youths against the negative effects of disasters by creating stable routines, providing opportunities for friendship and play, fostering hope, reducing stress, encouraging self-expression and promoting collaborative behaviour (Alexander, Boothby and Wessells, 2010; Masten, Gewirtz and Sapienza, 2013).
	- Psychosocial well-being is a significant precursor to learning, and is essential for academic achievement; it thus has an important bearing on the future prospects of both individuals and societies.
	- The psychosocial support approach works best when integrated into the different spheres of young people's lives. Since education settings bring children, youths and their peers, parents, families, and communities together, they can help create a supportive environment that promotes improved psychosocial well-being. - Ideally, the education and community settings that surround each child work together to ensure that they receive the best possible care and follow-up; this includes communication between teachers and parents, and counsellors, if needed.

9.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

MHPSS managers are not providing non-formal education and non-formal training by themselves, but they need to design programmes that envisage actions and resources to promote non-formal education and informal learning. They will also have to select and supervise educators and teachers who are core members of the PMTs, and agree on their action plans following the steps below.

- (a) Foster the involvement of the community: Community members should be especially engaged in these activities, not only as participants but to understand priorities, identify teachers and trainers, select activities and monitor outcomes. The selection and prioritization of the activities are based on three factors:
 - (i) Needs-based: Identification of needs in the community (school help, hygiene awareness, psychoeducation);
 - (ii) Resource-based: The identification of community resources whose agency can be empowered by organizing non-formal education activities for others (computer, languages, arts and crafts, music);
 - (iii) The possibility of the programme to cater for the needed materials, venues, security, among others.

Design and implementation, adaptation, location and identification of involved persons as well as linkages with other programmes should be discussed, defined and addressed with key actors of the affected community.

- (b) Wherever possible, support pre-existing facilities in the host community (music schools, sport schools, dance schools, computer schools, language schools) rather than creating parallel structures, and

assure access (transport, payment of fees if suitable) and inclusion.

- (c) Identify people with skills they can teach to the others in the displaced community and mobilize them in organizing non-formal education for defined groups. Support these activities in kind, training and eventually stipends for the facilitators.
- (d) Analyse the non-formal education potential of other support activities organized by the programme (theatre and drama, sport), and create spaces for exchanges between the facilitators of those activities and the educators on the team to emphasize this potential through structuring, pedagogical hints, and pre- and post-workshop discussions.
- (e) Finalize a plan of non-formal education activities, dividing them in:
 - (i) Inductions and information sessions (a few hours);
 - (ii) Workshops (a few days or a week);
 - (iii) Actual educational activities (school support, language classes, numeracy classes) that should be given a set duration, number of sessions and a closure in order to maximize participation and inclusion.
- (f) Provide training to volunteers, teachers and facilitators on interactive methods to facilitate sessions and basic MHPSS:
 - (i) Promote, wherever possible, ad hoc non-formal education activities for people with severe mental disorders or disabilities.
 - (ii) Organize service evaluations, at the end of each cycle of non-formal education activities.



Table 8: Examples of activities (non-exhaustive)

Health education (WHO definition)	Any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.
Hygiene promotion (SPHERE definition)	Hygiene promotion is a planned, systematic approach that enables people to take action to prevent and/or mitigate water, sanitation and hygiene-related diseases. It can also provide a practical way to facilitate community participation, accountability and monitoring in WASH programmes.
Life skills (WHO definition)	WHO in 1999 identified five core cross-cultural areas of life skills: decision-making and problem-solving; creative thinking (see also lateral thinking) and critical thinking; communication and interpersonal skills; self-awareness and empathy; and coping with emotions and stress.
Sport education	Many life skills can be taught through sport activities that contribute to development: concentration, collaboration with others, self-confidence, strategic thinking. Specifically, games and play can foster a sense of safety and contribute to children's well-being. Moreover, they constitute tools for social inclusion that contribute to the sense of community and togetherness.
Literacy and numeracy courses (UNESCO)	Proficiency in literacy and numeracy is essential if young people are to fully develop their potential as effective members of their community and for migrants to integrate. Where there are low levels of literacy and numeracy in the adult population, it is an indication of low basic skills and low employment levels. Those courses can be part of a broader catch-up plan.
Arts and crafts	Non-formal education in arts and crafts can make people relax, connect with others through an action, enhance self-esteem and, in some cases, act as an income-generating activity (see challenges).
Mine risk education (international mine action standards)	Refers to "activities which seek to reduce the risk of injury from mines and explosive remnants of war by raising awareness and promoting behavioural change, including public information dissemination, education and training, and community mine action liaison".

Non-formal education requires a close linkage with communities and a strong involvement from the beginning to ensure that non-formal education activities are adapted to the population's needs. Lack of involvement by the affected populations and the community could negatively impact non-formal education interventions by fostering limited interest in the programme or delivering messages that are not contextualized nor adapted to the population. The contents and material should be checked and approved by community members, who acknowledge the purpose and necessity of the programme to support it.

→ **9.3. CASE STUDY: FABLAB INITIATIVE FOR EMERGENCY AND HUMANITARIAN CONTEXTS**

Globally, a FabLab is defined as “a technical prototyping platform for innovation and invention, providing stimulus for local entrepreneurship. For Terre des hommes (TdH), the adaptation of this initiative to development and humanitarian contexts complements and heightens the impact of existing programming by providing an entry point to a broader package of services available within different TdH interventions adapted to needs and context.

It consists of a physical space equipped with tools (for example, 3D printers, laser cutters and circuit-makers), software (to programme the tools and support access to networks), and educational approaches and processes (for example, adapted training courses, management systems to open the space to innovators and peer-to-peer learning models). It is not simply piece(s) of equipment – rather, it is a way of engaging with children, youths and communities.

9.3.1 A new way of targeting youths, a hard-to-reach demographic

In crisis-affected areas, teenagers and youths experience significant protection risks, including but not limited to early marriage, school dropout, child labour, conflict or contact with the law, violence associated with the crisis, and association with armed conflict, including forced recruitment, and juvenile justice issues.

Despite being very frequently at risk, teenagers and youths are often extremely difficult to reach. There are few standardized approaches for engaging with teenagers and youths, and little consensus around basic issues, including what ages precisely constitute the term “youth” itself.

Attractive places for youths:

- Focus on cutting-edge yet easily accessible digital technologies, as youths have higher levels of engagement and interest in digital technologies compared with other demographic groups.
- Support creativity in a flexible and adaptable manner, which is key for a group that has fluctuating interests, capacities and needs, and whose needs are currently not sufficiently met by humanitarian responders.
- Organize time of activities considering issues such as child labour and school attendance.





English classes at Haj Ali IOM Community Center in Iraq.
© IOM 2017/Sandra BLACK

Table 9: Impact opportunities

Education	- Provides a good basis for provision of non-formal education, particularly in STEM (science, technology, engineering and mathematics), for the most vulnerable youths. - Enables the transfer of youths from non-formal education into formal education (university, high school or vocational training). - The safe space stimulates both learning and opportunities.
Affected populations-led participation and design	- Allow youth to lead and more actively participate in the development and implementation of projects and generate a tangible output. - People using FabLabs drive their own development, which gives affected populations the flexibility and the tools to design their own solutions while linking users to share experiences.
Child protection	- Provides an open, safe space for youths and communities in which they can build trust, work together to define their own priorities, and identify innovative solutions to their problems. - Aims to empower children and their communities to engage more effectively in dialogue and action to support child rights, leveraging digital tools and networks. - Privileged space for delivering MHPSS services and, when necessary, identifying and referring youths to TdH's other services (such as those provided by social workers and community mobilizers, among others).
Livelihood opportunities	- The hardware component represents an aspect of the digital economy to which few conflict-affected communities have access. - Can support vulnerable communities to engage in small-scale production and meet immediate needs in a more cost-effective and tailored fashion. - TdH FabLabs represent a valuable resource and access to livelihood for those who develop skills through the TdH FabLabs. - For the broader economy within the community, as it provides new models and a method for enhancing existing tech (and other) industries.

In conclusion, FabLab was a great opportunity of learning for youths and community members, and in the meantime to ensure high participation and involvement in the implementation to make the FabLab sustainable. It helps provide a safe place, to deliver adapted learning, to take sufficient time with youths for them to learn, to have fun, and finally to learn something around new technologies, together with other education contents (vocational training, basic reading and numeracy courses).

9.4. CHALLENGES AND CONSIDERATIONS

The differentiation between the various forms of education in emergency within MHPSS programmes is very important in terms of programming and community dynamics since, especially in emergencies, confusion often arises between formal and informal education, informal education and informal learning, and vocational and professional trainings. This leads to four series of problems:

- (a) Creative or socializing MHPSS workshops (informal learning) are often misinterpreted as non-formal education activities. For instance, a tailoring or crocheting group for women, primarily aimed at helping them gather together and express themselves, can be considered by the affected populations and at times by the project management as a non-formal course in tailoring. This can give rise to false expectations among participants and create an ambiguity in the planning of the activity, the necessary expertise of the trainer, and other things. Clarity on the nature and scope of activities needs to always be adopted in planning.
- (b) MHPSS programmes tend to certify non-formal educational activities. This is also done for very short inductions or information sessions. While this is often at the request of participants, and can represent an incentive for participation and boost their self-esteem, it can also bring two problems. On the one hand, participants may feel these certificates add to their professional capacities. On the other hand, in a humanitarian context characterized by the necessity to hire staff in a haste, certificates can be misinterpreted in their training value. Finally, the proliferation of certifications can devalue the legitimate certifications of those who followed an official curriculum in the country, affecting community dynamics.
- (c) Non-formal education and vocational and professional training need to be kept distinct. While people can be informally educated in an art or a craft, for their own interest, vocational trainings aiming at employability and income generation based on the same skills are part of a livelihood support protocol, and need to be designed with that aim in mind. Not doing so can create future frustrations in participants. The chapter on **Integrated MHPSS and livelihood support** will better describe how this integration can happen in vocational trainings without creating confusion.
- (d) Formal education is always a primary need and should be favoured. At times, however, in emergency situations, non-formal education risks being used as a substitute for formal education even when formal education is available but is (a) in remote locations, and (b) perceived as too difficult. In those situations, if resources are scarce, transportation to formal educational facilities should be prioritized as a response, vis-à-vis the organization of informal educational activities. In addition, while informal education can keep on being offered, sensitization on the importance of formal education needs to always be organized and mainstreamed, and schools in need of help for children and youths to adapt to the new curricula favoured vis-à-vis other forms of non-formal education.



→ FURTHER READING

Finn Church Aid (FCA)

2018 Improving Well-being Through Education – Integrating Community Based Psychosocial Support into Education in Emergencies. FCA, Helsinki.

International Network for Education in Emergency (INEE)

2010 *Minimum Standards for Education: Preparedness, Response, Recovery* (2nd ed.). INEE, Geneva.

2016 Background Paper on Psychosocial Support and Social and Emotional Learning. INEE, Geneva.

2018 Guidance Note on Psychosocial Support. INEE, Geneva.

For other references see the full bibliography [here](#).



10. INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN CONFLICT TRANSFORMATION AND MEDIATION



→ 10.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

One of the challenges that MHPSS teams frequently encounter in humanitarian emergencies is the pervasiveness and complexity of interpersonal and intercommunal conflicts. It is thus essential for MHPSS workers to acquire basic skills in managing and resolving conflicts. This chapter will discuss practical ways in which MHPSS workers can use their skills, resources and networks to respond to interpersonal and community-based conflicts. To this end, a brief introduction to concepts on conflict assessment is provided.

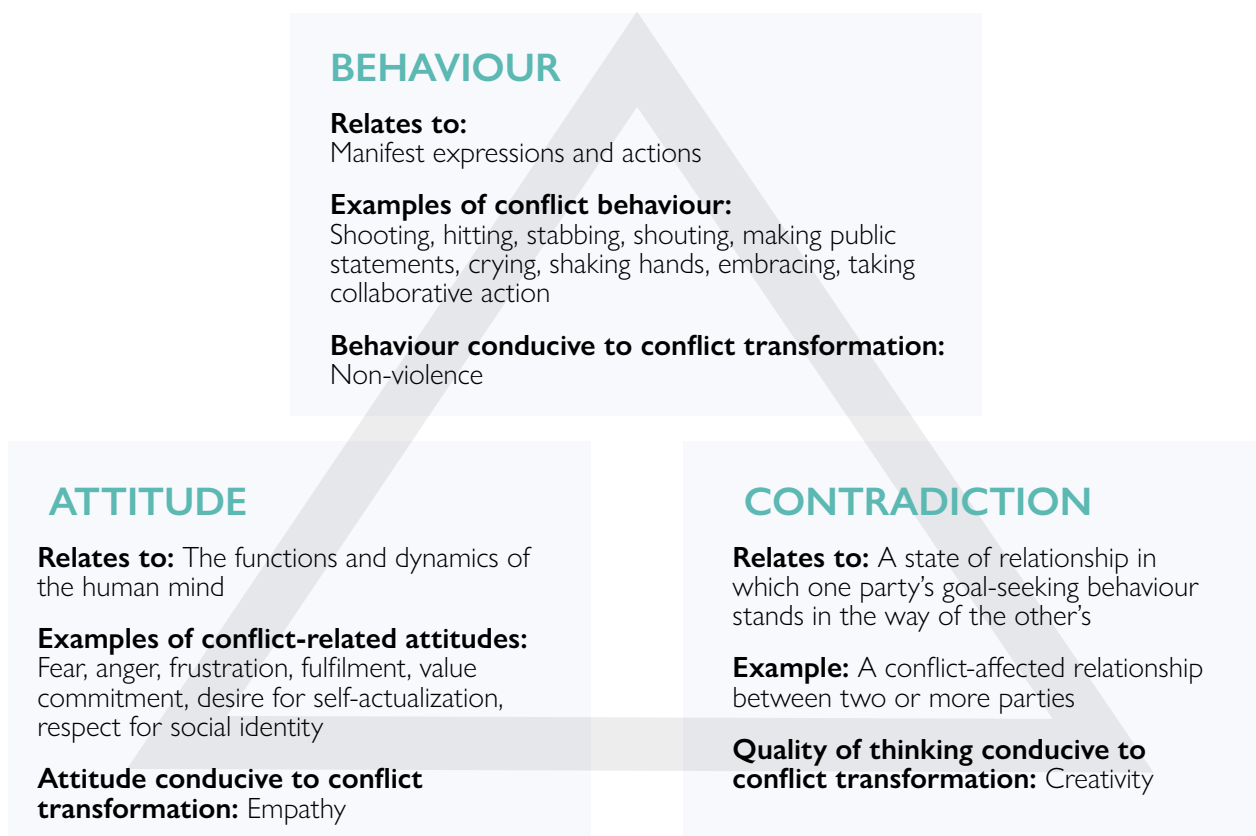
Conflict is a contradiction. It is a state of human relationships in which one side's attempt to achieve its goals stands in the way of the other side's. The following link provides a more detailed description of conflict as well as other related **concepts**.



Conflict in and of itself is neither destructive nor constructive. When parties in conflict lack the capacities and means to transform their conflict, the resulting frustration and enmity can turn the conflict into a destructive experience. When the parties have the capacity and means to see their conflict as a shared challenge to be overcome, the conflict becomes an opportunity for creative problem-solving and relationship-building.

According to pioneering peace researcher Johan Galtung, a social conflict at all levels, from interpersonal to international, has three dimensions: attitude (A), behaviour (B) and contradiction (C), as summarized in Figure 10.

Figure 10: ABC triangle



Source: Based on Galtung (1958).

The ABC triangle is a useful framework to help MHPSS programme managers examine the interconnected nature of attitude, behaviour and contradiction. Their practice in counselling, for example, can help individuals and groups to restore empathy, therefore facilitating attitudinal changes, which can in turn encourage them to adopt non-violent behaviours. Furthermore, their attitudinal and behavioural changes can contribute to building constructive relationships, and exercise the creative thinking skills necessary to resolve the incompatibility of their goals.

Humanitarian emergencies such as natural disasters, armed conflicts and migration crises make it difficult for individuals and communities to exercise empathy, non-violence and creativity. This is particularly true in cases of displacement, which often result in tensions between the displaced and host communities. MHPSS can help affected individuals and communities restore empathy with one another, promote non-violent behaviour, humanize their relationships, and encourage creative problem-solving.

Conflict transformation consists of finding a mutually acceptable solution to the underlying contradiction that strains human relationships, while promoting empathetic attitudes and non-violent behaviour. Conflict transformation contributes to building a secure and reassuring social environment in which individuals and communities affected by humanitarian emergencies can regain or develop their capacities to self-reflect, restore relationships, and seek and receive MHPSS effectively. The processes of MHPSS and conflict transformation are thus complementary and mutually reinforcing. For these reasons, MHPSS workers will find it useful to gain basic skills in conflict analysis and transformation, in order to deliver MHPSS services effectively.

Conflict transformation skills useful for MHPSS professionals working in humanitarian emergencies vary significantly depending on the circumstance in which they work. The skills summarized in this [link](#) suggest a possible

starting point, and could be used as a list for trainings that could be offered.

Box 43

Resources

Additional resources on conflict transformation may be found at the following sites (all sites accessed 17 April 2019):

- African Centre for the Constructive Resolution of Disputes (ACCORD) (www.accord.org.za);
- Alliance for Peacebuilding (<https://allianceforpeacebuilding.org/>);
- Beyond Intractability (www.beyondintractability.org/);
- CDA Collaborative Learning Projects (<https://www.cdacollaborative.org/>);
- Conciliation Resources (www.c-r.org/);
- Peace Insight (www.peaceinsight.org/);
- United Nations Mediation Resources (<https://peacemaker.un.org/resources>).
- Building Bridges in Conflict Areas (<https://en.unesco.org/interculturaldialogue/resources/546>)



10.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

- Be sensitive to conflict at all stages of an MHPSS programme.
- Use MHPSS activities in conflict transformation efforts or programmes.
- Introduce conflict mediation and social cohesion as a component of MHPSS programmes.

A prerequisite to these tasks above is conducting a conflict analysis and feasibility analysis, summarized in Box 44.



Box 44

Conflict and feasibility analysis

1. Conflict analysis

Conflict analysis is an analytical process through which to identify the sources and nature of a given social conflict systematically. Suggested steps to perform a conflict analysis include the following:

- Identify parties in conflict, defined as individuals and/or groups capable of exercising agency to develop and pursue goals.
- Learn and articulate the goals of each of the parties.
- Describe their relationships (for example, collaborating, opposing, or having no relationships).

See examples of conflict analysis. The first **example** addresses a simple two-party conflict; the second **example** analyses a more complex multiparty conflict. These examples of conflict analysis suggest opportunities for conflict transformation.

2. Feasibility analysis

This refers to an initial inquiry into the feasibility of intervention. Depending on the context of their work, MHPSS workers conducting a feasibility analysis may ask questions about the security, legal, political and institutional circumstances of the intervention. They must also examine the programme objectives, time frames, resources, expertise, availability of local partners, and other factors essential for making informed decisions about the desirability, ethicality and possible methods of intervention.

Conflict mediation training, Baalbeck, Lebanon. © IOM 2016



Findings from conflict analyses and feasibility analyses can help establish a well-informed basis for implementing each of the three suggested tasks:

- (a) Be sensitive to conflict at all stages of MHPSS programmes: Incorporating conflict sensitivity into all stages of an MHPSS programme is essential when working in conflict-affected societies. Conflict sensitivity refers to the process of (i) understanding the social context of the conflict in which an MHPSS programme is implemented, (ii) monitoring the interaction between the programme and its context, and (iii) proactively taking actions to minimize the programme's negative effects on the conflict and to maximize its positive impacts. The possible actions to be taken include a suspension of the programme where its continuation is likely to exacerbate the conflict. For more information on conflict sensitivity, as well as on the “do no harm” principle closely related to conflict sensitivity, please visit this [link](#).



Conflict sensitivity is particularly important in the selection of MHPSS programme sites, objectives, expected outcomes, staffing, and affected populations. With respect to staffing, the selection of PMT members requires attention to conflict sensitivity. Conflict analysis is especially important in this context, because the conflict-affected communities they serve will find it important that the team is balanced, representative and accessible to all affected populations without prejudice. For more information on the selection of PMT members, please see chapter on **Psychosocial mobile teams**.



Box 45

Livelihood support for women

With respect to the application of conflict sensitivity to the development of programme outcomes and affected populations, livelihood support for women presents a useful example. While support for women's empowerment in family and community life is an important programme objective, its possible consequences include an increase in men's resistance and in domestic violence. Considering these challenges, MHPSS workers must consult not only the participating women but also a broader scope of stakeholders who can either support or hinder the women's activities for economic empowerment. MHPSS workers must also inform the participating women of the possible adverse consequences of their participation, as well as of the choices the women can make to continue, discontinue or seek help. The example of women's livelihood development illustrates the complexity and difficulty of activities designed to tackle deeply structural and cultural contexts of programme design. It also illustrates the role of conflict sensitivity, not only about programme effectiveness but also in terms of ethics.

- (b) Use MHPSS activities in conflict transformation efforts and programmes: MHPSS programmes, as described in **the models of work**, address the interrelation of biopsychological, sociorelational and cultural factors of experiences. These programmes make use of recreational and **social, ritualistic, artistic, sport** and **educational activities**, capable of bringing people together and fostering social cohesion. Creative activities can stimulate imaginative thinking useful for creative problem-solving. In addition, individual and group counselling, as well as psychoeducation, can help conflict-affected individuals and communities develop empathy, promote non-violence and facilitate relationship-building. Three aspects of an MHPSS programme – counselling, psychoeducation, and social and recreational activities – can make an especially important contribution.



- (i) Counselling as a contribution to conflict transformation: MHPSS activities, which focus primarily on the attitudinal and behavioural dimensions of conflict, can be carried out in such a way as to help affected communities address the underlying contradictions in conflict-affected relationships. Counselling is an especially useful method for this purpose. In north-eastern Nigeria, for example, the MHPSS staff support the reintegration of former Boko Haram members into their home communities. The staff offers counselling to the returnees whose MHPSS needs are inseparably linked to long-standing challenges about their livelihood development, self-worth, education and need for social justice. While their counselling does not aim to resolve these and other social issues that contributed to the rise of Boko Haram's insurgency, it can nevertheless help former Boko Haram members reflect on these issues and explore ways to face them constructively.
- (ii) Psychoeducation as a contribution to conflict transformation: MHPSS education enables conflict-affected communities and individuals to understand how the human mind works under stress, grief and loss, what actions can be taken to manage these, and how communication can be positive in nature. In order to address the psychosocial effects of the war and the migration crisis in the Syrian Arab Republic, IOM produced *Self-Help for Men Facing Crisis and Displacement*, a guide for adult men seeking basic knowledge on the sources of stress and the practical measures they can take to mitigate the stress. The guide is available at [this link](#).
- (iii) Social and recreational activities as a contribution to conflict transformation: Social and recreational activities can bring together members of divided communities through mutual humanization and building social cohesion. In Libya, for example, the MHPSS staff is using a community centre to bring displaced people, migrants and local residents

together. The social and recreational activities offered at the centre enable the previously divided community members to get to know each other, build relationships, and a shared sense of community.

While each of the above three types of MHPSS activities can make a significant contribution to conflict transformation, their effectiveness can be enhanced further by institutional partnership and collaboration. Specifically, MHPSS workers can reach out to IOM's Transition and Recovery Divisions or Stabilization Units, whose activities are more closely aligned with conflict transformation. If these units are not readily available, MHPSS workers can identify and partner with other actors with expertise and experience in conflict transformation. For more information on forming these partnerships, reach out to contactpss@iom.int.

- (c) Introduce conflict mediation in MHPSS programmes: One of the most practical methods of conflict transformation that PMTs can learn and practice as part of their daily activities is conflict mediation. MHPSS managers can explore alternative means by which to introduce conflict mediation into their day-to-day activities. The alternative means described below are mutually supportive and complementary. They may be combined or sequenced in such a way as to maximize programme effectiveness:
 - (i) Hire an experienced conflict mediator: An MHPSS programme manager can hire an experienced conflict analyst, if funding permits. The MHPSS programme in Iraq, for example, hired a conflict specialist as a member of the MHPSS team. The specialist monitors the conflict dynamics at MHPSS centres implemented within the programme, and ensures their conflict sensitivity and programme effectiveness.
 - (ii) Identify and appoint a conflict mediator, as a core member of each PMT: A PMT may include a qualified team member to play the role of a conflict analyst and mediator,





whose responsibility is to monitor and work on conflict-related **issues**. This is to be done while being aware of the context's conflict dynamics, as engaging in mediation, even at the local level and informally, can be perceived on a sociopolitical level and give the perception that the entire PMT is not neutral in a conflict situation.

- (iii) Provide basic conflict mediation training to the whole of an MHPSS team: MHPSS workers equipped with basic conflict mediation skills can carry out MHPSS activities with greater conflict sensitivity, contributing to the management and prevention of violent conflicts, and granting effective service delivery when relationships between stakeholders are tense. The PMTs working in the aftermath of Boko Haram's insurgency in north-eastern Nigeria received trainings in the analysis and transformation of interpersonal and intercommunal conflicts. The training materials and curricula they used can be obtained by writing to contactpss@iom.int.
- (iv) Provide advanced trainings to selected PMT members to enable them to become conflict mediation focal points: Some of the PMT members may receive more advanced mediation trainings, gain practical experiences and become mediation focal points. The MHPSS staff in South Sudan adapted this strategy to its distinct programme needs. Together with selected community members, South Sudan's MHPSS staff members received advanced conflict mediation training. Based on the training, they became conflict mediation focal points in IDP camps. The training increased their capacity to address community conflicts on their own. The skills they gained contributed to creating both formal and informal structures of conflict management. The training materials and curricula can be obtained by writing to: contactpss@iom.int.
- (v) Identify and empower qualified community members to become conflict mediation focal points: MHPSS teams can find trusted

community members with conflict mediation skills, and support them to become focal points who can partner with the PMT. These local focal points may receive customized skill-building training. In addition, or alternatively, they can be included in the trainings for the PMT described in points (iii) and (iv) above. In Iraq, for example, IOM's MHPSS activities provide community members with intensive conflict mediation trainings, facilitate community members' participation in dialogue and leadership groups, and carry out youth peacebuilding activities. Through these IOM-sponsored activities, trained and qualified Iraqis have come to serve as conflict mediation focal points working side by side with the **PMTs**.



10.2.1 PMT members as mediators

PMT members and MHPSS workers in general can serve as conflict mediators in humanitarian emergencies. In many contexts of MHPSS activities in which MHPSS workers perform mediation, they do not hold the title of a mediator, nor do community members recognize MHPSS workers as mediators. Under these circumstances, MHPSS workers practice emergent mediation, defined as an informal, spontaneous process of assisted negotiation and problem-solving for which there is no formal mediation contract expected.

Emergent mediation can be initiated by casual conversations with clients of MHPSS services. Questions such as "Is there anything I can do to help you think through this relationship challenge together?" and "Would you mind telling me why you and the other person are refusing to communicate?" can serve as an invitation to emergent mediation.

Defining emergent mediation broadly, MHPSS workers can perform mediation in the following ways:

- (a) One-on-one dialogues: in addition to what is presented **here**, the chapter on **Counselling** offers useful insights into one-on-one dialogues.





(b) **Mediation between two or more parties.**

(c) Support for social, ritual, educational, recreational and artistic activities that promote relationship-building and problem-solving (See Box 46).

The three methods are usually applied to regular MHPSS activities in which relationship-building is important. They are complementary and mutually supportive. Two or more methods can be combined and performed simultaneously or sequentially, depending on the needs and contexts of the MHPSS activities.

Box 46

Linkages with prior chapters

Social, ritual, educational, recreational, artistic community-based activities, described in prior chapters, refer to a broad range of familiar community practices that can bring a larger number of people together to meet the community's shared needs and purposes. The people brought together for community-based activities may come from the same community or from different communities. When organized purposefully, community-based activities can help people from different sides of a conflict to humanize each other and build trust, and encourage them to overcome the underlying reasons for the conflict. MHPSS workers can offer community leaders the support they need to effectively utilize community-based activities in such a way as to address conflict issues and relationship challenges constructively. Illustrative examples of such community-based activities include:

- Traditional healing and reconciliation rituals;
- Wedding, funeral and naming ceremonies;
- Religious services and religious study sessions;
- Interfaith prayers for a common cause;
- Intercommunal markets and trade;
- Intercommunal collaboration for farming, animal rearing, fishing and forestry use;
- Cooperatives for intercommunal livelihood development;
- Community festivals;
- Intercommunal sports activities;
- Community theatre;
- Intercommunal disaster relief;
- Intercommunal neighbourhood clean-up, tree planting and environmental protection;
- Purposeful use of the media and social media for community-building;
- Curriculum development, teacher training and language instruction that promote community cohesion and intercommunal coexistence;
- Intercommunity dialogue sessions or meetings;
- Group support sessions.

For information on how to organize these activities, please see the prior chapters.



Box 47

Application of conflict analysis and transformation skills



Click [here](#) for case studies on how to apply skills in conflict analysis and transformation to real-world contexts of humanitarian emergency.

10.2.2 MHPSS workers' training needs in conflict transformation and mediation

The concepts, skills and methods of practice outlined in the preceding sections of this chapter suggest a range of topics that MHPSS workers can study to expand their capacity to address interpersonal and community-based conflicts in humanitarian emergencies. For information about what training curricula different IOM missions have used, please contact the IOM MHPSS Section at contactpss@iom.int. A concise summary of suggested topics can be found [here](#).



10.3. CHALLENGES AND CONSIDERATIONS

While an analysis of the relational, cultural and structural dimensions of conflict require highly abstract thinking, recognition of conflict behaviour does not require much abstraction, because behaviour is usually visible and tangible. When faced with violence and human suffering, the rational thinking necessary to grasp the complexity of conflict is at times compromised, and fundamental elements of the conflict, such as its history, the root causes of the violence, and other factors, are set aside. In the face of violence and humanitarian emergency, people may distance themselves from the kind of abstract thinking necessary to analyze, understand, and process complex conflict situations that led to an outbreak of violence, and may instead focus on an immediate evaluation of violent behaviors. Keeping the attitude–behaviour–contradiction (ABC) triangle in mind, MHPSS workers can support individuals and communities in conflict restore a holistic,

multidimensional image of Self and Other. Through such a process of sustained public education and dialogue, MHPSS workers can help parties in conflict and stakeholders regain a self-reflective capacity and psychosocial readiness to analyse conflict and prevent violence.

Violence makes parties in conflict pessimistic about their future possibilities. It discourages them from believing and investing in creative problem-solving. Under such circumstances of pessimism and hopelessness, MHPSS workers can help parties in conflict and community members restore creativity. Concretely, MHPSS workers can introduce successful examples and best practices of creative problem-solving from the parties' own communities, as well as from other credible sources. MHPSS workers can also share with the parties such skills and methods of conflict transformation and mediation as the ones described in this chapter, so they can expand their toolbox to tackle their conflicts constructively and creatively.

→ FURTHER READING

Arai, T.

2009 *Creativity and Conflict Resolution: Alternative Pathways to Peace*. Routledge, London.

2017 *Promoting Interreligious Harmony in Myanmar: A Guide to Training and Dialogue*. Peaceful Myanmar Initiatives, Yangon, Myanmar.

Barsky, A.E.

2014 *Conflict Resolution for the Helping Professions*. Oxford University Press, New York.

Beer, J.E. and C.C. Packard, with E. Stief

2012 *The Mediator's Handbook*. New Society Publishers, Gabriola Island, B.C., Canada.

Conflict Sensitivity Consortium

2012 *How to Guide to Conflict Sensitivity*.

Galtung, J.

2000 *Conflict Transformation by Peaceful Means (the Transcend Method)*. United Nations Disaster Management Training Programme.

For other references see full bibliography [here](#).



11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT



11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

→ 11.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

11.1.1 What is a livelihood?

Simply defined, a livelihood comprises the capabilities, assets and activities required for making a living. This may include subsistence strategies, income-earning activities, formal or informal employment, or a combination of all of these.

Livelihoods represent much more than income or employment. Livelihoods comprise individuals' spiritual, humane, social, political, financial, natural and physical capital or assets. What we do to earn a living often determines who we are in society, and the relationships we will have with others. It may define the opportunities we can access and the quality of life we can expect. Understood in this way, livelihoods are a fundamental component of overall psychosocial well-being.

In the humanitarian context, it is common to define a livelihood programming purely in terms of the economic reinforcement it offers to help people weather a crisis. In order to be sustainable, livelihood support needs to help individuals, families and communities withstand and recover from a shock with the same or improved capabilities as before the shock/crisis, without further threatening the natural resource base. See Box 48.

Box 48

Sustainable livelihoods

- Do not undermine the long-term availability of natural resources;
- Do not threaten the livelihoods of others;
- Are not dependent on outside resources, such as external funding.

11.1.2 Why to combine livelihoods programming with MHPSS

In emergency settings, people's access to livelihoods is often disrupted. There may be increased difficulties for the means of a livelihood, with inherent stress. Moreover, the loss of livelihood can often be one of the greatest impactors on both an individual's sense of social status and their individual sense of control. This can be particularly acute when a household head becomes a net "recipient" of aid support, rather than playing the breadwinner role they played before the crisis. To learn more about the relationships between access to livelihoods and mental health and psychosocial well-being, and better understand this chapter, see a series of [short videos](#) here, especially those from James Walsh, Guglielmo Schininà and Elisabeth Babcock.

The rationale for including livelihood support within MHPSS programme centres on two points. First, by promoting economic security, livelihood programming can help address the stressor of financial and material insecurity in emergency settings. This stressor is identified consistently by populations in a diverse array of settings. For example, rapid MHPSS needs assessments undertaken by IOM in different countries all indicated that insecure access to livelihoods comprised one of the greatest causes of distress and other negative feelings. Livelihood programmes help alleviate this stress ([Howe et al., 2018](#); Jalal, Frongillo and Warren, 2015).

Second, access to secure livelihoods can strengthen the protective factors that buffer against stress and promote agency. For example, being able to provide for oneself and one's family fosters a sense of self-efficacy. Livelihoods also may offer opportunities for skill-building, which can improve overall functioning and contribute to greater self-esteem. Quality employment can help reduce depression symptoms by fostering a greater sense of agency (Butterworth et al., 2011; van der Noordt et al., 2014). Additionally, the social connection that livelihoods often offer



can contribute to a greater sense of belonging and help counteract stigma.

MHPSS interventions can also be integrated into existing livelihood programmes with the same benefits. It is particularly indicated when people or communities have been severely affected by the crisis. They might experience difficulties functioning and struggle to start or maintain livelihood activities without appropriate MHPSS. In this case, the existing programme should follow the presented structure, and an assessment must be done on how to better integrate MHPSS aspects to support affected people.

Box 49

To learn more about the assessments, select any location below

- **North-east Nigeria;**
- **South Sudan;**
- **Post-earthquake Haiti;**
- **Urban areas of Lebanon with large populations of Iraqi refugees.**

11.1.3 What the evidence base tells us

Livelihood programming is not a panacea, and practitioners should not expect that simply adding a livelihood component to an MHPSS programme will automatically enhance outcomes, or vice versa.

While there are volumes of literature on livelihood programmes, the evidence base on programmes that combine livelihood support with MHPSS programming is quite limited, because many livelihood programmes are not designed with mental health or psychosocial well-being impacts in mind, and/or are not evaluated on these dimensions. Even fewer have been implemented in emergency settings. A systematic review by **Lund et al.** (2012) included only five evaluations of programmes that included indicators for both livelihoods and MHPSS outcomes, while that by Kumar and Willman (2017) found eight, with none having been done in situations considered emergencies.

Still, **there is promising evidence from other contexts** to allow for identifying some guiding principles to orient livelihood programming within MHPSS programmes in emergency settings. These are covered in the following section.



11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT



11.1.4 Guiding considerations for designing livelihood interventions to boost MHPSS

Interventions claiming the title “livelihood support” vary enormously in their objectives, design and scope. They range from cash-transfer and social insurance programmes to job training, entrepreneurship support and market facilitation activities. Even within particular categories of livelihood programmes, there is great diversity. A cash-transfer programme might be aimed strictly at boosting incomes, or it may have broader social objectives, such as empowering women or youths, restoring a sense of normalcy, or even reducing violence.

Moreover, the type of livelihood intervention options available will vary greatly with the degree of stability in a given context. In highly volatile situations, interventions are focused on saving lives: for example, through distribution of food, seeds or tools such as grinding machines. In more stable environments, interventions can focus on building assets, employment support or entrepreneurship. Ultimately, sustainability of livelihoods depends on people gaining access to markets so that they no longer rely on external support, which is often beyond the reach of MHPSS programmes in emergency settings. Livelihood programmes should be included from the onset of the emergency, but intervention options need to be tailored to the specific contextual situation.

There is no single design or “how to” guide that can cover the great diversity of livelihood programming. Because livelihoods are defined by local conditions, the choice and design of programmes should emerge from knowledge of the programme context. Camp contexts often present particular challenges for developing livelihoods. In particular, livelihoods thrive on stability (commonly lacking in camps), and the close concentration of people with limited means can limit opportunities.

This section is not intended to be comprehensive, but to serve as an orientation to some important

considerations. It builds on the **Minimum Economic Recovery Standards of the Small Enterprise Education and Promotion Network**, which presents minimum standards to facilitate economic recovery in crisis situations, providing guidance on what to consider when planning livelihood activities.

Livelihood interventions that work to alleviate sources of stress and strengthen protective factors have been most effective in boosting mental health and psychosocial well-being. For this, it is helpful to:

- Keep expectations realistic: Start small, and be honest with affected populations about the objectives and constraints.
- Avoid adding more stress: Keep projects simple and sensitive to the stresses people already are facing.
- Focus on building assets to enhance people's ability to weather shocks over time.
- Alleviate key stressors such as food insecurity or social tensions.
- Connect to social relationships where safe/ possible, to build on sources of resilience (existing support groups, local procurement systems).
- Match needs and capacities with markets to set people up for success: Be sure to conduct a market systems assessment (see 11.2.3 for details). Link the human capital identified in the affected populations with the need for financial capital in the market. Social capital and networks among people in the affected population and host communities should be explored and taken into consideration to develop an effective intervention.
- Consider sensitivities of targeting. Consult with stakeholders to ensure that targeting does not privilege certain groups, and that decisions are communicated clearly.

For more information on the above-mentioned points check [here](#)):



11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

➔ 11.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

11.2.1 Assess whether the agency is already running a livelihood programme

If the agency is already running a livelihood programme, managers should provide their assistance in:

- Raising awareness among colleagues working in livelihood support on the MHPSS aspects of their work, using the following online **training**.
- Looking at possible synergies between the MHPSS programme and livelihood programmes, which can include:
 - Inclusion of MHPSS components (discussion groups, group sessions, individual counselling) in livelihood support programmes;
 - Targeting the same communities with coordinated interventions;
 - Sharing information on vulnerabilities and resources identified in the community.

11.2.2 Include a livelihoods specialist as part of the team and train livelihood-related staff

Few people can be expected to be conversant in both the MHPSS and livelihood fields. For this reason, in case livelihood experts are not already present in their agency/mission, teams would contract a livelihoods specialist to design and deliver the activities as part of a broader programme of MHPSS. They should also be responsible for training short-term team members in these new areas. Ideally, this person would be recruited locally in order to have a strong knowledge of the context, but could be recruited internationally, depending on the scale of the programme. They should have

in-depth knowledge of the context and market, and some experience in conducting market system assessments and overseeing livelihood programmes. S/he should also be trained in basic MHPSS concepts. At a minimum, s/he could take this **online training** course and learn relevant chapters of *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007)*.

Local talent can often be recruited to support specific livelihood activities. For example, if the livelihood interventions linked with MHPSS will deliver trainings in trades such as tailoring or carpentry, local tradespeople can help lead trainings and mentor project participants.

Livelihood staff and implementing partners – including trainers, instructors and facilitators – should be trained in (a) basic MHPSS considerations, (b) the effect of toxic levels of stress on livelihood programmes, (c) how to account for toxic levels of stress in the devising and implementation of livelihood opportunities, and (d) referral mechanisms and identification of protection and MHPSS risks.

Such trainings can be derived from:

- Elizabeth Babcock's video **here**;
- The comprehensive USIP training on livelihood and **MHPSS**;
- Contacting **contactpss@iom.int**.

11.2.3 Assess market systems to match livelihood support with demand

A market system is made up of the producers, suppliers, traders and consumers that match the supply of goods and services with demand. These systems are critical in emergency settings because they help people meet basic needs and protect livelihoods. Markets can be particularly important to consider, given the variability of camp/non-camp settings. Camps often are detached from local markets, but conversely offer unique opportunities of concentrated

11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT



demand. For more guidance on how to conduct a market assessment, see [here](#).

From an MHPSS perspective, it is important to match the information derived from the market analysis, with the expectations of the people involved in the programmes, their skills and objectives. It is indeed important to respect people's existing coping mechanisms and expectations, while offering suitable marketable options. Programme design needs to balance these two elements, as explained in the following section.

11.2.4 Explore trade-offs

Using the market systems assessment, it is possible to explore potential options and trade-offs in order to decide what type of livelihood intervention may have the most MHPSS impact. The trade-offs do not imply that the interventions are not worth pursuing; only that mitigation measures might be needed to address potential negative impacts.

Some important trade-offs to consider are:

- Adding versus alleviating distress: All interventions introduce some distress. It is important to understand what this distress might look like, and how/whether it can be mitigated by the benefits of the intervention. Will the distress of, say, a microcredit loan outweigh the potential benefits in savings/income? In an MHPSS programme, one would avoid any livelihood activity likely to add additional stress into the life of affected populations.
- Targeting the most vulnerable versus more likely to succeed: Because resources are often limited and risks are high in emergency settings, programmes can't address everyone's needs all at once. An important trade-off arises between targeting individuals who are already doing well, such that they can then contribute more to local economies, versus targeting the most vulnerable for more potential social impact. This is important to consider in MHPSS programmes addressed to the most vulnerable populations.



Hairdressing class at the protection of Civilian site in Bor, South Sudan. © IOM 2013

11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

- Short-term versus long-term/systemic benefit: How will the programme balance the need to respond to people's urgent needs today with the importance of investing in more systemic change? For example, a cash-for-work programme could provide a needed boost to the local economy, but its sustainability will be limited if people confront structural barriers, such as exclusion from markets because of migrant status or gender.
- Targeting specific groups versus a territorial approach: Emergency settings are often contexts of social instability and division. Interventions that target a particular group – refugees or migrants – can improve the well-being of that group, but may also risk contributing to tensions with other groups, including host communities. Decisions need to be made about whether to prioritize the well-being of a smaller group versus interventions that serve a broader group – for example, all those living in a defined geographic area.
- Boosting local economies versus distorting markets: One of the critical questions in many livelihood programmes – especially cash-for-work and cash transfers – is how big the stipend or transfer should be. If it is too small, its impact will be limited or even negligible. Too big, and it can create the wrong incentives – for example, hoarding of food/goods bought with the cash, or dissuading people from other income-earning opportunities that are not dependent on external support. Likewise, programmes that provide livestock run some risk of distorting the market prices for that livestock simply by increasing supply, though most programmes are too small-scale for this to be a key concern.
- Detracting from other MHPSS interventions: Livelihood initiatives are likely to offer great appeal to certain groups, particularly if cash or asset transfers are involved. When introducing such initiatives, it is critical to coordinate with other service providers

to ensure that this does not compete with or detract from other critical MHPSS interventions. This could involve coordinating activity schedules accordingly to enable participants to attend both types of activities, or requiring participation as a prerequisite for livelihood support.

11.2.5 Continually assess risks, especially risks to personal safety

Bringing resources into a community can expose people to new threats and risks. It can attract crime or increase household conflict by altering the balance of control over finances between men and women, or across generations. Activities that challenge social norms – for example, job training for women in non-traditional fields – can inadvertently increase risk for the people who access them (**Women's Refugee Commission, 2015**). **Here** is a useful framework for understanding and assessing risks in emergency settings.



These risks need to be assessed initially and monitored throughout implementation. Managers should ask people what kinds of considerations could be helpful: for example, locating trainings or meetings nearer where people live, holding events during daylight hours, or including meetings with families/households to help partners feel included and see the benefits of the programme. This will reduce the risk of experiencing distress associated with taking part in livelihood activities such as those related to walking to the venue at night or family disagreement regarding participation.

11.2.6 Evaluate the advantages and potential drawbacks of different types of programmes

Using the information gathered in the assessment and the analysis of trade-offs, one can evaluate the suitability of different types of livelihood programmes. Table 10 presents some of the key advantages and disadvantages of different types of interventions, which could also be



Computer courses at Haj Ali Camp, Iraq. © IOM 2015/Aziz RABER

combined as different activities of one programme. There is no accepted rule on which interventions work better in camps or non-camp contexts. This is one of the many variables that needs to be ascertained from the needs assessment. However, these examples have been structured based on the likelihood of them being implemented in a camp context. This table is not exhaustive of all the options, but gives examples of some of the trade-offs outlined above:

Table 10: Advantages and drawbacks of different forms of livelihood support from an MHPSS angle

Livelihood Programme	Description	Advantages/drawbacks
	Direct transfers	
Social direct cash transfers	Cash – either directly, or as vouchers – is given to participants with few or no conditions. If the objective is to enable people to buy basic goods, transfer amount is low. If the objective is to promote economic security, transfer amount is typically much greater than average.	<i>Livelihood advantages</i> Where access to credit and capital is the main constraint to accessing livelihoods, cash transfers can provide needed capital for investments (materials, tools, training) to promote financial security and stimulate local economies. <i>MHPSS advantages</i> Allow people to self-prioritize their own needs and can target the most vulnerable. <i>Potential drawbacks</i> Limited impact where other barriers to financial security predominate (social norms or disrupted access to markets, for example). Can drive increased inflation, or distort local markets and power relations if amount of the transfer is too large and/or risk mitigation measures are inadequate. Can reduce the sense of agency and be a source of social shame.

11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

Food for work or cash for work	Participants receive food aid or cash in exchange for work, usually on public works projects (building or restoring infrastructure, trash pickup, among others).	<i>Livelihood advantages</i> Promotes food security, helps prevent people selling off assets and helps stimulate local economy. <i>MHPSS advantages</i> Food for work and cash for work can incorporate skill-building and can connect people to productive activities. Labour can be used to rehabilitate community assets/infrastructure, which can boost communities' sense of a return to normalcy, as well as increase their sense of purpose. <i>Potential drawbacks</i> Estimating the appropriate amount of food or cash is critical to avoid distorting markets and overly disturbing power dynamics. Can contribute to dependency. Inexperienced programmes may not be inclusive due to lack of understanding of how to address barriers experienced by persons with disabilities. Work can be demeaning and short term, and therefore may not help build sustainable livelihoods. Community infrastructure projects need to be well thought out. For example, could the choice of public works to be rehabilitated exacerbate tensions between individuals/groups?
Employment and job training		
Wage employment within emergency response	Identify opportunities for employment within the emergency response, from delivery of direct services to affected population, to the supportive and administrative structures.	<i>Livelihood advantages</i> Can mobilize people's existing skills and provide opportunities for training and additional skill acquisition. Can promote activated development and a sense of purpose and agency. <i>MHPSS advantages</i> Can provide meaning and purpose to affected populations and improve their perception within the community. Promotes activated development and sense of agency. Can be combined with skill training. It is a common form of livelihood support in MHPSS programmes. <i>Potential drawbacks</i> Can create resentment in socially complex contexts, and/or be complex to implement in an egalitarian way. A market analysis is needed to avoid it. Engaging underqualified individuals, who may be dealing with their own stresses, can undermine the response and the psychosocial well-being of affected populations.
Job/skills training and placement	Programmes that seek to equip individuals for waged jobs based on market opportunities. Provision of training in basic job skills.	<i>Livelihood advantages</i> Creates portable assets. If training is matched to available labour market opportunities, can stimulate labour market and promote economic security. Can promote activated development and sense of agency. <i>MHPSS advantages</i> Can contribute to promoting self-esteem and self-efficacy. Can help establish social networks. <i>Potential drawbacks</i> Few jobs (formal or informal) available in crisis contexts. Training without placement may lead to raised expectations, or lack of applicability to real world of work. May be difficult if training is not matched to available job opportunities, or participants are not legally able to work. Can create resentment if local labour is displaced.

11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

Access to information and communication technologies	With potential to connect to wider MHPSS offerings, information resource or IT centres can be used to provide access to online courses, get information on market prices or demand, or even (in rare cases) access online employment opportunities.	<i>Livelihood advantages</i> In very high-capacity contexts, opportunity to earn income through freelancing and connection to global markets. <i>MHPSS advantages</i> Low risk. Allows individuals to get what they need and chart their own journey. <i>Potential drawbacks</i> Unlikely to have significant impact on livelihoods in the short term, unless combined with other activities. High set-up costs unless integrated with other camp interventions (for instance, safe spaces). It discriminates against persons who are illiterate.
Assets for generating income		
Income-generating activities – group agricultural support	Grants or materials (seeds, tools) are provided to support/re-establish group business. This may be in agriculture – crop production – but could also exist in livestock/fishing or non-agricultural businesses, such as sewing clothes or bakeries.	<i>Livelihood advantages</i> Can mobilize the skills people bring with them, produce needed goods, stimulate local economy. Agricultural interventions can promote food security, stimulate local economy if people produce enough for sale. <i>MHPSS advantages</i> Can build a sense of community between group members who have access to markets. Can incorporate training and skill-building. Favours group work, which can build a sense of community. <i>Potential drawbacks</i> Inexperienced programmes may target persons without disabilities as beneficiaries due to lack of understanding of how to address barriers experienced by persons with disabilities. Potential to distort market prices for assets or livestock provided by the programme. Can contribute to competition for resources and degradation of environment. Asset replacement projects can be hard to assess accurately, and may privilege those who had more to start with. It can increase stress and anxieties and bring frustration.
Income-generating activities – individual livestock or fishing support	Provision of livestock, or materials to support small business or income-generating activities such as livestock or fishing (water, food, veterinary care, nets). Used to build assets and income, and promote food security. Can also involve asset replacement after a disaster.	<i>Livelihood advantages</i> Can contribute to income generation. Can promote food security, build assets and increase food security. The assets may be portable if affected people were displaced and return home. <i>MHPSS advantages</i> Can incorporate training and skill-building. Can increase interaction with host communities as customers/vendors, allowing displaced people to extend their network. Can promote activated development and sense of agency. <i>Potential drawbacks</i> Inexperienced programmes may target persons without disabilities as beneficiaries due to lack of understanding of how to address barriers experienced by persons with disabilities. Potential to distort market prices for assets or livestock provided by the programme. Can contribute to competition for resources and degradation of environment. Asset replacement projects can be hard to assess accurately and may privilege those who had more to begin with. It can increase stress and anxieties and bring frustrations.

11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

Other common types of livelihood programmes, such as village savings and loans and microcredits, are not considered in this chapter, as they are beyond the scope of MHPSS programmes.

11.2.7 Identify facilitative partners where possible

Given the importance of connections to the market, programme managers should seek to identify market actors to partner with where possible. Do seeds need to be given out, or can suppliers be invited to establish themselves in the location or camp to distribute them in return for cash or vouchers? Can a financial services provider be engaged to manage cash transfers, which will convert into personal accounts after the intervention ends? This creates greater opportunity for sustainability and long-term economic relationships to be built. Similarly, simply negotiating greater access to local and regional markets for target populations, particularly those in camps, can function as a major intervention in itself. Market actors can be targeted with awareness of the MHPSS needs of affected populations, especially when working with groups with vulnerabilities.

11.2.8 Develop clear transition strategies

In engaging with communities, it is critical to set a clear end point for livelihood interventions, so that affected populations are able to plan for the future. This must be communicated clearly in community outreach, as well as part of any trainings provided. Clear communication prevents stress and supports affected people to gain self-reliance and recover their sense of hope.

11.2.9 Build integrated monitoring and evaluation processes

Given the importance of market suitability, a monitoring and evaluation (M&E) system needs to continually monitor not only the impact of the interventions on the target group, but the

evolving changes in the market (which are likely to experience significant flux, particularly in the early post-crisis period). An intervention may need to be adapted to keep up with market changes. Most importantly for MHPSS programming, the intervention should always be monitored and evaluated in relation to the MHPSS objectives set by the programme, for which people can refer to chapter on **Monitoring and evaluation**. Given the trade-offs outlined above, an M&E framework which also looks for risk of negative impacts on other members of the community can also be important. An example can be found [here](#).



11.2.10 Consider supplementing the “core” intervention with additional support for certain groups

Some subsets of the affected population may need additional support to benefit from the intervention. It could be that certain groups are more illiterate, have roles within the community that forbid them from certain activities, or experience barriers to participating to livelihood activities. This may require offering adapted interventions, or supplementary supports, to help them get the most out of the support. For instance, addressing environmental, attitudinal and policy barriers experienced by persons with disabilities, raising awareness in the community to facilitate access to specific activities, offering leadership courses to empower certain groups or courses on specific skills required to have access to livelihoods. This could be language classes, literacy classes, learning how to navigate in a new environment or how recruitment processes work in a new location.



11.3. CASE STUDIES

For examples of livelihood programmes adopting MHPSS considerations, see Nigeria’s Community-Based Conflict Management and Cooperative Use of Resources (CONCUR) [here](#), and IOM Iraq’s integrated programming [here](#).



➔ 11.4. CHALLENGES AND CONSIDERATIONS

For the challenges and considerations associated with integrating MHPSS and livelihood support, please refer to section 11.2.4 on trade-offs and section 11.2.6 on benefits and drawbacks.



➔ FURTHER READING

Blattman, C., J. Jamison and M. Sheridan

2015 Reducing Crime and Violence: Experimental Evidence on Adult Non-Cognitive Investments in Liberia. Working Paper No. 21204, National Bureau of Economic Research, Cambridge, Massachusetts, United States.



Butterworth, P., L. Leach, L. Strazdins, S. Olesen, B. Rodgers and D. Broom

2011 The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results from a Longitudinal National Household Panel Survey. *Occupational and Environmental Medicine*, 68(11):806–812.



Jalal, C.S., E. Frongillo and A. Warren

2015 Food Insecurity Mediates the Effect of a Poverty Alleviation Programme on Psychosocial Health Among the Ultra-Poor in Bangladesh. *The Journal of Nutrition*, 145:1934–1941, doi:10.3945/jn.115.210799.



Mani, A., S. Mullainathan, E. Sharif and J. Zhao

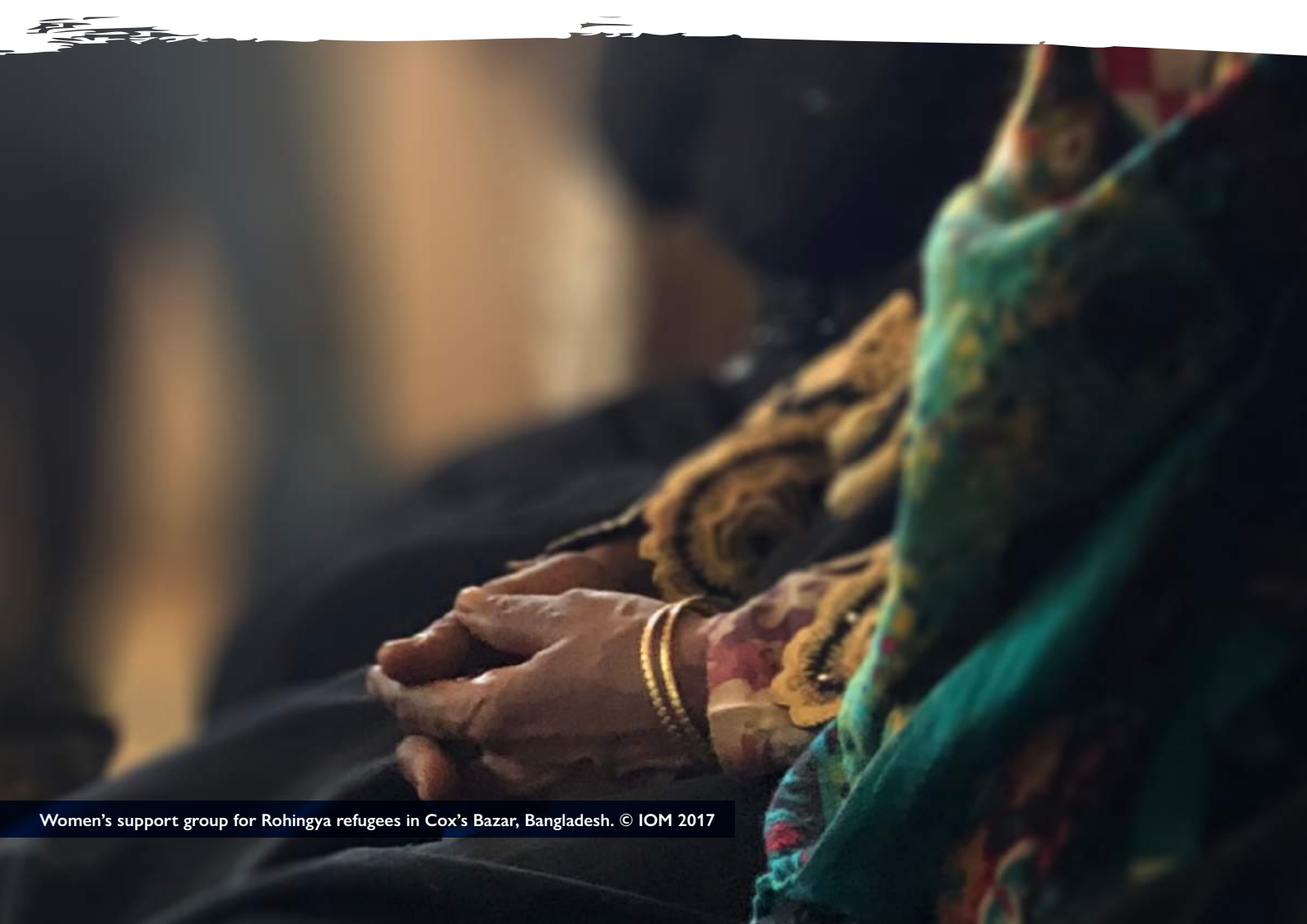
2013 Poverty Impedes Cognitive Function. *Science*, 341:76–80.



For more references, see the full bibliography [here](#).



12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION



12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

➔ 12.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

The Inter-Agency Standing Committee (IASC) defines protection as:

All activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law, i.e. human rights law (IHRL), international humanitarian law (IHL), international refugee law (IRL) (IASC, 2016).

Protection is the responsibility of all actors intervening in a humanitarian setting (see Box 50 and IASC, 2016), and it is particularly so for MHPSS actors, since “an intimate relationship exists between the promotion of mental health and psychosocial well-being and the protection and promotion of human rights”, as stated in *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007). Accordingly, human rights and equity are the first core MHPSS principles promoted by the Guidelines (see Box 51), and three action sheets (3.1, 3.2, 3.3) are dedicated to the relation between MHPSS interventions and human rights violations and **protection**.

Box 50

The Centrality of Protection in Humanitarian Action – Statement by the IASC Principals (IASC, 2013)

Protection of all persons affected and at risk must inform humanitarian decision-making and response, including engagement with States and non-State parties to conflict. It must be central to our preparedness efforts, as part of immediate and life-saving activities, and throughout the duration of humanitarian response and beyond. In practical terms, this means identifying who is at risk, how and why at the very outset of a crisis and thereafter; taking into account the specific vulnerabilities that underlie these risks, including those experienced by men, women, girls and boys, and groups such as internally displaced persons, older persons, persons with disabilities, and persons belonging to sexual and other **minorities**.

Human rights are founded on the respect of the dignity and worth of each individual with their unique characteristics, capacities and resilience. In emergencies, and resulting migration and displacement, individuals are more likely to:

- Be at risk for their lives;
- Lose a sense of dignity;
- Be deliberately targeted or threatened with violence, abuse and exploitation;
- Be discriminated against in their access to food and water, shelter, health care and other basic needs;
- Find obstacles in accessing education or civil documentation.

States are responsible for promoting, respecting and protecting human rights for all, without discrimination as to “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”, including migratory status. This is in compliance with the humanitarian principles of humanity, neutrality, impartiality and **independence**.

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

More practically, four key elements of protection mainstreaming into other sectors have been identified to operationalize the protection principles of the Sphere Standards. These are:

- Enhance the safety, dignity and rights of people, and avoid exposing them to harm.
- Ensure people's access to assistance according to need and without discrimination.
- Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation.
- Help people claim their **rights**.

Box 51

IASC principles

Principle 1: Human rights and equity

Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations. Humanitarian actors should also promote equity and non-discrimination. That is, they should aim to maximize fairness in the availability and accessibility of mental health and psychosocial support among affected populations, across gender, age groups, language groups, ethnic groups and localities, according to identified needs (IASC, 2007: 9).

12.1.1 Who might be in need of protection

In its **Principles for Humanitarian Action**, IOM (2015b) identifies four interrelated vulnerability factors that determine the need for protection: (a) individual characteristics; (b) pre-existing social, economic, environmental and political conditions; (c) external disruptive factors induced, or resulting from, forced migration; (d) the specific situation of displacement or migration (section IV.4).

The interrelatedness of these factors can be illustrated through the equation at figure 11.

Figure 11: The protection equation

$$\text{RISK} = \frac{\text{THREATS} \times \text{VULNERABILITIES}}{\text{CAPACITIES}}$$

Source: DG ECHO (2016).

Although this evaluation of factors remains highly contextual and can't always be generalized in categories that fit all emergency situations, individuals who may require specialized protective measures, especially in relation to the protection of their mental and psychosocial well-being, could include:

- **Survivors of GBV;**
- Survivors of trafficking;
- Unaccompanied and separated children;
- Persons with disabilities;
- Individuals with mental, neurological and substance use disorders;
- Chronically ill patients;
- **Stranded or detained migrants;**
- **Other groups to be determined based on context.**

The list is not exhaustive, but it offers a basis for prioritizing specific groups of people in relation to their vulnerability to specific threats. More information on providing support to these groups within the context of COVID-19 can be found in **this toolkit**. As **an annex** to this chapter, IOM's MHPSS and Protection HQ teams developed guidance on the specificities of addressing gender-based violence within MHPSS programmes in conjunction with Protection actors. The annex's training is available through contacting contactpss@iom.int.

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

Box 52

Protection in IOM

IOM is committed to mainstreaming protection in all its activities in humanitarian settings, in ways that seek to do no harm, prioritize safety and dignity, foster empowerment and participation, and are non-discriminatory and based on needs. In addition, IOM works across all commonly accepted dimensions of protection.

IOM policy on humanitarian principles formalizes the organization's adherence to the IASC humanitarian principles and can be found [here](#).

IOM protection mainstreaming in emergencies schematizes how IOM engages with protection and can be found [here](#).

can contribute to the empowerment and increased resilience of affected individuals and communities to reclaim their rights, participate actively in the decision-making processes of their communities, and resort to positive coping mechanisms when faced with crises, thus contributing to increasing their protection.

Synergies and coordinated actions should be implemented throughout the whole project's cycles, as depicted in the following seven-step operational framework.

12.2.1 How to include protection concerns in MHPSS programming

12.2.1.1 Context analysis

MHPSS programme managers should have an understanding of the general protection context and be aware of existing protection risk analysis when devising responses to the actual and potential impact of violations and abuses on mental health and psychosocial well-being of vulnerable populations. In most humanitarian contexts, this information can be obtained from:

- (a) The protection cluster and its Area of Responsibilities (AoRs):
 - (i) Child protection;
 - (ii) GBV;
 - (iii) Housing land and property;
 - (iv) Mine Action.
- (b) The MHPSS working group where there is one.
- (c) The Health and Education Clusters.
- (d) The United Nations Country Team/ Humanitarian Country Team strategy.
- (e) The Humanitarian Response Planning.
- (f) The Humanitarian Need Overview.

Thus, for an MHPSS manager, participation of the protection cluster and relevant sub-clusters and regular exchanges with protection actors is critical.

12.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

MHPSS is understood to be a specialized and integral part of protection and complementary activities, and close collaboration between MHPSS programmes and protection programmes should be the norm in the field. MHPSS programmes should contribute to diminishing the protection risks, strengthening existing capacities, and mitigating threats and vulnerabilities (see Box 54). They should provide MHPSS for identified protection cases, and refer to protection actors MHPSS clients who are also in need of protection assistance. MHPSS practitioners should work hand in hand with protection case managers when present to assess the protection risks and design case management plans that cover treatment, risk assessments and safety planning to help reduce or diminish these risks. Follow-up and collaboration between MHPSS and protection actors are crucial to achieve positive protection outcomes. MHPSS activities can therefore contribute to different positive protection outcomes within the protection egg (see Figure 12), which extends to the fact that they

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION



The understanding of the protection context and risk analysis will feed into the MHPSS **needs assessments** to guide a better response.

12.2.1.2 Coordination and partnership

Given the complementariness of their objectives and principles, MHPSS and protection actors should coordinate activities to ensure that they effectively and efficiently work towards protection outcomes and respect the rights of the affected populations. This implies that MHPSS programme managers should make sure that:

- (a) Protection referral pathways are known to the MHPSS teams, which includes knowing and understanding the available services and their nature.
- (b) MHPSS is included in the referral pathways of protection teams and actors.
- (c) Both MHPSS teams and protection actors are aware of their respective identification indicators for referral.
- (d) There is an agreement on informed consent, data sharing, data protection and confidentiality principles and procedures for mutual referral throughout the period of care.
- (e) Referrals of MHPSS clients to protection actors should be followed up and documented, while respecting clients' confidentiality.
- (f) An MHPSS staff member will be in charge of liaising with external organizations to ensure consistency of the referral pathways of protection cases and timely communication among partners. In the PMTs, this will be the social worker.
- (g) Dissemination of information on existing MHPSS referral pathways for protection cases is agreed upon with relevant protection actors.
- (h) Joint projects and programmes can maximize financial and human resources, and help to

advocate for unified messages.

12.2.1.3 Capacity-building

MHPSS teams, including PMTs, should be trained in:

- (a) General protection.
- (b) Operational standards and procedures used by the protection actors in specific areas (for example, child protection, GBV or counter-trafficking).
- (c) Specific MHPSS needs and best practices for response for specific protection cases of IOM concern:
 - (i) Survivors of GBV;
 - (ii) Displaced populations and vulnerable migrants;
 - (iii) Survivors of trafficking;
 - (iv) Migrants in detention;
 - (v) Unaccompanied and separated children;
 - (vi) The protection dimension of assisting people with mental, neurological and substance use disorders;
 - (vii) Elderly, especially if unaccompanied;
 - (viii) People living with disabilities.
- (d) Psychoeducation of families.

MHPSS managers should offer trainings to protection actors, as follows:

- (a) General MHPSS and the IASC Guidelines (IASC, 2007).
- (b) MHPSS services available in the given emergency.
- (c) Impact of violence on mental health and psychosocial well-being.
- (d) The protection dimension of assisting people with mental, neurological and substance use disorders.
- (e) PFA and positive communication.
- (f) Identifying people in need of MHPSS referral.
- (g) Psychological consequences of:
 - (i) Displacement;

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

- (ii) Trafficking;
- (iii) Administrative detention;
- (iv) GBV;
- (v) Travelling unaccompanied and separated children.

For further information on all the above-mentioned trainings, both for MHPSS teams and protection actors, please contact the IOM MHPSS Section at contactpss@iom.int. Some of them can be offered jointly to MHPSS and protection actors/teams, based on professional background and other determinants. Community members can be added to the trainings, since they have an essential function in granting and promoting protection and well-being. This includes civil society and human rights organizations.

MHPSS staff, especially when working in close collaboration with protection actors, can be included in protection-specific trainings on issues pertaining to their context, such as child protection, GBV, human trafficking and detention.

Similarly, protection actors often conduct activities that need psychosocial competencies, such as building community-based protection networks or committees, launching awareness campaigns, interviewing potential victims of human rights violations, and conducting focus group discussions with various categories of the population. Moreover, they are often in direct communication with persons going through distressing situations. They can be included in trainings in counselling skills, and community mobilization, conflict sensitivity, mediation and others usually offered to PMTs.

Training is not the only way to reinforce partnership, and MHPSS programme managers should be proactive in identifying manners to reinforce or complement current protection activities.

12.2.1.4 Multi-layered response.

Cases referred to MHPSS programmes by protection actors should receive services at all levels of the IASC pyramid of MHPSS. While usually referral tends to happen only for those with severe mental disorders or in need of more focused counselling, PMTs should as much as possible include clients in all activities that the programme proposes, including socializing and recreational activities, if and when appropriate in terms of general and psychological safety. In addition, services should not be segregated, especially in the first stages of assistance. This means, for instance, that a counselling centre for survivors of GBV is to be avoided in a camp. By contrast, dedicated protocols and methods can be used to provide counselling to survivors of specific human rights violations, such as the Solution-Focused Brief Therapy model for survivors of GBV or **torture**. Existing staff working in camps or displacement areas should be trained in those methods, to be able to provide the necessary assistance when needed, avoiding, however, the certainty of separate facilities. Moreover, specific socializing activities, as well as peer-support or dedicated support groups, could be offered to specific categories of victims and survivors, based on their identified common needs and resources (see, for example, the testimonial theater activities proposed in chapter 6 on **Creative and art-based activities**). Survivors of violence might choose to engage in the community or in public debates, campaigns and sensitization activities as part of their personal resilient and restorative psychosocial path (for example, acceptance, self-confidence, agency and activism).

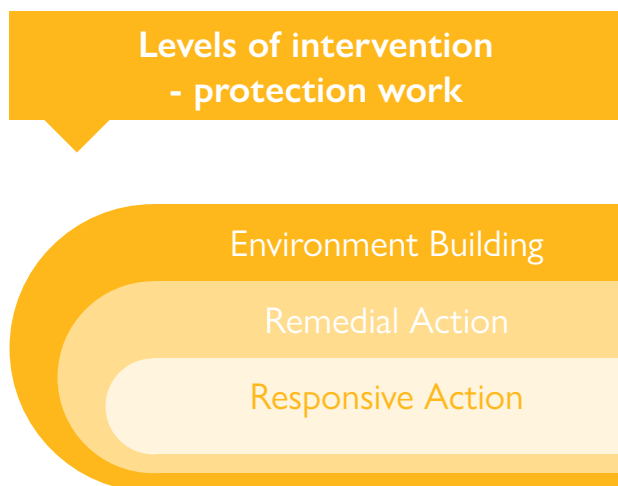
Box 53

GBV, MHPSS & Protection

For more detailed information on how MHPSS and Protection actors can address issues relating to GBV, see **Annex 3**.

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

Figure 12: MHPSS activities contributing to different positive protection outcomes within the protection egg



Source: **Based on ICRC (2001).**

Box 54

Targeting subgroups

Avoid singling out or targeting specific subgroups for assistance, unless this is critical and justified in the specific context to prevent further harm. Integrated support helps to reduce discrimination and may build social connectedness. Consider, for example, providing women's groups rather than groups for women who have been raped (IASC, 2007:61).

12.2.1.5 Safe locations

While MHPSS activities in emergencies usually take place in a variety of settings, counselling of persons with protection needs should happen in a setting that guarantees privacy, security, confidentiality and safety, and yet is not stigmatizing. The space should be accessible, and contain accessible information with positive images or messages in local languages, and message boards with updated information on referral systems, services and useful contacts. The counselling space should

not contain physical, verbal or symbolic cues that could trigger negative emotions.

12.2.1.6 Social, art-based and recreational activities

CB MHPSS programmes as explained in this Manual include socializing, sport, theatre, and arts-based and ritual activities. These can be important venues not only to promote psychosocial well-being of survivors of human rights violations: they can also be considered ways to promote human rights messages and concepts; for identifying persons with specific protection needs to be referred; and for understanding trends of human rights violations or patterns linked to a lack of respect or knowledge on human rights topics, which can guide further awareness or empowering activities. In some circumstances, these activities can be purposively organized with a more explicit protection objective in mind, involving protection actors. Such joint activities that involve specific community leaders and members could reduce human rights violations and abusive behaviour, while increasing collective awareness on rights and standards of protection. See, for example:

- A booklet on domestic violence elaborated by IOM **Iraq**;
- The **Girl Effect programme**, and its creative use of media for girls' empowerment and protection in various African countries.



12.2.1.7 Monitoring and evaluation indicators

For **monitoring and evaluation** activities, including those related to protection, see chapter 6 on **Creative and art-based activities**. The following indicators identified in *IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings* (IASC, 2017), are related to protection:



12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

- (a) Number of reported human rights violations, where possible and required;
- (b) Percentage of target communities with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women and people with severe mental disorders);
- (c) Percentage of target communities where representatives of target groups are included in decision-making processes on their safety;
- (d) Percentage of target group members who, after training, use new skills and knowledge for prevention of risks and referral;
- (e) Number of members of at-risk groups (such as children or survivors of sexual violence) who use safe spaces;
- (f) Percentage of target group members (such as the general population or at-risk groups) who feel safe;
- (g) Number of protection mechanisms (such as social services or community protection networks) and/or number of people who receive help from formal and informal protection mechanisms;
- (h) Number of people who have reported human rights violations and perceptions about **the responses of institutions addressing their case.**

Indicators should be identified through participatory exercises in the target groups and subgroups. Indeed, a common understanding of abuses and threats should be at the basis of this exercise and prior work on language and culturally appropriate methodologies may be needed.



Box 55

IOM safe locations in South Sudan

In Wau, South Sudan, the counselling rooms are located inside IOM clinics. They provide a quiet and private space for those who are seeking counselling, including caregivers, clients and people referred from protection actors: for instance, **survivors of sexual and gender-based violence** or people living with HIV/AIDS. Counsellors who work inside the clinics can receive those needing support in collaboration with the health workers who have been trained in MHPSS. In addition, an on-call counsellor and team leader are designated on shifts to ensure the timely provision of support, whether they are at the clinic or in the vicinity of the **community**. There is also at least a counselling space available in the psychosocial support resource centres. In the centres, there are rooms that can be used for group activities or for counselling. When the room is needed for counselling, the PMTs are alerted on the schedule. The counselling space is prepared and maintained clean and available at all times. Often there are counselling sessions that need follow-up after group activities; therefore, it is necessary to have a private space available for use. Protective factors are also included in the design of the space. The spaces for activities are free from possible hazards, ventilated and with semi-transparent parts on the walls, for people to see that social activities are safely taking place (especially activities for children). The composition of PMTs in each activity also matters; they should not dominate in numbers. If the activities (individual or group) are done outside of the centre, the same principles about having safe locations are applied. Consultations with communities on their concept of “safe places” are very important when planning or designing activities, or when identifying venues or physical structures to be constructed or rehabilitated.



12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

➔ 12.3. CHALLENGES AND CONSIDERATIONS

- (a) Project-based interventions, absence of integrated programming and siloed humanitarian interventions are key challenges to improving protection outcomes and to promoting psychological wellbeing in situations of protracted crises. Without collective efforts from the entire humanitarian community to systematically mainstream MHPSS as a cross-cutting issue, the impact of MHPSS and protection interventions can face significant limitations.
- (b) Humanitarian organizations and national institutions may operationally frame protective interventions as individually-centred and normative-based approaches, which make coordination and joint programming with community-based MHPSS programmes either ineffective, or even antagonistic. In this respect, capacity-building and mutual referral can be efficacious tools to find common grounds.
- (c) New protection measures and safety networks are at times introduced without properly considering pre-existing ones. This can reduce the capacity of the affected communities to protect themselves. The mainstreaming and collaboration of MHPSS programmes with protection programmes will still be coordinated with the community programme steering **committee**, and subject to community feedback. In addition, MHPSS assessments are usually able to identify existing practices and networks, which need to be factored into these collaborations. The “do no harm” principle must be considered in all interventions. 
- (d) People can cope with crises by resorting to pre-existing social or traditional harmful practices and/or they can develop new crisis-induced negative coping mechanisms (female genital mutilation, early marriage, child labour, marginalization of persons with disabilities, segregation or forced institutionalization of persons with mental, neurological and substance use disorders). These might not comply with human rights and humanitarian standards, and eradicating them may require longer-term social, cultural and structural changes at the community level. MHPSS activities should be inscribed within a multilayered, longer-term strategy, with increased coordination with transition and development actors, whenever present.
- (e) Human rights violations can also be perpetrated by humanitarian staff, and IOM has taken specific measures to prevent sexual abuse by humanitarian staff in its policy on **community Protection against Sexual Exploitation and Abuse** and staff standards of **conduct**, in line with the inter-agency policies on the issue. 

- (f) There could be the tendency to overrefer “cases”, congesting some organizations and reducing their capacities to provide quality services to the ones most in need. There are also often challenges of overidentifying when there are no specific services available (for example, identifying unaccompanied and separated children, or specifically street children, when no actor actually provides alternative care, protection, access to health care or other services to them). The identification of a group or individual at risk brings an ethical duty to provide care and follow-up. This means that the MHPSS actor should refer to protection services and, where no services are available, to inform responsible or relevant actors, or duty bearers, of the particular issue or the cases, while respecting data protection, consent and confidentiality principles, and keeping the security of the persons or group as the primary consideration. This should be done within the protection cluster or/and its sub-clusters, or in liaison with protection actors.

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

Box 56

Reporting human rights and other violations

MHPSS staff will invariably witness the disclosure of abuses that could be classed as human rights violations, while providing assistance to affected individuals. It is not the function of MHPSS workers to investigate allegations of abuse, but they can certainly play a key role in supporting survivors in accessing justice where possible.

Where a MHPSS worker is told about an abuse by a client, they should continue providing care and not interrupting it and, upon receiving consent to do so, refer the case for additional support to:

- a) an IOM protection officer if they exist; OR
- b) ask the manager to consult the Protection Cluster Coordinator for the appropriate referral entry point, based on the survivor's wishes, his or her immediate and long-term needs, and the type of abuse. For example, the referral procedure for a case of suspected child abuse will vary significantly from an allegation of torture made by an adult male in detention. Referral options may include the provision of immediate medical or protection assistance, or legal, livelihood and reintegration support. Referrals should not be made to service providers, who are linked to alleged perpetrators.

Notwithstanding the advice provided by the Protection Cluster or other similar bodies, MHPSS practitioners should at minimum be familiar with, and where existent and possible, integrate into, the existing working groups and/or referral pathways for the following types of abuse:

- **Sexual and gender-based violence (SGBV);**
- Forced recruitment/trafficking;
- Child abuse;
- The six grave violations against **children**;
- Attacks on civilians;
- Torture and ill-treatment;
- Enforced disappearance.

All referrals should be made in line with respect for survivor autonomy, which means respecting survivor choices, upholding full and informed consent, and respecting the principle of confidentiality where possible. MHPSS staff should know that not all help professional categories are protected from court-ordered requests to disclose information about survivors. Before promising full confidentiality, staff should understand the limits of what they can guarantee.



12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

➔ FURTHER READING

The Alliance for Child Protection in Humanitarian Settings

2018b *Child Neglect in Humanitarian Settings*. The Alliance for Child Protection in Humanitarian Settings, Geneva.

Inter-Agency Standing Committee (IASC) Task Force on Humanitarian Action and Human Rights

2004 *FAQ on IHL, IHRL and IRL*. IASC, Geneva.

International Committee of the Red Cross (ICRC)

2004 *Inter-Agency Guiding Principles on Unaccompanied and Separated Children*. ICRC, Geneva.

2018 *Professional Standards for Protection Work* (3rd ed.). ICRC, Geneva.

International Organization for Migration (IOM)

2009b *Caring for Trafficked Persons: Guidance for Health Providers*. IOM, Geneva.

2010b *Data Protection Manual*. IOM, Geneva.

2020 *Mental Health and Psychosocial Support (MHPSS) in the COVID-19 Response:*

Guidance and Toolkit for the use of IOM MHPSS Teams: Version III-Final. IOM, Geneva.

Office of the United Nations High Commissioner for Refugees (UNHCR)

2011 *Age, Gender and Diversity Policy: Working with People for Equality and Protection*. UNHCR, Geneva.

2014a *Child Protection Issue Brief: Mental Health and Psychosocial Well-being of Children*. UNHCR, Geneva.

2014b *Understanding Community-Based Protection*. UNHCR, Geneva.

United Nations Office of the High Commissioner for Human Rights (OHCHR)

2011 *International Legal Protection of Human Rights in Armed Conflict*. OHCHR, Geneva

For other references see the full bibliography [here](#).



13. COUNSELLING





13.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Managers of MHPSS programmes are not directly providing counselling services, but they design programmes and take implementation decisions that regard counselling. These have to do with selecting which counselling models and tools to use in the programme, based on contextual capacities and needs. MHPSS programme managers have to:

- Identify, alone or together with the technical supervisor, training programmes that are suitable to enhance the existing counselling capacities in the given context.
- Consider issues of scalability, and of adaptation and training, when devising counselling interventions in emergencies.
- Consider the issue of squared cultural and linguistic differences and, at times, of working with interpreters when offering counselling to migrants.
- Monitor adherence to adopted methodologies. Organizing and supervising the technical supervision is also part of the manager's duties.

This chapter therefore serves as a guide to better understand the definition, practices and modalities around the provision of counselling services in an emergency, with particular regard to those methods that better serve a community-based approach, such as one that empowers and entitles communities in finding their own responses. In order to understand the definitions of counselling, resilience and other terms used in the chapter, see [here](#).

Box 57

Adaptations in Pandemic Response

For guidance on remote MHPSS service delivery during the COVID-19 pandemic, see [this report](#) developed by IOM Iraq.

13.1.2 Concepts

13.1.2.1 Counselling

Counselling is a supportive conversation. There are many types of conversations that take place between community members that may have a therapeutic benefit. These can range from spontaneous, mutually supportive conversations, to problem-solving associated with particular activities. In this Manual, counselling refers to those structured conversations that may take place with individuals and groups, and that have a **therapeutic outcome** as their goal.

Counselling is a rich and diverse field, which may also be practiced by other disciplines, such as social work and clinical psychology. The hallmark of counselling is its particular emphasis on mobilizing suffering persons' resilience (Fraenkel, 2014). Of great importance in counselling is how to create and maintain healing and ethically sound relationships between the counsellor and those being counselled.

Features that stand out in a contextually-sensitive counselling approach are:

- Mobilizing suffering persons' resilience, and their psychological and relational strengths and resources, in order to solve their problems: This will often include facilitating the collective capacities for resilience that reside in family and community relationships, and that are drawn from cultural and religious traditions.
- Effective counselling: This involves teaching important skills, such as active listening, respect and avoiding causing emotional harm. Effective counselling is enhanced by the social-emotional and relational intelligence of the practitioner and client, as well as other supportive members of the community.
- Counselling for many, and particularly for those who have been displaced from home, family, and community, creates a space of "protected intimacy": An important capacity for preventing a sense of psychological homelessness (Saul, 2018).

A number of recent studies support the

importance of counselling in emergency settings (Jordans, Pigott, and Tol, 2016; Patel, 2012; Murray et al., 2014; Ramaswamy et al., 2018; Tol, et al., 2011; Watters, 2017). These MHPSS interventions can build healing connections that may both reduce ongoing distress and prevent future mental health difficulties.

At a most basic level, counselling helps re-establish connections between people, so that one is not struggling with adversity in isolation – a serious risk factor for mental health difficulties. Since humanitarian emergencies are so destabilizing and often unpredictable, the connection with others can help in gaining perspective and composure, and support the shoring up of resilience: for example, recognizing and accessing resources important for adaptation and problem-solving.

Active and perceived social support has been found to be the most important protective factor in highly stressful situations, such as during and following emergencies, since both giving and receiving help are adaptive activities (Hobfoll et al., 2007). Following a disaster, there is an evolutionarily-based biological capacity for people to come together and bond. This natural healing process may be supported through counselling at the individual and communal levels, particularly when it helps restore connections that may have been broken, as well as build new ones.



In the IASC pyramid of MHPSS intervention in emergencies, the counselling techniques and models described in this chapter are included at the third level (focused interventions), even though they require different levels of specialization.

13.1.2.2 Community-based counselling

Community-based counselling is one of the many approaches of counselling and has the advantage of addressing not only psychological issues resulting from stress, grief, loss, depression and other individual mental health difficulties, but also the psychosocial impacts and challenges resulting from the collective injuries to families and communities. These approaches are aimed

at strengthening collective resilience and social capital, and mobilizing the community's engaged action and response. Community-based approaches aim at understanding the sociocultural and environmental parameters that both hinder and promote the kinds of interactions and conversations that lead to well-being. This includes the relationships between people and between groups; their culture; and existing structural inequalities based on race, ethnicity, gender, class, and the physical, political and economic environment. This approach also includes a historical understanding of the narratives that have shaped identities and the current situation or crisis.

A community-based approach is particularly relevant in crisis situations, where not only individual clients, but their families and communities, are affected, directly or indirectly, by stressful and disruptive events. Counsellors, too, are part of the system. They are affected by their work, which includes reciprocal interactions with clients, with their own work teams and organizations, and with their own families and communities. “Vulnerability” and “resilience” are concepts that apply to counsellors as well as those they seek to help.

Community-based approaches isolate problematic behaviours or feelings not only in the individual, but also in the web of relationships in which a person is embedded. The problems will always have both an individual and relational or collective dimension. Counsellors will therefore understand the context and meaning of counselling in particular situations – for instance, does having a counsellor from outside the family or community intervening to help solve the problems of children in some way undermine the parents' authority and competency? For example, does it send the message “You can't do it yourself, we must help you”? This problem often presents itself when counsellors work directly with children and ignore the competencies of parents.

Table 11 clarifies principles for community-based counselling. While many counselling

approaches focus primarily on the individual, and not every approach is reflective and responsive to the community, a standard can be set in which any individual and group counselling approach can be adapted to make it more community-based and contextualized.

Table 11: Community-based counselling approaches – minimum and optimal standards

Minimum standards	Optimal standards
Programmes are often provider-driven, with participation of community leaders and members to aid in programme implementation.	Programmes engage the community's participation at all stages – planning, assessment, prioritizing, implementation, evaluation and dissemination. Programmes may fall along a continuum of outside provider/inside community-driven programme development.
Primary focus on screening for and addressing multiple mental health problems as well as specific diagnosable disorders. Symptomatology, idioms and constricts are validated with the community.	There is an assessment of needs, challenges and priorities of the target population to determine the most effective and appropriate counselling approach.
Primary focus is on treatment of individuals and reduction of psychological symptoms. Tools are translated.	Focus may be on addressing the particular challenges in families, in the community as a whole, or groups and organizations within the community. The emphasis is on relational repair as much as symptom relief.
Exploration of culture and context to understand how best to implement and scale up interventions.	An initial assessment is made of culture and context, to understand individual and collective strengths, resources and coping capacities, as well as problems. Culture is central to determining local understandings, priorities and meanings of potential interventions (see IASC, 2007:38–48). Care is taken not to undermine local meanings, resources and coping capacities at the levels of individual, family and community.
Adapt evidence-based programmes developed in other contexts to current context. The particularities of context and culture are explored to facilitate implementation.	Programme development is an iterative process based on ongoing community input, revision and approval. Cultural meanings are central to determining priorities, available resources and preferred ways of addressing distress or challenges, using participatory methods as above (Bragin, 2014).
Criteria for programme success are determined by established indicators developed in testing programmes, and in solution-focused counselling in client-identified goal setting and steps.	The criteria for success in evaluating a programme are determined by client-identified goals and in collaboration between outside providers and the community.



Some types of counselling approaches used in emergency situations – including cognitive behavioural approaches, narrative exposure therapy, eye movement desensitization and reprocessing, Rogerian approaches, some art therapy and dramatherapy techniques – tend not to take into consideration the social and ecological context of the person(s) being counselled, nor the context of the counsellors and the counselling situation itself. There are, however, counselling approaches, such as strength-based **solution therapy approaches**, that are grounded in a social ecological approach (see models of **work**). Furthermore, the above-mentioned counselling approaches, although not being community-based in themselves, can





Group counselling session, Lebanon. © IOM 2017

be integrated into a more socially and ecologically contextual approach and programme, contributing to its overall objectives.

13.1.2.3 The counselling process

The counselling process is determined by the context in which therapeutic interactions take place, as well as the particular theoretical model of the counselling approach, usually in structured multimeeting programmes. Counselling may take place in professional spaces or MHPSS centres – such as IOM’s recreational and counselling centres and **hubs**, other **safe spaces**, health centres, or in communal or cultural spaces that have been identified – where an individual would go in need of guidance and support – and during certain crises, counselling may take place **community remotely** (Abramowitz, 2010; Chibanda et al., 2016). Counselling may take the form of accompaniment: for instance, by a volunteer who helps a client navigate to resources in new and unfamiliar situations – a popular approach in Latin America, which builds on social work approaches to case management (Valdivieso and Andersson, 2017; Pinheiro, 2017).



The process of counselling most often includes an initial stage of joining or gathering, and various forms of listening and speaking:

- Some of these conversations may have particular culture-based guidelines about how to speak and who can speak with whom and in what order.
- There may be cultural conventions or restrictions on the giving and receiving of advice (in traditional communities, for example, married couples experiencing difficulty will meet with the in-laws to help resolve marital conflict or solve problems).
- There may be cultural prohibitions on speaking to strangers outside of the family.
- Counselling may be directive or non-directive, and may focus primarily on providing emotional support or giving advice.
- It may focus on solving problems or finding solutions, exploring painful feelings or strengthening the coping capacities of individuals, families or groups.
- Many counselling approaches, especially in emergency situations, will involve some form of strengthening of emotional regulation skills, through training in relaxation or mindfulness techniques, or physical exercise and movement (Wessells, 2009).

The counselling process can vary due to the types of people who are meeting, whether the groups are facilitated by professionals or trained paraprofessionals, or follow culturally prescribed ritual guidelines around life transitions and crises.

Box 58

What distinguishes a systems or community-oriented approach to counselling from an individual-oriented approach

- Rather than exclusively focusing on internal psychological processes, it attends to patterns in relationships among people in families, couples, groups and in the community, through community approaches.
- It attributes psychological and social dysfunction to problems lying not solely within the individual, but also in larger systems.
- It pays attention to structural issues of race, ethnicity, religion, class and gender as social determinants of mental health difficulties. It is structurally competent.
- It acknowledges that the problems of individuals and groups always occur within context, as do the solutions, which must be meaningful and acceptable in the person's social context – family, friends, peer groups, faith-based groups and organizations.
- It sees the social context as not only sustaining problems, but also as the source for solutions. To ignore both is to narrow the scope and potential effectiveness of counselling. For instance, if a child who is exhibiting problem behaviour is removed from his social context to solve his problem, when he is returned to that context he is also returning to the relational forces in the family or school that may have sustained the problem in the first place.
- It can be more challenging with highly mobile populations – such as refugees and migrants, or with displaced persons, whose sense of community has been fractured – and more difficult to reproduce/scale up.

Group counselling session. © IOM 2015





Male support Group, Erbil IDP site, Iraq. © IOM 2017

13.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

The decision about what kind of counselling programme(s) to implement in an emergency situation may be guided by the three core principles:

13.2.1 Understanding the complexity of the situation in which counselling is being provided

The basic starting point for understanding the complexity of the situation is a descriptive account of the humanitarian emergency and of the population affected (how many people, when did they arrive and where from, what has their journey been like, how many available health and mental health professionals are present, and so on). This “thick description” (Geertz, 1973) may serve as a first step on which a “situation analysis” can be made: that is, a tool for creating a detailed understanding of an interpersonal episode or complex state of affairs (the situation) in the context of the larger narrative of which it is a part (the embedding drama). “Situation analysis creates a detailed description of the situation and links that particular situation to the larger drama of which

it is a part in order to identify the factors driving the situation, as well as to highlight the most useful points for intervention” (Green-Rennis et al., 2013).

An important part of understanding the complexity of the situation is to describe the structural factors at play. These structural factors could be at the level of community, neighbourhood, institution (housing, schools, corrections, clinical services), and at the policy level (state policy on housing, policies of international aid groups, the impact of war and political violence). Referred to as “structural competency”, this approach to clinical training and practice addresses the social and political aspects of mental health and psychosocial well-being. Focusing on structure can promote a more collaborative approach that makes use of local resources. This is in lieu of an approach that venerates individual behaviour change in the face of overwhelming environmental adversity (Metzl and Hansen, 2014). This recognition of larger social forces is essential to understanding the social disparities in global mental health. Inequalities based on race, ethnicity, gender and social class are major drivers of poor mental health outcomes.

Other important questions to ask are: What are the complexities of the stories? How do narratives shape the experience of the

population, the providers and the developing collaboration – and the way the manager thinks about designing interventions?

13.2.2 Recognizing existing individual and collective processes and resources for recovery

Through interviews and observations, it is important to understand the positive social processes that have already been taking place in the target population and the humanitarian environment, which may be considered forms of counselling and may serve as the foundation for the further development of counselling approaches for a community. The aim is not to undermine already-existing resources and resilience processes important for recovery. An understanding of these resources will provide important information on the preferred help-seeking patterns in a population, and help identify leadership capacities, skill sets and motivated community members, who may be important collaborators in developing counselling programmes.

Resilience has now emerged as a new paradigm in the fields of development and mental health (Ager et al., 2013). What is distinctive about a resilience-based approach is:

- An emphasis on strengths, resources and capacities rather than deficits;
- Anticipation of actions that reduce the impact of adversity;
- Attention to multiple levels of influence, ranging from the structural and cultural through to the community, family and the individual;
- Mapping influences within ecologically-nested systems (ibid.).

Influences are bidirectional, in that an individual's resilience is fostered by family, social and cultural resources embedded in one's social ecology, as well as the collective capacities or ways that

families and communities exhibit resilience themselves in response to stress and challenges. This may involve adjustments and adaptations of subsystems within the community – that is, individuals, groups and organizations – or it may involve the interactions of the entire community with its environment, including other social, economic and political entities (Kirmayer et al., 2009).

Approaches to resource mapping have been presented in previous sections of this Manual. Here we may add that, in developing resilience-based approaches to counselling, mapping sources of resilience at different systemic levels will be important in determining points of intervention. A variety of maps have been developed (see Landau and Weaver (2006) later in this chapter) that will be helpful to programme planners as a kind of checklist of the potential points of intervention.

13.2.3 Enhancing and building on what already exists

In collaboration with community representatives, it is important to understand which existing processes could benefit from support by providers. For example, a group of volunteer parents running a sports programme for youths might request help from counsellors to address some of the MHPSS needs of programme participants that come up in the groups they are facilitating. This non-stigmatizing site may be an important place to offer information on understanding stress reactions and tools to cope with stress, anger management and routes to other forms of counselling, if needed. The sports group itself may have the capacity to function as a kind of peer support group with the aid of a psychosocial counsellor.

In trying to determine what types of counselling may need to be added to what already exists, it will be important to understand the different effects or impacts of migration and displacement at different levels. Often, when looking at a counselling approach, one can find his or her

approach to counselling in individual level factors (symptoms, mental health disorders), but not the disruptions that take place at the level of the family and the level of the community. One needs to be able to consider interventions that not only strengthen family and community supports, but address the impact that stress, grief, transition and loss can have on family and community interactions.

Multilevel approaches to determining which counselling methods to use do consider the impacts of expressed community needs at multiple systemic levels.

Family stress needs to be addressed at the family level, often with community support. When determining what needs to be strengthened, enhanced or added to the community's counselling efforts, the community's desired goals and priorities for counselling must first be established with the community. Based on this vision of recovery, one can then explore with the community the different options for counselling as a part of the process of developing a strategic plan for a set of counselling interventions that are the most important for this early phase of intervention.

What is the process for establishing the priorities and how are these priorities negotiated among community members and with providers? That process may include a discussion of different types of counselling approaches that are traditionally utilized or preferred by the community, potential limitations of these approaches, and what additional approaches are needed to complement existing services in order to address the unique challenges of the current emergency situation. Available resources also need to be determined—trained community members available for training as paraprofessionals, for example. In the process of negotiating priorities, the following may be useful guiding principles:

- Provide preventive value – to the extent that the counselling approaches strengthen protective factors (such as promoting social support and problem-solving).
- Address the most vulnerable and high-risk community members.
- Promote social cohesion and be effective in promoting cross-community communication and preventing communal fragmentation.
- Acknowledge the diversity of needs and determine which counselling interventions will most likely lead to practical success and thus increase the efficacy of the community.
- The development of the priority must respect or take into consideration the power dynamics in the community. The issue of sharing and distributing resources in a fair and equitable way brings in a more ethical dimension for how priorities are established.
- It is important for practitioners to be both culturally and structurally competent in facilitating this process of negotiation.

In the context of understanding the community situation and broadly assessing its needs and resources, the goal is then to determine which counselling approaches would be most desirable, feasible and viable in the situation. A framework is recommended here that is based on relationally-oriented design thinking adapted from IDEO U (2016) and Bava (2017).

The choice of particular counselling approaches should be determined by the goals and priorities articulated by the community. Then the community may explore with provider organizations which counselling options may be available, feasible to implement and most viable. The needs of the community do not

always coincide with the resources that are being offered by humanitarian organizations. The community would benefit from knowing about counselling programmes that most closely fit their goals, so that trainers in these particular approaches may be sought. This determination is accomplished by interviewing community members, stakeholders and provider organizations. Some of the options for community-based counselling approaches at different levels are presented below.

→ 13.3. OVERVIEW OF COMMUNITY-BASED COUNSELLING INTERVENTIONS

Ideally, a counselling programme in emergencies for IOM should not follow a precise and predetermined intervention protocol, but should be based on a solid foundation of skills of the counsellors, and the sensitivities and competencies described beforehand in the chapter. A group of trained counsellors, constantly retrained and supervised, should be allowed to adopt flexible approaches in intervening with groups and individuals, while adhering to precise ethical principles and overarching models of work.

However, various community-based counselling interventions – or psychological interventions, as some call them – have been developed at the level of the individual, family, groups and communities as a whole in humanitarian settings. Others have been developed in a variety of other settings, but have the potential to be implemented in emergency humanitarian contexts. These are more structured and validated, and are therefore potentially easier to scale in case resources or capacity are scarce.

During the initial months of a humanitarian emergency, it is important to allow some time for people to access on their own the coping

strategies they find most useful, so as not to interfere with or undermine a population's natural coping capacities. It will be important to wait before offering counselling that targets specific mental health difficulties that only become apparent months after an initial crisis. However, in this initial stage, counselling that addresses the immediate impact of a crisis may be useful, such as:

- Practical problem solving and problem management (see PM+, section 13.4.1 below);
- Ambiguous loss groups (see section 13.6 below);
- LINC Community Resilience Model (Landau and Weaver, 2006);
- Socioterapy (see [section 13.3.3 below](#)).

At a second stage, more approaches can be used, including the ones above.

13.3.1 Individual level counselling approaches

Problem Management Plus: PM+, in individual and group format, is an innovative psychological intervention that provides clients with skills to improve their management of practical problems (unemployment, interpersonal conflict, among others) and associated common mental health problems, via the provision of four strategies: problem-solving counselling, stress management, behavioural activation and strengthening social support.

13.3.2 Peer-support counselling programmes

Friendship Bench Programme in Zimbabwe: Located in the grounds of health clinics around Harare and other major cities in Zimbabwe, the practitioners are lay health workers known as community “Grandmothers”, trained to listen to and support patients living with anxiety,



Lay Counselling at the Protection of Civilians site in Malakal, South Sudan. © IOM 2018



depression and other common mental disorders (see “**Friendship Bench**”).

Being Buddies – IOM Nigeria: The buddy system is an intervention similar to peer-to-peer counselling, which consists of the identification, training and constant supervision by professional counsellors of various community members who can provide support to their peers in the neighbourhood, families, workplaces and groups. It was originally developed in non-emergency contexts, in settings such as workplaces or schools. In schools, programmes have been put in place to promote students’ psychosocial well-being through buddy support, with the idea that students would be more responsive to receiving support from their peers, to whom they could relate to more, than from a school staff member. Such approaches have proved particularly relevant in some emergency settings, such as north-eastern Nigeria. In this context, counsellors and psychologists are scarce. Moreover, seeking assistance from a counsellor or psychologist is quite the exception, whereas most affected individuals would seek assistance

through other support systems, friends, neighbours and colleagues, which would be perceived as more effective and appropriate by them.

This methodology puts both participants in a more equal position. In humanitarian settings, very often, affected populations are seen as passive recipients of assistance. The buddy system approach allows for a different view and promotes a different self-identification, because affected individuals become both providers and receivers of such services. Through the buddy system approach, a positive sense of identity is encouraged, providing affected individuals with an opportunity to become positive role models.

In emergency and displacement settings, neighbourhood support structures are often broken down, and the buddy system can help weave and strengthen the social fabric. By encouraging interactions through “buddies”, groups can be created at the grassroots level to recreate neighbourhood or problem-based **support**.



Through the buddy systems approach, individuals are equipped with MHPSS skills in order to provide effective support to their peers, and can pair up with individuals needing more support. The MHPSS manager and supervisor's role is to build capacity of the buddies, provide guidance and ensure that they do no harm. Buddies should be provided with supervision, to explore any challenges they may encounter, and reflect on their practices and experiences. Finally, in emergency settings and particularly in protracted crises, populations can experience numerous displacements. With the buddy system approach, the trained individuals will be moving with the affected population and still be able to provide MHPSS, even in situations where humanitarian actors may not be able to reach the affected population.

13.3.3 Group counselling

Group interpersonal therapy (IPT) was originally developed in the United States as an individual treatment for unipolar, non-psychotic depression (Klerman et al., 1984). In treating depression, IPT targets the connection between the onset of symptoms and current interpersonal problems. The IPT therapist begins with a systematic diagnostic assessment, explains the diagnosis, and works with the patient to identify the problem areas associated with the onset of the current symptoms. Difficulties in four interpersonal areas are considered triggers of depressive episodes and become the focus of treatment: grief (due to death of a loved one), interpersonal disputes (disagreements with important people in one's life), role transitions (changes in life circumstances, negative as well as positive) and deficits (persistent problems in initiating or sustaining relationships).

IPT is specified in a manual, has been tested in numerous randomized controlled trials, and is efficacious for a number of mood and non-mood disorders (depressive and bipolar disorder, post-traumatic stress disorder (PTSD), eating disorders,

among others), age groups (adolescent, adult and geriatric populations), settings (outpatient mental health facilities, primary care, school-based clinics, community settings, among others), and modalities (for example, individual, group and telephone).

There is a growing body of evidence showing the effectiveness of IPT in low-resource regions and settings. IPT was used in a group format, was culturally adapted, and showed efficacy for depressed adults and adolescents in both southern and northern Ugandan communities; for depressed primary care patients in Goa, India and Ethiopia; and with women with post-partum depression in China and Kenya. The last group was HIV positive and included survivors of intimate partner violence. Group IPT was adapted for global dissemination by **WHO**.



Sociotherapy is a therapeutic system with strong theoretical and historical links to Sociology. This approach to therapy emphasizes social, cultural, environmental and interpersonal factors, taking into account the living environment of groups of clients to support their interpersonal adjustment and reach treatment objectives. While psychotherapy is centred on the individual, sociotherapy considers that individual psychological concerns frequently have social or environmental causes that limit the effectiveness of psychotherapy. Sociotherapy intends to provide substantial solutions to sociopsychological problems, helping clients to regain harmony with their community.

Sociotherapy targets groups of clients, using interaction and socialization as a way to collect information on clients' limitations and as a therapeutic tool. Clients learn roles and adequate interpersonal behaviour through experiencing social interactions (Whiteley, 1986); relearning established roles and behaviours in a safe environment. Thoughts and feelings on the process are discussed with all group members and the sociotherapists, who support the group to adjust to their daily lives in their specific social context.



Richters (2010) states that “sociotherapy helps people regain self-respect, rebuild trust, feel safe again, overcome unjustified self-blame, re-establish a moral equilibrium, have hope, live without terror, forgive those who have harmed them, apologize to those whom they have wronged, and regain their rightful place in the community”. This approach has been successfully used in different contexts, and for more information, please see examples of its use in Rwanda, where it has been used since 2005 to support communities after the war and the 1994 genocide ([here](#) and [here](#)).



13.3.4 Family counselling, Ambiguous loss – Working with families with missing members

Counselling approaches that work with families struggling with ambiguous loss are important in humanitarian emergencies. Boss (2004) defines ambiguous loss as “an unclear loss – a loved one missing either physically or psychologically. It results from various situations of not knowing if a person is dead or alive, absent or present, permanently lost or coming back.”

The issues that families with a missing member(s) must contend with are multiple, and need counsellors who understand the impact this kind of temporal dislocation and uncertainty can have on a family system. Counsellors will need strategies for preventing and addressing the polarization and conflict that can occur in families when coping with a situation of a missing member(s). Family reunification programmes are also important in this phase and go hand in hand with programmes that address ambiguous loss (Boss, 2018; IFRC, 2001, 2014; Killian, 2016; Robbins, 2013). For practical guidance see [here](#) and [here](#).



The collaborative family programme development model is a collaborative research-based approach to creating community-based programmes for families. In this approach, families are viewed as experts on the nature of their challenges and on what they desire in a programme. This approach

is particularly useful in developing programmes for families who have experienced social oppression and who may have been reluctant to participate in programmes created for them by professionals without their consultation. In contrast, when professionals adopt the stance of respectful learners, families respond by actively engaging in the programme development research and in the programme created from it. This article describes the nature and complexities of a collaborative programme development stance (Fraenkel, 2006).

13.3.5 Technological and social media-based counselling approaches

Social media-based counselling approaches are a new field of development. Although best reproducible practices could not be identified at the moment, a series of readings is recommended for inspiration: Ungar et al. (2013), Ruzek et al. (2016), and Ruzek and Yeager (2017).

13.3.6 Self help tools

Often, in emergency situations, access to populations made most vulnerable is not possible. This lack of access can jeopardize the possibility to offer direct counselling services, and to present and promote online mechanisms of distant counselling. In these situations, IOM uses self-help printed and online tools that can be included in distribution packages, or other primary goods distributions. The process to create these tools can be done in four ways/ steps:

- Focus groups are conducted with relatable groups who are accessible to identify main stressors, concerns and viable solutions.
- A mixed group of psychologists, anthropologists and visual artists create self help tools on the identified issues and building on identified resilience factors, that are conversational in tone and that include visuals.

- The resulting messages and pictures are validated in new focus groups.
- The final booklets are printed and included in distribution packages, health facilities, educational kits, and made available online.

See [here](#) the English version booklet *Self Help for Men in Crises and Displacement*, specifically tailored in 2015 for Syrian men living in inaccessible areas in the Syrian Arab Republic. The booklet has since been distributed, translated, adapted and used as supporting material in face to face and group counselling sessions for men in several countries.



13.3.7 Other focused psychosocial supports

Other forms of focused psychosocial support are presented in this Manual, as follows:

- Problem-based, programme-generated support groups and peer support **groups**;
- Problem-based and programme-generated art-based interventions (dramatherapy, social theatre, art therapy and **others**).



In addition, *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007) include PFA as a third-level intervention. See Box 59 for the presentation and discussion of PFA.

➔ 13.4. ADAPTATION, TRANSLATION, TRAINING AND CULTURAL COMPLEXITIES IN WORKING WITH MIGRANTS

The mentioned existing counselling interventions can be used within a CB MHPSS programme. Yet these interventions, in order to be adapted and scaled up, will require:

- A meaningful selection of the best intervention for the context;
- The adaptation and translation of the relevant tools in the new language, if necessary;
- Training of the counsellors on the method and protocols.

For how to choose the best intervention for a specific setting and to adapt and translate the model accordingly, please refer to the following chapters of the forthcoming WHO *Psychological Interventions Operational Manual: Integrating Psychological Interventions in Existing Services*:

- Chapter 2 – Choosing the best intervention for a specific setting;
- Chapter 3 – Translation and adaptation of psychological interventions.

The forthcoming WHO manual will be found here in the online version of the present Manual, as soon as it will be published.

When working with migrants and displaced populations and their host communities, the issues related to adaptation and translation become more complex and three-tiered.

The translation of the tool in the mainstream language, which is well captured in the WHO operational manual, may not be enough because migrants and displaced people come from other cultures and may speak one or more different languages. One possible solution is to adapt and translate the protocols, tools, training modules and supporting materials in more languages. But this is not always feasible, since several

languages can be at play, and the process can become lengthy and costly.

Increasingly, especially in sudden onsets of emergencies but also in protracted situations, such as the ones of the refugee camps in Greece or in Kenya, it is necessary to envisage ways that allow the counsellors to work, with the help of translators, with a client who does not speak their same language and comes from a different culture. This is never a neutral process, because all counselling models and psychological interventions are based on a one-to-one relationship or a one-to-a-group relationship, and the presence of a third person in the equation needs to be carefully planned and requires special safeguards that include:

- Training the counsellors in providing counselling through translation.
- Training the identified translators, who often are not professional translators, in how to translate in a counselling setting, and on basic confidentiality and active listening skills.
- Providing for the salary or in-kind support of the translator.
- Educating the counsellors in cultural diversity management. This includes two kinds of trainings, one more specific to the cultural do's and don'ts of the culture of the client, and one more on how to address the key issue of cultural diversity in the counselling session.

To receive guidance in the organization of these trainings, please contact contactpss@iom.int.

13.5 Challenges and considerations

Some of the most common issues facing non-specialists working in such situations is that these community members often share the same kinds of challenges as those they may be counselling. Personal reactions may make it difficult to provide effective counselling, requiring a structure to be put in place for initial and

ongoing training, and ongoing monitoring and **supervision**.

It is important to have a code of conduct that include guidelines for maintaining professional relationships. **Wessells (2009)**, describes the following principles for maintaining a “do no harm” approach:

- Allow time for critical reflection on ethical issues before, during and after each emergency response in order to mitigate or minimize harm.
- Develop and provide specific ethical guidelines with regard to appropriate conduct in international emergencies.
- Document and improve efficacy of MHPSS interventions in emergency contexts.
- Ensure preparedness of MHPSS workers in international emergencies.

Limited **resources, access** and capacities will determine the types of counselling programmes to be implemented, but in these situations a great deal of creativity and ingenuity often takes place, and sometimes even the most useful resources and hidden capacities might emerge.

This chapter provides a broader perspective than is usually attributed to an individual model of counselling in its attention to situational and contextual factors that need to be addressed in a counselling situation, in the multiplicity of spaces and interactions in which counselling may take place, and with the consideration that more informal types of counselling are often taking place spontaneously and on a regular basis. In communities, these natural processes should not be harmed and the programme shall even enhance the opportunities for these interactions to take place when possible.

Providing support (for staff welfare) and technical supervision to counsellors is important and challenging. This is addressed in the **chapter on Technical supervision**.



Box 59

Psychological first aid

Psychological first aid (PFA) is an evidence-based approach that involves humane, supportive and practical help to fellow human beings suffering serious crisis events, provided by people in a position to help others who have experienced a distressing event. PFA was conceived as an alternative to critical incident psychological debriefing and other forms of one-off psychological interventions after disruptive events that focused on trauma paradigms and retelling. These interventions have been proved to be harmful in the medium term and are discouraged by several agencies, including IOM. PFA allows providing emotional comfort and practical support, without leading people to tell what happened to them.

It gives a framework to immediately support people in ways that respect their dignity, culture and abilities. PFA is short one-off supportive intervention and cannot be considered a counselling method or a service that can be offered several times to the same individual. If more than PFA is needed, it should be addressed with **referral**.

PFA entails different components, including initial contact with the affected person, providing safety and comfort, emotional stabilization, providing information and practical help, connecting the person with their social network, connecting the person with available services, and providing information. The PFA providers must always ensure protection from further harm for themselves and the supported people, and be prepared for the intervention, analysing the situation and gathering information beforehand.

Despite the fact that *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007) place this intervention on the third level of the intervention pyramid (focused support), for IOM PFA should be used at all levels:

- First level of intervention – basic services and security: Camp coordination and camp management (CCCM), Health and Emergency response staff, among others, should be trained in PFA, as they are commonly the first respondents in an emergency. PFA allows them to provide information and support the affected population in an effective way, preventing humanitarian intervention-induced distress.
- Second level of intervention – community and family support: PFA can be used at the community level. Groups of volunteers in the local population interested in supporting others can be trained in PFA to support their peers experiencing highly distressful events.
- Third level of intervention – focused supports: PFA is usually the first intervention for people in need of support after an emergency. MHPSS workers must be trained in PFA to help stabilize affected people before determining if further counselling or social support is needed through referral.
- Fourth level of intervention – specialized services: PFA can, in certain circumstances, be useful to offer initial support to people with pre-existing or emerging mental disorders, and their families and caregivers.

All MHPSS workers must be trained in PFA. The most common tools used for training are WHO's *Psychological first aid: Guide for field workers* (WHO, 2011) and *Psychological first aid: facilitator's manual for orienting field workers* (WHO, 2013). Additional tools can be used depending on the context ([here](#), [here](#) and [here](#)).

Although no specific MHPSS background is needed to be trained on PFA, some basic skills are necessary, such as active listening, compassion and flexibility. PFA tools contextualized to COVID-19 can be found [here](#).



→ FURTHER READING

Betancourt, T. S., S.E. Meyers-Ohki, A.P. Charrow and W.A. Tol

2013 Interventions for Children Affected by War: An Ecological Perspective on Psychosocial Support and Mental Health Care. *Harvard Review of Psychiatry*, 21(2):70–91.



Bragin, M.

2014 Clinical social work with survivors of disaster and terrorism: A social ecological approach. In: *Essentials of Clinical Social Work* (2nd ed.) (J. Brandell, ed.). Sage, Thousand Oaks, CA, pp. 366–401.



International Organization for Migration (IOM)

2020 Mental Health and Psychosocial Support (MHPSS) in the COVID-19 Response: Guidance and Toolkit for the use of IOM MHPSS Teams: Version III-Final. IOM, Geneva.



Nicolas, G., B. Schwartz and E. Pierre

2009 Weathering the Storms Like Bamboo: The Strengths of Haitians in Coping with Natural Disasters. In: *International Handbook of Emotional Healing: Rituals and Practices for Resilience after Mass Trauma* (A. Kalayjian, D. Eugene and G. Reyes, eds.). Greenwood Publishing Group, Inc., Westport, CT, pp. 96–106.



Nordbrandt, M.S., J. Carlsson, L.G. Lindberg, H. Sandahl and E.L. Mortensen

2015 Treatment of Traumatised Refugees with Basic Body Awareness Therapy Versus Mixed Physical Activity as Add-On Treatment: Study Protocol of a Randomised Controlled Trial. *Trials*, 16(1).



Patel V. et al.

2018 *Where There is no Psychiatrist*. Royal College of Psychiatrists.



Scholte, W. F. and A.K. Ager

2014 Social Capital and Mental Health. *Intervention*, 12(2):210–218.



For other references, see the full bibliography [here](#).



14. COMMUNITY-BASED SUPPORT FOR PEOPLE WITH SEVERE MENTAL DISORDERS



Support group for persons with disabilities at the Protection of Civilians site in Wau, South Sudan. © IOM 2018

→ 14.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Mental disorders have a range of manifestations, but are most commonly characterized by a combination of distorted thoughts, perceptions, beliefs, emotions, behaviours and relationships with others (WHO, 2018b). When these problems last for long and/or are very pronounced, they strongly impact the life of affected persons and significantly decrease their ability to function. These are termed “severe mental disorders” and require high levels of care.

Typical examples of severe mental disorders are:

- Psychotic disorders of all kinds (including manic psychosis);
- Severely disabling presentations of mood and anxiety disorders (including severely disabling presentations of depression, bipolar disorder and PTSD);
- Severe clinical conditions due to the use of alcohol or other psychoactive substances;

- Risk behaviours commonly associated with mental disorder (such as suicidal feelings, self-harm).

According to WHO (2018b), the determinants of mental health and disorder include, “not only individual attributes such as the ability to manage one’s thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, standards of living, working conditions, and community support.”

During emergencies, the percentage of people with a severe mental disorder may increase from a baseline of 2–3 percent, to 3–4 percent (WHO and UNHCR, 2012). Emergencies not only lead to an increase in the number of people who are affected by a severe mental disorder, but the conditions of those who already had such a disorder often deteriorate (see Weissbecker et al., 2019). In addition to destabilizing existing health and mental health services, the emergency situations can deprive people of social supports and other means of coping that had previously sustained them. Families can be distressed by the burden of care, and be more stigmatized or alienated in their own communities than before the emergency. This puts people with severe mental disorders at an elevated risk of abandonment or neglect during emergencies (Jones et al., 2009).

People on the move face several stressors that can cause high levels of distress and worsen their mental well-being. Some reports and research suggest a very high prevalence of mental disorder in migrants and refugees, with some even assuming that most migrants and refugees have mental disorders. However, the evidence base for such claims is contested because of methodological limits, and the tendency to conflate all emotional distress with mental disorder (Rodin and Van Ommeren, 2009; **Schininà and Zanghellini**,

The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007) also note that many of the actions to be taken to protect and support persons with severe mental disorders apply for persons with other severe disorders and conditions, such as:

- Developmental disabilities with high support needs;
- Neurological disorders and neuropsychiatric conditions such as epilepsy, delirium and dementia;
- Locally defined severe mental health conditions;



2018). In fact, critical and systematic research on the prevalence and incidence of mental disorders among migrant and non-migrant populations in European studies did not find substantial differences between migrants, including refugees and non-migrants (Priebe et al., 2016). Worldwide, research suggests a higher prevalence of psychotic disorders in migrants, although the differences are generally marginal (Hollander et al., 2016). Public narratives on migration are certainly dominated by the discourse on migrants' vulnerability – how vulnerable migrants are, and how vulnerable they make societies – and such discourse may itself serve to compound the psychological problems of migrants (**Schininà and Zanghellini, 2018**).



The United Nations special rapporteur on the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health (2018) cautions against the use of “alarming statistics related to the scale of mental disorders of migrants since this can route problems in a biomedical model which may lead to less focus on policy, empowerment and investing in enabling conditions, and more on treating individual conditions, leading to ineffective and potentially harmful outcomes”.

IOM MHPSS programmes should not reinforce unhelpful and incorrect ideas that all or most migrant and displaced populations suffer from severe mental disorders or psychological problems. Words matter, and it is important for MHPSS programme managers and teams not to use language that pathologizes the psychosocial difficulties faced by migrants and crisis-affected populations, and erroneously labels a whole group as mentally ill. However, in situations of armed conflicts, natural disasters, mass displacement and migration crises, the relatively small number of people with severe mental disorders are among the most vulnerable. IOM MHPSS managers should therefore prioritize the responses for this group, both

in terms of access to clinical care, and in other protection, such as strengthening protection measures.

The causes of most severe mental disorders are not known. Discussion on the complex interplay between biological factors and factors within the social environment in determining severe mental disorders can be found at greater length in WHO (2014) and Patel et al. (2018). As a consequence, treatment and support of people with severe mental disorders typically includes a combination of biological, social and psychological interventions. Even where pharmacological medication is prescribed, this should never be in isolation of other forms of individual and social support. Many people with mental disorders (depression, anxiety, PTSD) can be helped with psychological and social interventions alone, without medication. During emergencies, there is a well-documented risk of both undertreating and/or overmedicalizing severe mental disorders. Those with severe mental disorders need to receive appropriate care, and this care is better offered in a community-based fashion, such as:

- Avoiding hospitalization in dedicated institutions;
- Providing mental health care that is integrated in general and primary health care;
- Involving the family and other caregivers in the treatment;
- Focusing on improving social and occupational functioning of the person, if possible.

14.1.1 Global developments and best practices

A number of global guidelines strive to improve care for people with severe mental disorders in emergencies, and these have a primary focus on facility-based care for individuals.

The Inter-Agency Standing Committee (IASC) *Guidelines on MHPSS in Emergency Settings* (IASC, 2007) **Action Sheet 6.2** includes:

- Ensuring essential psychotropic medications are in emergency medical kits;
- Enabling at least one member of the emergency primary health-care team to be able to provide frontline mental health care;
- Training and supervising available primary health-care staff without overburdening them;
- Establishing mental health-care at logical points of access (in health facilities, but this can also be through home visits or in schools and child-friendly spaces);
- Avoiding the creation of parallel structures;
- Informing populations about the availability of mental health services;
- Working with local community structures to discover, visit and assist people with severe mental disorders.

Action Sheet 6.2 advocates strongly for integration within existing health structures and in order to do this well, community-based approaches are important (these are flagged in bold in the list above).

The WHO Mental Health Gap Action Programme (mhGAP) aims at scaling up services for mental, neurological and substance use (MNS) disorders, especially in low- and middle-income countries. The **mhGAP Humanitarian Intervention Guide (mhGAP-HIG)** contains first-line management recommendations for MNS conditions for use in humanitarian emergencies (WHO and UNHCR, 2015). It recommends that non-specialist health-care providers in primary health facilities are trained to identify and manage common mental health conditions. The package is focused on the use of pharmacological treatment for certain disorders, but it also contains non-

pharmacological elements, including brief psychotherapies and strengthening social support. The emphasis is on providing both pharmacological and non-pharmacological elements. One risk with mhGAP implementation is that these psychosocial elements may be easily ignored – because staff has limited time or training to do these interventions, leading to an overemphasis on pharmacological approaches (Ventevogel, 2014). The mhGAP package is facility-based; however, trained community health workers and other volunteers can have important roles, including:

- Community engagement activities, including providing mental health awareness;
- Identification and referral of people with mental health conditions;
- Follow-up of people with severe mental disorders through home visits and practical and emotional support;
- Organizing support groups: for example, for people with epilepsy, parents of children with intellectual disabilities, and people with severe mental disorders;
- With adequate training and supervision: Providing scalable psychological interventions, such as:
 - o **Problem Management Plus (PM+)**;
 - o **Thinking Healthy**;
 - o **Group Interpersonal Therapy**.

These scalable psychological interventions are reviewed in the chapter on **Counselling**.

Box 60

Liaison with IOM emergency health teams

IOM MHPSS programme managers in the field should liaise with IOM emergency health teams to make sure that:

- IOM-run or partners' emergency primary health-care teams include a member able to provide mental health care;
- IOM-run or partners' emergency primary health-care teams are trained in PFA, and included in existing mhGAP–HIG trainings;
- Based on the existing national humanitarian mechanisms, IOM pharmacies or identified pharmacies and facilities have enough essential drugs for MNS conditions (see the full list [here](#)).

14.1.2 Why a community-based approach

Global guidelines for severe mental disorders tend to focus on facility-based health care for individuals, with limited emphasis on community-based approaches. However, communities are crucial to the care and support for people with severe mental disorders and their caregivers. Two overarching principles are important:

- **Person-focused:** An individual is more than their mental health condition or diagnosis, and their individual needs and strengths remain central. When taking a community-based approach, inputs from families and the wider community are used to create effective change within individuals.
- **Community-focused:** It is also necessary to directly address the wider community system in order to protect and promote well-being, and to reduce stigma and the severity of mental disorders.

These two concepts define community-based approaches to supporting people with severe mental disorders, which include the following:

The recently revised Mental Health standard in the **Sphere Handbook** (Sphere Association, 2018) refers to the mhGAP–HIG, and emphasizes the training of health workers, provision of essential psychotropic medications and monitoring of human rights issues. The standards also recommend working with community members, including marginalized people, to strengthen community self-help and social support, and to organize a referral mechanism between health-care providers and community-based support.

➔ 14.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

The approach and actions that need to be taken to promote community-based forms of support to people with severe mental disorders can be summarized in eight steps:

- Meet lived realities at the community level through participatory, culturally-relevant assessments;
- Map and build on existing community-based knowledge and resources;
- Include people with severe mental disorders and their families and caregivers in planning and implementation of MHPSS programmes;

- (d) Establish community-driven referrals and follow-up (from community to health services and vice versa);
- (e) Inform the wider population about the availability of services;
- (f) Cover the full spectrum of MHPSS needs, including making sure that people with severe mental disorders and their caregivers access basic needs and community-based supports;
- (g) Actively involve community members in clinical intervention (including peer support, caregiver interventions and civil society groups);
- (h) Promote recovery at the community level.

These eight elements will be described through the course of this chapter.

14.2.1 Meet lived realities at the community level through participatory, culturally-relevant assessments



See chapter on **Engaging with communities**.

14.2.2 Map and build on existing community-based knowledge and resources



For these items, see the dedicated section of chapter 2 on Engaging with communities, **here**.

In addition, while conducting mapping, it is important from the one side to look at traditional and religious systems, and on the other to make sure that mapping is accompanied by an evaluation of the human rights compliance and quality of the existing clinical services. This will include working with traditional and faith based systems. For more information, click **here**.

14.2.2.1 Human rights and quality standards

People with severe mental disorders may be at particularly high risk of human rights violations, through abuse and exploitation, especially in emergencies. It is the responsibility of all humanitarian actors to intervene. Taking a community approach may reveal more of these violations, either in institutions, facilities or within the community. At the same time, community approaches can help key people better understand the human rights of people with severe mental disorders, and can reduce human rights violations. Strategies can be found at the community level to end discrimination, ill treatment or violence, and promote the right to health, education and freedom from discrimination.

Assessment and mapping of existing services and resources must include a human rights lens and respect quality standards. Before starting a referral system towards an institution or service, a **WHO Quality Rights** assessment is strongly recommended, (**see assessment toolkit here**). IOM does not promote or facilitate referrals to institutions or services that do not respect basic quality criteria and human rights standards.

In addition, IOM MHPSS programmes do not promote or facilitate referrals to institutions or services using inhumane forms of treatment and constriction, such as chaining patients. Electroconvulsive therapy has been harshly criticized by patients' associations and human rights groups for years. In certain clinical contexts, it is accepted if provided under anaesthesia and after receiving full consent from the clients. However, in many places, these conditions are not met. In the typical displacement and migration context, in addition, it is often challenging to obtain full consent because of issues related to language difficulties, cultural misunderstanding, lack of





Support Group Session with families of people with severe mental disorders at the Protection of Civilians site in Bentiu, South Sudan. © IOM 2017

psychoeducation, referrals happening mainly in an emergency fashion, poor guardianship mechanisms, absence of families and the power inequalities often inherent in health care for migrants. In practice, therefore, IOM avoids referral of people with severe mental disorders to health-care centres that practice electroconvulsive therapy.

All the above-mentioned conditions need to be ascertained before the referrals start, during mapping, through a quality-rights and additional assessments. If a service or existing resource does not comply, IOM can start a series of capacity-building actions to bring the facility up to these standards, but must not use it in the interim. Tools 4 and 5 of the **WHO and UNHCR Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings (WHO and UNHCR, 2012)** can support processes for modifying practices to be in line with human rights principles.

14.2.3 Include people with severe mental disorders and their families and caregivers in the planning and implementation of MHPSS programmes

It is necessary to continue to actively involve people with severe mental disorders and their families and caregivers in the process of designing and modifying interventions and programmes. This involvement should be maintained throughout the project cycle and should be participatory in nature, and include mechanisms for ongoing dialogue already identified in the chapter on **Engaging with communities**, such as local programme committees.



14.2.4 Establish community-driven referrals and follow-up

Many people with severe mental disorders fail to come for formal treatment, or drop out of treatment, because of isolation, stigma,

fear, self-neglect, disability, poor access or because services are perceived as socially or culturally inappropriate (IASC, 2007). Once existing attitudes, sources of care and resources are well understood, it is possible for programmers to develop and agree on effective mechanisms to support people to access care.

Robust referral and follow-up mechanisms can be established with identified community personnel, including resource persons, traditional/hybrid and faith-based healers and other influential persons. Interventions may choose to establish more “formal” referral and follow-up mechanisms that are community-based but act as an extension of facility-based interventions: for example, health-care workers themselves, and trained community-based workers or volunteers providing home visits and/or supporting home-based care.

Two-way referral pathways (for example, community–facility and facility–community) can also be agreed upon with community-based resources, working with traditional and faith-based healing systems. Facility-to-community referral pathways are a necessary component of the mhGAP–HIG. Cross-cutting the treatment guidelines is the need to refer to community-based social or protection services; shelter; food and non-food items; community centres; self-help and support groups; income-generating activities and other vocational activities; and formal/informal education and child-friendly spaces or other structured activities (WHO and UNHCR, 2015).

Families, peers, and the wider community are also crucial points of referral, and are necessary for effective follow-up for those with severe mental disorders.

composed of a psychiatric nurse, a social worker and a driver, or similar professionals or activists who are appropriately trained and supervised. Team members are usually sourced from the affected communities and therefore can act as community catalysts for referrals. **These teams** may include translators or cultural mediators during migration crises. They are tasked with:

- (a) Identifying people with severe mental disorders;
- (b) Receiving referrals of people with severe mental disorders from the PMTs, families and/or other partners;
- (c) Facilitating appointments for people with severe mental disorders to the closest care facility, avoiding institutionalization to the extent possible, always preferring outpatient care, and limiting inpatient care to the minimum when the conditions of the client or the logistics of the movement do not allow outpatient care;
- (d) Following up with the client in the community, especially:
 - (i) Checking on whether medication protocols are being followed;
 - (ii) Supporting social needs through referral;
 - (iii) Supporting caregivers in their roles, through psychoeducation and counselling;
 - (iv) Making sure that a continuum of care is granted, linking the client and the caregivers with the various activities offered by the PMTs at recreational, socialization, artistic and counselling levels;
 - (v) Organizing peer-support for caregivers ((iii), (iv) and (v) are discussed further below).



The IOM **PMT model** should include, when resources allow, separate and dedicated Referral Teams. Referral Teams are usually

Box 61

People living in institutions in emergencies

Emergency contexts can affect the integrity of existing institutions. As the IASC MHPSS Guidelines highlight: “Some people with severe mental disorders living in institutions are (too) dependent on institutionalised care to easily go elsewhere during an emergency.”

In emergencies, those previously living in institutions may find themselves in the community once again. Key recommended steps from **Action Sheet 6.3** include:

- Make sure one agency takes responsibility, ideally in supporting the government, for supporting people living in institutions.
- If they remain open, protect the dignity and rights of the people there (see section 14.4.2.2) and ensure that ongoing basic health and mental health care is available.
- If temporarily closed (because of, for example, an earthquake) or abandoned by health-care workers, mobilize community resources by discussing with community leaders the responsibilities of the community in providing a supportive and protective network, which may include health-care workers, community health workers, informal health providers (such as religious leaders, traditional healers), social workers, community groups and family members.
- Provide these community networks with basic training and close ongoing supervision on, for example, crisis management and ethical use of constraints.

In certain situations, psychiatric institutions may remain open, even if damaged, and people with severe mental disorders, further excluded by long stays in these often-residential facilities, may remain to live in the damaged premises. As such, they will be in need of shelter, food, water, sanitation, clothing and essential medical and psychiatric care.

In Haiti, following the 2010 earthquake, residential psychiatric facilities physically collapsed, but a sizeable number of residents remained inside living in the ruins. Most service providers could not reach the facility for days. In such situations, IOM would consider the psychiatric facility area as a camp, extending to the residents all services provided in priority camps under the Camp Coordination and Camp Management Framework, until other more sustainable solutions are found.



14.2.5 Inform the wider population about the availability of services

For referrals, awareness must be raised with the wider community about the content and availability of services.

Community resources may be used in the dissemination of this information, as information coming from a trusted source is more likely to be believed and acted upon. In IOM, the dedicated Referral Teams can organize sensitization and information workshops, the PMT will provide this information during workshop and events, and clear information about existing mental health services for people with severe mental disorders will always be visible at the MHPSS hubs. More information on raising awareness and advocacy can be found in the **WHO mhGAP Operations Manual** (WHO, 2018e).

Box 62

Availability of services

Sensitization around the availability of services should be carried out with consideration to “supply” meeting “demand”, to avoid frustration and, more importantly, inconsistent access to treatment. Community- and facility-based approaches therefore complement each other.

14.2.6 Cover the full spectrum of MHPSS needs

In humanitarian settings, basic services, social structures, family life and security are often disrupted. People with severe mental disorders are often confronted with these extra challenges to their daily routines and basic self-care. The physical health needs of people with severe mental disorders can often be ignored, despite evidence that they can live 10–20 years less than the rest of the population (WHO, 2018a). Therefore, all layers of the IASC MHPSS Guidelines (IASC, 2007) pyramid are crucial to consider, and special considerations are likely necessary for the bottom layers – access to and social considerations of basic services and security, and strengthening family/community supports (which are largely community-based in approach) – to be adequately met.

The mhGAP–HIG highlights the need to support people with severe mental disorders to safely access services necessary for survival and for a dignified way of living – such as water, sanitation, food aid, shelter, livelihood support – through the following actions:

- Advise about the availability and location of basic services and security mechanisms;
- Advise about basic self-care (nutrition, physical);
- Actively refer and work with the social sector to connect people to social services (such as social work-type case management);
- Advise about security issues when the person

is not sufficiently aware of threats to security (WHO and UNHCR, 2015).

People with severe mental disorders may also require additional help to access culturally appropriate community and family support, which is well covered in this chapter. Participation in mainstream programmes should be enabled, and recreational activities, other sporting activities, and computer and literacy classes can be provided (UNHCR, 2018a).

The above should be supported by IOM PMTs for people with severe mental disorders, including through social work-oriented case management and referral to other activities organized by the PMTs. The IOM PMTs model should be tasked with making sure that a continuum of care is provided when linking client and caregivers with the various activities offered by the PMTs at the recreational, socialization, artistic and counselling level.

14.2.7 Actively involve community members in clinical intervention

A number of intervention models for severe mental disorders are community-based, actively involve community members and are appropriate for use in emergency settings. Three examples are given below with reference, where possible, to useful toolkits for implementation. In addition, please click [here](#) to know more on how to engage spiritual and traditional leaders in the provision of CB support for people with severe mental disorders.



14.2.7.1 Peer support

Peer support has been widely used in mental health, as it (a) creates a safe environment to freely express and share emotions and thoughts about one’s current situation and challenges; (b) allows one to learn from other similar situations; (c) creates the occasion to build new relationships and reinforce social support networks; and (d)

helps group members to access resources and support (WHO, 2017a).

For peer support groups for people with severe mental disorders, see [WHO, Creating peer support groups in mental health and related areas](#) (ibid.).

Individualized peer support is a form of one-to-one support provided by a peer with the experience of having a mental health problem and of recovery, to another peer who would like to benefit from this experience and support (ibid.). Guidelines for providing individualized peer support can be found [here](#).

UNHCR (2017) describes engaging individual refugees as volunteers to support other refugees. With adequate training, supervision and support, refugees can successfully provide culturally appropriate support, given their deep knowledge of their communities. The guidelines describe how “the engagement of refugees is also key to building their own self-esteem and dignity, and strengthens their ability to cope with their own problem”, and can be found [here](#).

Box 63

Cross-cutting issue – Stigma and discrimination

Community-level stigma and discrimination create additional barriers for people with severe mental disorders, with negative effects on their mental health. This stigma at times includes biased discourses that consider people with severe mental disorders evil, dangerous, criminal and so on. Since migrants and refugees are often stigmatized as such, severe mental disorders in refugees and migrants can cause stigmatization and prevent affected people and their caregivers from seeking help. One could have several strategies to combat stigma.

For guidelines around managing stigma, [The International Federation of Anti-Leprosy Associations](#) has developed [a series of guides](#) for managers, health workers and social workers, which have been applied for use in mental health.

Other strategies involve:

- Ensuring that community members are actively involved: As described throughout this chapter, this can increase understanding and produce more “mental health advocates”.
- Awareness-raising: [The WHO campaigns on depression](#) can be considered a valid tool in this respect.
- Involving people with lived experience of severe mental disorders.

IOM PMTs should address the stigmatization of mental disorders through:

- Including people with severe mental disorders in their [livelihood, sociocultural](#) and recreational and [sport and play](#) activities;
- Organizing anti-stigmatization campaigns and talks in the community, especially following reports or incidents of stigmatization;
- Ad hoc events, such as the celebration of Mental Health Day in Nigeria.

Sourcing team members from both the host and the displaced community can help incorporate local knowledge to address stigma and to avoid socially inappropriate discourses.

Box 64

Language and cultural considerations in specialized mental health care

Cultural considerations in globally recognized focused and specialized interventions must be strengthened, especially when working with migrants and displaced populations who speak different languages and come from very different cultural backgrounds. Models such as mhGAP, when culturally adapted in a country ([see the mhGAP Operations Manual](#) (WHO, 2018e)) will usually be adapted to the mainstream culture of that country, not considering the heightened cultural complications of working with minorities, subgroups and migrants who do not speak the local language or share the local culture. Those delivering focused and specialized interventions may not be equipped to appreciate that cultural expressions of mental disorder can vary and are easily misinterpreted, especially during emergencies, or to work through an interpreter–translator.

MHPSS programme managers should consider the following activities based on needs:

- Including a module, in coordination with WHO and UNHCR on working with migrants and in translation within the mhGAP–HIG trainings.
- Organizing short trainings in mental health and population mobility, and working with translators for existing mental health services in the referral mechanism: For training content, contact the IOM MHPSS Section at contactpss@iom.int.
- Training a group of migrants with knowledge of both the origin and the local language as mental health mediators: For training content, contact the IOM MHPSS Section at contactpss@iom.int.
- Adding a translator to the dedicated referral teams or directly seconded to mental health services mostly used by certain populations of migrants.
- Working with translators is neither easy nor neutral, and requires preparation and safeguards. For more information see [here](#).



14.2.7.2 Caregiver interventions

Families and caregivers are crucial to the well-being of individuals with severe mental disorders. Considering this crucial role, there is space to build their capacity around providing support. For reference, see WHO (2015b), [Caregiver skills training for the management of developmental disorders](#).

The UNICEF (2018) Operational Guidelines: *Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families* (field test version) and the UNICEF (2021) *Compendium of Community Based MHPSS Resources* also offers guidance for supporting parents and caregivers.

The tasks of dedicated referral teams within the IOM PMT model should include, when resources allow:

- Supporting caregivers in their role, through psychoeducation, support groups and counselling;
- Organizing individual and peer support for caregivers themselves.



In terms of support directed at the caregivers themselves, the mhGAP–HIG recommends the following steps:

- Ask the caregiver(s) about their concerns, capacities, physical and psychological well-being, and their own social support system.
- Give them information on relevant community services and supports, and discuss respite care (another family member or a suitable person can take over the care of the person temporarily).
- Refer them to PMTs to offer basic stress management, and encourage them to access their social support or, if needed, provide more focused support.
- Acknowledge that it is stressful to care for people, but stress to them that it is important to continue doing so (WHO and UNHCR, 2015).

Box 65

Peer support in Kenyan refugee camps

Previous patients of the hospital's mental health clinic signed up as “volunteer refugee workers” to support follow-up of current patients. They were of special value when individuals and families disengaged with treatment by making home visits to collect and address concerns, offer basic social and emotional support, and act as a bridge between the health facility and the community. They also served as a powerful “anti-stigma” tool by providing an example that individuals are more than their mental health condition, and that working productively and living well is possible.

14.2.7.3 Multifamily psychoeducation groups

One of the most promising evidence-based counselling approaches is the multifamily psychoeducational group. One example of this family and community resilience-based approach was implemented in post-war Kosovo¹ during the months following the cessation of conflict. The Kosovo Family Professional Educational Collaborative, a team of mental health professionals from the University of Pristina School of Medicine and the American Family Therapy Academy, developed a multifamily psychoeducational approach focused on allowing people with severe mental disorders to live in the community under the care and supervision of family members. The groups strengthened the capacities of families to care for members with severe mental disorders by helping them understand the nature of mental disorders and develop skills to provide home care. They also helped the families develop a support system by meeting with other families who were faced with similar challenges. The multifamily groups included presentations on psychiatric symptoms and the clinical course of chronic mental disorders, medication use and side effects, the role of psychosocial factors in precipitating or preventing relapse, responses to common problems and crises, and resilience-building approaches to severe mental illness. See [Weine, Ukshini, Griffith, Agani et al. \(2005\)](#) for further details on the group process and session topics.



14.3.8 Promote recovery at the community level

The meaning of “recovery” from a mental disorder can vary among different people. For many, it is

¹ References to Kosovo shall be understood to be in the context of United Nations Security Council resolution 1244 (1999).

not only about being “cured”, but about “regaining control of their identity and life, having hope for their life, and living a life that has meaning for them, whether that be through work, relationships, community engagement or some or all of these” (WHO, 2017).

Key components of recovery can include inclusion, relationships, meaning and purpose, dreams and aspirations, control and choice, managing ups and downs, and positive risk-taking (WHO, 2015c).

Activities that promote recovery may be most effective when delivered at the community level. Two examples are given below.

14.3.8.1 Vocational and economic inclusion

Different types of interventions that enhance vocational inclusion and employment are often labelled as “recovery-orientated” (Slade et al. 2014). **Livelihood interventions** have also been used for people with mental disorders.

WHO (2015c) concludes that recovery-oriented strategies enhancing vocational and economic inclusion should be contextualized to their social and cultural environment. For more information, [see here](#).

14.3.8.2 Independent living

People with psychotic disorders have a high risk of experiencing homelessness and housing instability (Fazel et al., 2008). The facilitation of assisted living, independent living and supported housing can act as a base from which people with severe mental disorders can achieve numerous recovery goals (Slade et al., 2014).

WHO (2015d) advises that interventions are culturally and contextually appropriate, consider local resources and local cultural norms, and involve people, their families/caregivers and wider community in their design and implementation. For more information, [see link](#).

FURTHER READING

Jones, L., J.B. Asare, M. El Masri, A. Mohanraj, H. Sherief and M. Van Ommeren

2009 Severe mental disorders in complex emergencies. *The Lancet*, 374(9690):654–661.

Tungpunkom, P.

2012 Life skills programmes for chronic mental illnesses. *Cochrane Database Systematic Review* (1).

Weissbecker, I., F. Hanna, M. El Shazly, J. Gao and P. Ventevogel

2019 Integrative Mental Health and Psychosocial Support Interventions for Refugees in Humanitarian Crisis Settings. In: *Uncertain safety. Understanding and assisting the 21st century refugees* (T. Wenzel and B. Drozdek, eds.). Springer, New York, pp. 117–153.

World Health Organization (WHO)

2018b *Mental Disorders*. WHO, Geneva.

For other references, see the full bibliography [here](#).

I. TECHNICAL SUPERVISION

→ 15.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

In IOM MHPSS programmes, “technical supervision” refers to bringing skilled supervisors, PMTs and other MHPSS teams together in order to reflect upon the work. It is a process of support and reflection, and is separate from managerial performance appraisal. It is about empowerment and relationship, not control. In this sense, it is different from the way in which “technical supervision” is understood in other fields, where it includes a component of monitoring programme standards.

The overarching principle guiding technical supervision in the field of CB MHPSS is that of improving the quality of the offered services and preventing harm to affected individuals and communities receiving those services, as well as to the staff involved. Technical supervision addresses the intersection of the personal and professional development of the **supervised staff**. Technical supervision must be coordinated and integrated with managerial supervision, in order to maintain a functional programme.

- Staff support: The MHPSS teams are given the opportunity to talk about their difficulties on the job. It is important to remember that, in emergencies, some MHPSS staff experience a formal role of helper for the first time. Even when they are experienced helpers, they are confronted with new factors, and are continually hearing stories of difficult experiences that are new to them.

Box 66

Staff care

Members of the MHPSS teams might be survivors themselves or might face contextual challenges similar to the ones their clients are experiencing. For personal support to the staff, supervisors should coordinate with the managers and the Staff Care Unit of the Organization. IOM staff can refer to the Organization’s Occupational Health Unit at swo@iom.int. Technical supervision is indeed an essential part of staff care, but it is not the only element of holistic staff care in emergencies, which is also based on human resources policies and personal support.

15.1.1 The objectives of technical supervision

Technical supervision pursues two main objectives:

- Professional standards: Supervisors assist the PMTs and MHPSS teams to learn from their experiences and to progress in expertise, as well as to ensure quality service provision to the individuals to whom they offer services. This includes both skill development and ethical accountability. This way of providing technical supervision is linked to individual staff well-being, and can help ensure better client outcomes.

15.1.2 Whom technical supervision is for

Technical supervision is necessary for both new and experienced MHPSS staff, ideally at all levels (service providers and supervisors themselves). Many staff are living a double role, being helpers (work life) as well as people affected by the emergency (personal life). Providing supervision at all levels ensures support to MHPSS teams and improves skill levels, but it also demonstrates a culture of learning and self-reflection when supervision is for everyone.

15.1.3 What technical supervision is about

In practical terms, technical supervision consists of MHPSS teams meeting regularly with a skilled supervisor to discuss individual clients, groups, community-based interventions and any other MHPSS activities they perform, in a **structured** way. It also includes on-the-job training. Supervision should be considered a mutual sharing of questions, observations and speculation to aid in the selection of alternatives to apply in practice. The MHPSS teams can bring up questions about the cases (which may be individual clients, families, groups or communities), or activities they are having difficulties with, and about how the assistance they are providing can be improved. Likewise, the supervisor can bring questions that can help the MHPSS staff to critically review and analyse what they are doing in their practice, with an aim to strengthen services. In addition, the supervisor will collaborate with the managers in designing a training plan for the team that results from the gaps and problems that emerged during the supervision.



More specifically, the supervision may focus on:

- The methods and modalities of the MHPSS work;
- Concerns the MHPSS teams have in relation to any aspect of an MHPSS activity;
- Lack of progress or difficulties with a case activity;
- Awareness of the potential impact of the MHPSS team members' personal values on their practice;
- Identification of any negative impact on the MHPSS teams from a case they are managing, and self-care strategies;
- Issues related to establishing and maintaining appropriate boundaries with the affected population;
- Issues related to team dynamics;
- Ethical and professional practice and compliance with codes of conduct;
- Professional identity and role development;
- Skill and knowledge development.

It is important to differentiate between technical support and personal support in the supervision process. It can still be helpful for workers to seek their own personal support, but it is important to be clear that the technical supervision process is related to work issues. This is due to a number of reasons, including respecting the workers' personal boundaries and avoiding dual relationships; the power dynamics of potentially fearing losing one's job due to personal issues; and the fact that staff care should be considered an organizational duty and not a responsibility of each project or programme, which may create an unequal offer of personal support opportunities among staff members working for different programmes in the same **mission**.



15.1.4 Technical supervision: What it is and what it is not

Figure 13 shows what technical supervision is and what it is not.

15.1.5 Requirements of technical supervision

The requirements of technical supervision include the following:

(a) Technical supervision is embedded in a culture of respect and support: It is important to clarify that the objective of supervision is grounded in the organizational responsibility to support the worker and the client in providing and receiving a service that is more likely to meet quality standards and avoid harm, rather than serving as a way to criticize or check somebody's work. Technical supervision, as pointed out before, inscribes itself in the broader context of staff care and staff development, which represent an organizational responsibility.

(b) Technical supervision provides a learning environment: It becomes by default a way to educate staff on the job in a participatory fashion. In addition, through the supervision, the technical supervisor can identify gaps in knowledge or skills that the teams need to fill, and suggest that management organize additional training or education accordingly.

(c) Technical supervision is a space to grant fidelity and innovation to the model: Supervision can ensure that the MHPSS teams provide the intended interventions. There are reasons that the intervention is structured the way it is, and it can be important for the worker to provide the essential components in specific ways. This is a part of ensuring the quality of services for the clients. However, it is also often necessary and helpful to adapt the intervention based on the client's needs or the MHPSS staff skills. If there are new techniques that the MHPSS staff members have learned or prefer implementing, or if there are

Figure 13: Yes and no of technical supervision

What technical supervision IS	What technical supervision is NOT
It should aim to create a safe place, where MHPSS staff can feel comfortable to talk about the technical aspects of their jobs, discussing freely any challenges they might be having. It should be a supportive and encouraging space that facilitates growth and allows mistakes.	It is NOT a performance management tool that will be used to evaluate performance in managerial terms.
It should be entirely dedicated to the technical aspects of the work and how they affect the staff well-being.	It is NOT a space spent on administrative issues and complaints such as pay raises, days off, disciplinary actions or deadlines.
It is time spent discussing the difficulties associated with the role of the MHPSS team members, especially for those cases where the professional side cannot be easily separated from personal issues, such as when a staff knows its clients privately outside of work. Technical supervision diminishes the possibility that difficulties and dilemmas will affect the personal well-being of the MHPSS team member.	It is NOT in itself a space to discuss personal issues that are unrelated to the cases or the MHPSS activities.

ways of acting within the community that they have been taught, technical supervision helps to ascertain that the learned services are correctly incorporated into the service or intervention. Additionally, technical supervision can serve as a place for feedback on the intervention model itself. The model can be questioned as to whether it is a true reflection of the needs encountered in the field, or if it is a best fit in the experience of the teams. This is an ethical dilemma that, if emerged, needs to be addressed at different levels, and in conjunction with feedback from the monitoring and evaluation system. The manager and the supervisor should establish a mechanism for feedback that is responsive to potential changes and can inform management decisions and future project development.

15.2 WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

Programme managers should address the following:

- (a) **Accountability:** Technical supervision should be kept distinct from management supervision. This means that, while designing a project, a position should be created for a technical supervisor. In IOM, the technical supervisor responds to but is distinct from the project manager. For some other agencies, often for budgetary reasons, this can be a unique professional covering the two roles. Supervisory sessions will also concern managerial aspects and administrative issues.
- (b) **International or national supervisors?** Depending on the size of the operation, the supervisor can be a dedicated international professional or a dedicated national expert, or a team of national experts. When the size of the project allows the hiring of an international expert, it may be good to pair him or her with a national expert who can bring a more culturally apt perspective to the supervision. Nevertheless, this cannot be the standard approach, because in some contexts – such as situations of civil and tribal conflict, conflictual community dynamics, or discrimination or mistrust within the community – PMTs and MHPSS teams may perceive an international supervisor as more neutral and trustworthy. In case the size and budget of the operations or other logistical constraints do not allow the deployment of supervisors, the option of **remote supervision** (for example, by Skype) should be considered ideally accompanied by an inception and closing face-to-face meeting. 
- (c) **One or more supervisors?** The principal supervisor can coordinate other technical supervisors who are more specifically competent in certain models or practices engaged by the programme. As already mentioned, the supervisor will collaborate with the managers in designing a training plan for the team that results from the gaps and problems emerged during the supervision. In this sense, he or she will support and coordinate the identified expert trainers in devising a contextualized **plan**. 

Box 67

How to structure a technical supervision meeting

Plan and notify in advance the supervision meeting, inviting the participants according to the chosen model – individual, group, peer – and the form, in person or remotely. In case of individual supervision, collect in advance if possible all the information about the case the psychosocial support worker wants to discuss. In case of group supervision, choose or verify that the location can be sufficiently spacious and free of distraction. Place a number of chairs in circle according to the number of the participants. In case of peer supervision, decide who is going to manage the flow of the meeting.

Physical set-up:

In case of individual supervision: A room, two chairs placed equally. In case of remote supervision, ask the supervisee to limit all distractions, and provide PCs, connection to the Internet and a Skype-like programme.

In case of group supervision: A room, chairs, white papers, a clipboard. In case of remote supervision, a widescreen PC, connection to the Internet and a Skype-like programme.

In case of peer supervision: It is the same as for groups.

Time required (approximately):

From a minimum of one hour to a maximum of two hours.

One time per week, or once every other week at a mutually scheduled, predetermined time.

Flow of the meeting:

The supervisor invites the participant or one of the participants to share the information about a work case in a narrative form. He/she then invites the participants to comment on what has been heard and provides comments on the roles and the actions performed, and the effectiveness of the choices that have been made, and proposes alternatives in a non-judgemental way.

Important concepts to maintain throughout the technical supervision:

- “Do no harm”;
- Non-judgement;
- Empowerment;
- Self-care.

Sample of a supervision session breakdown:

- Brief introduction of the supervisor and of the supervisees;
- Brief check-ins or small talk to create the atmosphere;
- Link to the previous supervision session, if necessary;
- Invitation to bring up a question, dilemma or specific work case;
- Invitation for the participant/s to comment;
- Paraphrasing what has been told;
- Evaluation of the actions taken;
- Proposition of alternative views and actions;
- Invitation to ask questions and answer the questions, promoting interaction;
- Recap of the most important points;
- Closure of the supervision session;
- Planning of the following session.

15.2.1 Modalities of technical supervision

Technical supervision must be flexible in order to meet the needs of MHPSS teams, also considering the different stages of their work experience. It can be provided mainly in individual or group settings:

- (a) Individual supervision: It can be offered at a regularly scheduled time, or when a specific need emerges for it. It gives full attention to the MHPSS worker and affords more time to discuss specific issues, particularly how a specific case affects the worker.
- (b) Group supervision: This is often offered at a regularly scheduled time. The entire supervised group is present, and the supervision is offered to all members of the group or, conversely, teams can be offered supervision being divided per location, or per role within the team (for example, counsellors by themselves, or educators by themselves). This allows the MHPSS workers to know what others besides themselves are also facing, and thus bring in the sense of confidence that he/she is not alone. Supervision provided in a group promotes peer learning and support.

Box 68

Technical supervision of PMTs in IOM Nigeria

In north-eastern Nigeria, technical supervision is provided to IOM MHPSS mobile teams on a weekly basis. Due to the large number of MHPSS teams, with 120 members deployed in three of the most affected states – Borno, Adamawa and Yobe – technical supervision is provided by one international and two national MHPSS specialists. Standardization and the quality of the supervision among the supervisors are ensured by the international supervisor, who has the role of supervising the other supervisors, with support from the MHPSS programme manager, who is an experienced MHPSS expert. Technical supervision is also offered by IOM specialized staff or expert network on specific themes or models of work, upon request of the MHPSS supervisor.

The supervision sessions are provided on a weekly basis (every Friday) for a period of two to three hours, depending on the number of team members involved in the specific session, and the relevance of the issues presented or raised for discussion by the teams or the supervisors. The location is usually an IOM office meeting room, where flip charts, markers, paper and notebooks are available to facilitate the discussion.

The supervisor starts the session by emphasizing self-care, confidentiality and “do no harm” principles for the discussion. He or she then introduces and explores the main subject of the session, which can be a case, an activity or a dynamic that emerged the prior week. The subject of the session is chosen by the supervisor based on the written reports received the week before from each team. On some occasions, the same subject can take up to three supervisory sessions. In this case, the team members provide an update on how the issue is progressing, also based on changes implemented based on the supervision. Staff members are asked to prepare the discussion of the cases–activities beforehand, in order to maximize the support they can receive. The session has plenary and group work components, and sensitive issues may be further discussed in smaller groups. This forum is important for all teams to interact, learn, suggest alternative views and enhance their skills. A part of the session is dedicated to feedback on main challenges faced in the field the current week. A recap of the main points discussed and a few updates close the session. Skills gaps and training needs are identified by the technical supervisors, discussed every third session with the teams, and then shared with the programme manager to inform training plans.

- (c) Peer supervision: This is a form of supervision where the participants have the same role and approximately the same expertise. The group is not directed by a supervisor and so this kind of supervision works well with “mature teams” that have worked together for a certain period. It should never be the first choice, as individual and group supervision are to be preferred for the first stages.
- (d) Remote supervision: Although face-to-face clinical supervision is the preferred method of delivery, other methods of clinical supervision delivery – including email, video, audio recording or teleconferencing – may be employed where necessary. The use of these alternative methods may be particularly necessary for MHPSS teams working in rural and remote locations. The frequency of remote supervision sessions should be the same as in the face-to-face modality.

Box 69

Remote supervision

In case face-to-face supervision is logistically impossible, or additional supervisors who are located elsewhere need to be consulted, remote supervision by Skype, phone, Zoom, or other internet-based solutions, can be offered as a viable alternative.

15.2.2 Frequency of technical supervision

Technical supervision should be offered at the following frequency:

- (a) Individual supervision: At a regularly scheduled interval, and/or every time a need emerges. Duration: 1–1.5 hours.
- (b) Group supervision: Every week at the beginning and every second week after the initial phase. Duration: 1.5–2 hours.
- (c) Peer supervision: It is up to the group to choose the frequency of what can also be

termed “intervision” meetings. It is suggested at least every second week. Duration: 1.5–2 hours.

15.2.3 Competencies of technical supervisors

Becoming an effective and fully competent technical supervisor is a developmental process. The competencies of supervisors must include:

- Skills:
 - o Demonstrated mastery of the intervention being provided;
 - o Communication;
 - o Conflict resolution;
 - o Group facilitation;
 - o Supervision techniques;
 - o Team-building;
 - o Development of the supervisory relationship;
 - o Responsiveness to changing needs of supervisees;
 - o Compassion and supportiveness.
- Knowledge:
 - o Group dynamics;
 - o Ethical regulatory issues;
 - o Evaluation tools and processes;
 - o Supervision methods;
 - o Conflict resolution and facilitation;
 - o Self-care competences.
- Attitudes:
 - o “Do no harm” approach;
 - o Non-judgmental;
 - o Empowering and strengths-based;
 - o Patient and empathetic;
 - o Open to receiving feedback;
 - o Open to **improving skills**.

More specifically, a technical supervisor in the MHPSS field should know how to leverage diversity to be able to create an inclusive environment, manage conflicts in order to keep people in dialogue as means to build trust and unity, and balance between methodological adherence and emerging needs.



15.2.4 Supervision approaches

In the context of community-based projects, two efficacious supervisory approaches are:

(a) Systemic supervision is based on the system approach to supervision, which is derived from social work models of supervision in non-humanitarian settings. It identifies different dimensions of supervision:

- The supervisor;
- The supervisees;
- The organization;
- The affected population;
- The supervisor's functions;
- The learning tasks of the supervisees.

The model encourages supervisors to recognize and to show the supervisees the importance of cultural factors, and draw attention to how they interact with other contextual factors. The supervisor's main tasks are:

- Technical counselling;
- Case conceptualization;

- Supporting in finding a solution;
- Instructing and advising;
- Consulting and exploring.

During the supervision session, space is given to sharing beliefs, feelings and thoughts of the supervisees, and to the search for practical solutions to concrete issues. For a theoretical view of the system approach to supervision, see the book *Clinical Supervision Essentials*.



(b) Consensus methodologies build on the awareness that valuable knowledge is gained by supporting the reflection process of professionals. It is based on experiential, reflective learning as an important source for developing professional expertise. This form of supervision is valuable for more mature groups, and is not the first option. See a case study on best practice in care and protection of children in crisis-affected settings.



15.2.5 How are the supervisors trained and supervised

The supervision of supervisors assists technical supervisors to meet their learning, accountability and support needs. It should be provided by one or more individuals who have a high level of demonstrated competence in the contents of the programme as well as in the provision of practical supervision. In IOM, technical supervisors are managerially accountable to the project managers of the relevant MHPSS project, who are technically accountable to the global MHPSS Section, which will provide supervision directly and through referral to its international expert network.

PMT leaders can be trained by technical supervisors to supervise the teams more closely at the field level, especially in areas where access is limited. The technical supervisor tasks include the identification of the training needs of team leaders and the organization of **training sessions** for them.



Box 70

Systems model of staff stress management

Humanitarian work presents an array of different stressors. There are inherent stressors reflecting the content of the work, such as exposure to gruesome sites, onsite dangers, and powerlessness in not being able to apply the level of help needed. Non-inherent stressors occur at the team and managerial levels, including: lack of skills or training needed to do the job, poor role definitions/unclear expectations, unnecessarily bureaucratic agency policies, and conflict and mistrust within the team. Particularly, national staff commonly work at the intersection of these multilevel stressors, which often remain overlooked by the organizational strategies. Thus, in order to address these various levels of stressors, a non-traditional stress management model is needed that looks beyond individual self-care. The systems model of staff stress management is both systematic and multisystemic, focusing on building resilience across three dimensions. The first dimension builds a response across all the stages of stress over time: prior to the stressor occurring, when it occurs, and after the stressor has ended. This response may work to prevent or reduce the intensity of the stressors through decreasing workloads, reduce the vulnerability through training workers or developing team cohesion, and improve coping mechanisms. Second, the model works to build resilience across all socioecological levels – individual, family, team, agency and the larger community – as a systemic policy, not just a series of actions. The third dimension of stress and risk reduction applies to those working on interventions at each phase of deployment, including careful staff selection, predeployment training, in-field support, transitional support, technical supervision and follow-up support postdeployment. Technical supervision is a part of a systems model of staff care, but only a part of it (Saul and Simon, 2016; Antares Foundation, 2005).

Figure 14: Systems model of staff stress management: Dimensions



II TRAINING

→ 15.3. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

The subjects of specific training programmes related with each of the activities presented in this manual are discussed in the respective chapters. This chapter will instead describe the process of designing trainings within a CB MHPSS programme in IOM. Training is a necessary component of a CB MHPSS programme in any emergency situation. This is true on the short term, since people in emergency are usually asked to respond to situations that are novel to them, and that challenge their existing capacities. In addition, in the specific field of MHPSS, the emergency may catalyse needs and therefore may require capacities that were not present altogether before the crisis took place. In order to be able to respond with quality, helpers, including those with MHPSS functions, often need training and technical support.

Training and capacity-building offered during the emergency phase are a programmatic necessity on the short-term, but they do provide the nexus between emergency humanitarian response, preparedness and long-term development, because they create skills that can be reactivated on the mid-term, and contribute to the overall resilience of a community, including long-term mental health system strengthening. Training indeed focusses on supporting the agency of affected people. The success of an international CB MHPSS intervention in an emergency is determined by the quality and scope of technical knowledge and support the relevant programme is able to provide to local formal and informal respondents, both those employed or engaged by the organization's MHPSS programme, and those in the larger community of practice.

Training can indeed play a double role in CB MHPSS programmes. From one side it is addressed to those working on the programme, being part of the organizational implementation process; on the other, training addressed to external actors can be a programmatic activity or a specific deliverable of the programme.

Process training that is part of the process of implementing a CB MHPSS programme include:

- Training for the staff of the programme;
- Training for other units of the organization, whose job is connected with the CB MHPSS one;
- Training for implementers and partners on how to (better) perform activities to deliver under the programme;
- Training for the sector under which the programme is implemented;
- Training for the technical supervisors;
- Training for MHPSS programme managers.

Training that is delivered as an activity or a deliverable of the programme, includes, for example:

- The organization of Master's, Diploma, Certificate programmes on MHPSS related disciplines and capacities for a wider community of practice in a country;
- The organization of trainings in a certain counselling method, in a psychological intervention or an art-based MHPSS technique, to enhance the general capacity of a community to respond to a situation;
- MhGAP **trainings** for health workers in certain areas;
- **PFA trainings** for professional associations or humanitarian sectors not directly involved in the programme activities as agents;
- Transcultural trainings for psychiatrists in high migration or high displacement areas.

This differentiation is not necessarily rigid.



Internal trainings for the staff of the programme can be opened to the staff of government institutions, partner organizations, civil society actors and activists, whenever this is appropriate, reaching a wider impact. Likewise, trainings implemented as an activity of the programme can involve a defined number of internal MHPSS programme staff on top of the external participants, enhancing the programme's capacity to respond.

Process trainings tend to be focused on the capacity-building necessities of a programme as it was designed, while trainings as programme activities are designed to reach a wider capacity-building objective aimed at covering important capacity gaps in the countrywide MHPSS response systems, identified through needs assessments and mapping.

Of importance, a community-based approach to training in MHPSS does not aim to impose hierarchical practices or ready-made tools, but to create new models of collaborative intervention between the organization, the expert trainers and the students-practitioners, that need to be participatory and adapted to the specific situation. Local, community-based ownership and a sustainable approach stem from this basic model of work.

The range of what is usually included under the vast definition of training goes from inductions lasting a few hours, aimed at passing essential procedural, professional or academic information; to Executive Master programmes, that engage participants for several months on a subject matter, building their skills, understanding and capacity to operate in a specific technical domain of MHPSS.

It is impossible to account for all the modalities of trainings one can employ in a MHPSS programme in this manual. These will be largely determined by a combination of various factors including duration, scope, available resources, existing skills on which the training builds on, and others. In general, it is important to be

aware while designing MHPSS programmes of the relation between training objectives, methodology and duration. For instance, if one works in a locality where no one has ever been trained in MHPSS-related disciplines and no foundation skills exist, and programme resources allow to organize one day of training only, then this can be a training on PFA, but not on counselling skills. Yet, if the programme aims at providing counselling services in the same situation, then proper, longer-term training should be included in the programme design. Moreover, trainings that aim at passing skills to be duplicated or employed directly in the field need to always be organized in 3 steps:

- (a) Passing of information-knowledge-procedure;
- (b) Testing the acquired skills in a protected space, which can be done through simulations, role plays, intervision or others;
- (c) Testing the acquired skills in the real world, under supervision.

This is valid for all trainings of the sort, no matter how short/long and how focused/general they are.

For IOM, trainings both for internal MHPSS staff and for external students and experts follow this logic, whereas point (b) is resolved with the teaching methodology and point (c) by technical supervision for internal staff, and mentoring and supervised fieldwork for trainings offered to the wider community of practice.

On-the-job training, due to the specificities of an emergency situation, can be the most efficacious way to build capacity without slowing down the response. This is a training that is provided during working hours, with the trainers joining the teams during field activities. Even on-the-job training, however, should encompass the three steps to be efficacious and safe.

In terms of process training, such as training for the staff and functions of a CB MHPSS programme, the scope of training will be inversely proportional to the foundation skills

existing in the given emergency context. As mentioned, in some situations the programme will need to create the foundation of certain skills in its staff, while in others, staff may be already proficient and training will be mainly dedicated to harmonization of practices, extra skills and emerging needs identified through technical **supervision**.

The following chapter will give practical indications on how to organize both process training and activity training within a CB MHPSS programme.

→ 15.4. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

15.4.1 Mapping and partnership

Assessment and mapping should include an evaluation of existing capacities and gaps, including existing training needs and training resources in the country in the various facets of a MHPSS **programme**. The resulting analysis will help in determining:

- The expectable capacities of the PMT members, and their training needs;
- Existing training capacities in the country, mapped versus needs;
- Identify which training capacities are lacking in the country;
- Budget the training accordingly in project planning;
- Identify trainers and supervisors.

15.4.2 Process training

15.4.2.1 Training for the staff of the programme

Based on the existing foundation skills of the staff members and the PMTs, a training plan will be envisaged for the staff. In addition to weekly technical supervision, the staff will be trained monthly, first on a core curriculum established at inception, and afterwards to respond to emerging needs identified through the technical supervision sessions. The monthly trainings will be provided either on the job or in the form of a workshop, and will be delivered by national or international trainers, in coordination with the programme manager and the technical supervisor. Trainings will be organized for all the staff, or with a differential approach, in which members of the teams can be grouped and trained by function (all counsellors, all community mobilizers, etc.). More information on essential training can be found in the chapter on **Psychosocial mobile teams**. More information on additional trainings on specific activities can be found in the respective chapters.

15.4.2.2 Training for other units of the organization

This is specific to each organization. In IOM, MHPSS programmes aim to train:

- Colleagues working in DTM in PFA;
- Colleagues working in **Livelihood, Protection, and Conflict transformation** in subjects identified in the relevant chapters;
- Colleagues working in Health in subjects identified in the chapter on **Community-based support to people with severe mental disorders**;
- For colleagues working in CCCM, see paragraph **15.4.2.4**.

The MHPSS programme managers will liaise with their counterparts in other units to organize

these trainings, including resource mobilization. Trainings can be conducted by members of the MHPSS teams. For further guidance on contents, contact contactpss@iom.int.

15.4.2.3 Training for implementers and implementing partners



As already described in the chapter on **PMTs**, whenever institutions, civil society or professional groups exist that can perform the functions inherent to the work of PMTs, they should implement the activities and IOM or other agencies should support their work. The support shall include technical supervision and training, based on gaps in their capacity participatorily identified during the mapping, and training needs emerging through the work and the technical supervision. The process will be the same used for the training of the PMTs, and logistics and priorities will be coordinated with the leaders of these groups.

15.4.2.4 Training for the sector under which the programme is implemented

In several emergencies, IOM leads the CCCM cluster. Naturally, a MHPSS programme implemented by IOM will support the CCCM cluster actors and the sector in many ways, including referral, exchange of information, liaison between the CCCM cluster and the MHPSS working group, and in training. In particular, the IOM MHPSS teams will train CCCM actors and camp managers in:

- PFA. A special PFA training package has been elaborated for CCCM actors and can be received from contactpss@iom.int;
- Active listening, supportive communication and non-violent communication and mediation. A relevant training module is included in the core CCCM training, and can be received writing to contactpss@iom.int or globalcccm@iom.int;

- MHPSS essential knowledge for CCCM actors, based on the booklet linked [here](#).



IOM or other agencies may operate under other sectors. Training packages and resources can be found organized per sector in the IASC associated entity MHPSS RG and on mhpss.net, the online platform for MHPSS practitioners that can be joined subscribing free of charge clicking [here](#).



15.4.2.5 Training for the technical supervisors and the MHPSS programme managers

Technical supervisors and MHPSS programme managers need also to be trained, at inception and throughout implementation. As for inception trainings, IOM, in collaboration with the Scuola Sant'Anna di Studi Accademici e Perfezionamento in Pisa, Italy, has organized a yearly Summer School in Psychosocial Interventions in Migration, Emergency and Displacement for the last nine years. The summer school includes 100 hours of teaching over 12 days, a final exam, and grants 5 academic credits. It is primarily meant to serve the IOM MHPSS programme managers and technical supervisors, but offers 20 seats to managers and supervisors of other organizations as well. The subjects of the training reflect the ones of this manual, with a more critical, research-oriented and academic approach, although remaining quite practical. The School has graduated 210 students from 45 different organizations.

The Psychosocial Training Institute in Cairo organizes training courses more oriented towards urban displacement and NGO work, which can also be used by organizations to give solid inductions to their teams.

Other offered courses can be found on the dedicated section of mhpss.net.



15.4.3 Trainings as deliverables of programmes



Initial assessment and **mapping** should be analysed to identify capacity gaps in country or subcountry MHPSS systems, and trainings can be envisaged as programmatic actions with an aim to cover these gaps and be able to provide a more quality response. In addition, a community-based approach implies the mobilization of existing formal and informal sociocultural activity groups, artistic, interest and sport groups and individual artists, sportsmen, religious and traditional leaders and activists to respond to specific MHPSS problems, or to promote social cohesion, with explicit psychosocial objectives. In this case the programme should support trainings for the identified resources that could support them in giving a new focus to their activities in a safe and quality fashion.

In this second case, the approach will be a bottom- up one. Artistic, sociocultural and other resources will be identified. When a critical number of committed professionals, activists or artists is brought in, specific trainings can be organized for them in:



- Facilitation of support groups or peer support **groups**.
- More specific psychosocial skills related with their own function-skills, such as:
 - o Social theatre trainings for performance artists;
 - o Elements of art-therapy for visual artists;
 - o Trainings in coaching skills, both technical and psychosocial for animators of sport groups;
 - o And so on.

The trainings will be organized:

- For people that are interested and have proved to have a sincere interest in helping others and switching the focus of their activity;

- When a critical number of people is identified. This will help not only to be cost effective, but to focus on activities that are likely to be more popular or more culturally meaningful in a specific context;
- When trainers and supervisors are available.

They will follow the usual organization in three steps, and will include supervision.

For further information, see the chapters on **Sociocultural activities, Creative and art-based activities, Sport and play**.



15.4.3.1 Counselling skills and psychological interventions training

The assessment and mapping may indicate that there is a lack of qualified provision of counselling or psychological therapy or psychological interventions. To respond to such a need, there could be two options, each presenting a trade-off.

One possibility is to train people in brief psychological interventions, like **PM+**, so that a sizeable number of responders can be deployed and mobilized in a relatively short-time to provide an evidence-based service.



The other is to engage a number of individuals with the right attitude and ethics in a mid-term capacity building in the foundation of counselling and psychological care. This will allow professionals to be more versatile and comprehensive in their provision of care, but their training will be completed in a much longer period of time.

IOM favours investing in foundation courses that build broader skillsets, rather than focussing on relatively shorter trainings focussing on brief interventions or a precise model only, in situations where foundation courses do not exist. The counsellors in training will still be able to provide services in a gradual fashion thanks to on-the-job trainings and technical supervision,

while building a more solid and flexible base of competences, likely to be more sustainable in the long-term. For more information, see the paragraphs on trainings and adaptation of the chapter on **Counselling**.

the field and to be supervised in their fieldwork.



15.5. CASE STUDIES

15.4.3.2 Academic professional courses

One main feature of IOM CB MHPSS programmes has been the organization of executive Master's, Diploma or Certificate courses on psychosocial approaches to population mobility in low-resource or crisis-affected countries and communities. These courses have taken place from the Balkans to the Middle East and to South America, being adapted to the specific needs emerged during the assessment and mapping, and the cultural, social and political conditions of the context. They are designed in collaboration with national universities, respecting the requirements for accreditation. They are organized every second weekend, as they target professionals already providing critical services in the field for governments, agencies, and civil society groups. The courses are free of charge, and students are selected through a competitive process that evaluates, inter alia, the impact the applicants can have on shaping the provision of MHPSS. Pedagogically, they are organized in lectures, participatory and interactive workshops, simulations and supervised fieldwork. The courses, no matter their main MHPSS subjects, always promote a systemic approach that will help the students to comprehend and manage the complex interactions between the geopolitical, historical, inter- and intra-personal, humanitarian, communitarian and cultural/sub-cultural systems. The courses are functioning as a space for dialogue between international experts identified by the IOM's Mental Health, Psychosocial Response and Intercultural Communication Section, national academic experts brought on board by the national university and field practitioners. They respond to an identified urgent capacity need, build on preparedness and development, and allow participants to keep on providing services in

15.5.1 Case study for process training: The experiences of the Psychosocial Training Institute in Cairo (PSTIC) in urban settings.



Models of MHPSS intervention are most effective when culturally and contextually designed in response to the needs and problems of a population. PSTIC operates mainly in Cairo, in Egypt. Egypt is home to 240,000 refugees and asylum seekers from 58 countries. Most live in Cairo, the capital city, intermixed in urban neighbourhoods alongside 22 million Egyptians. Most refugees must support themselves. The quality of life common to the poorest Egyptian is amplified for refugees. Neighbourhoods and public health and education facilities are impoverished and overcrowded. The cost of living is higher than the daily wage. Refugees dream of resettlement yet few leave. Most live for years in poverty, feeling unsafe with few future opportunities. PSTIC has crafted an urban model in which a network of well-trained refugees offer community and home based MHPSS care 24 hours a day, 7 days a week.

The PSTIC team is a multilingual-multicultural-multidisciplinary network of workers from several countries; 90 percent of them being refugees. PSTIC targets the most vulnerable, especially those who do not seek facility-based care. No one is refused services and all efforts are made to assist – refer to other organizations – or, when nothing is available, just encourage those in need. Supportive services are offered at all layers of the Interagency (IASC) Standing Committee Guidelines for MHPSS in Emergency Settings intervention pyramid. This includes a 24 hours a day, 7 days a week helpline answered by a team available to give information and respond to any emergency; a roving multilingual

team, which shares information daily in community sites; support to secure and safe housing; advocacy when seeking health care especially during emergencies; and advocacy for those detained. In addition, professionally trained refugee Psychosocial Workers (PSW) work alongside their communities to provide case management, individual, family and group psychosocial support and counselling, problem solving and mediation; accompaniment and referral to other services. Finally, Egyptian psychiatrists work alongside the refugee team 24 hours a day, 7 days a week to ensure the combined psychiatric and psychosocial support needed for acute and chronic mental health care.

Few PSW join PSTIC with prior MHPSS training. PSW are carefully selected from their communities based on personality traits and their prior commitment to assisting others. Before beginning to work, they complete 5 weeks of daily training whose content starts with ethics and includes essential psychological, social and health knowledge, practical development of helping skills, and work skills such as time management. After this, training and skill enhancement continues weekly. PSW also have individual and group supervision. Each worker is part of a small multinational team lead by a senior refugee worker and a psychiatrist. The team meets weekly to review challenging cases and issues in an open and safe learning environment. A few essentials are necessary: Commitment to the care of refugee workers includes ensuring they are paid; a work environment that allows for open sharing about the complicated dual allegiance for community workers to their communities and the organization; and continual activities that encourage team building and self-care.



To know more, find a webinar slideshow [here](#).

15.5.2 Case study of training as programme activity. The executive Masters in Psychosocial Support and Dialogue in Lebanon.

In 2013, the organization devised a programme to respond to the psychosocial needs of Syrians residing in the Syrian Arab Republic and decided to focus the intervention on the capacity-building of local psychosocial practitioners responding to the crisis. Among different initiatives IOM designed, a one-year Executive Masters programme in 'Psychosocial Support and Dialogue' for Syrians was developed at the Lebanese University after several consultations with Lebanese colleagues and groups of Syrian practitioners. The programme was set up for two generations of students. In 2017, a similar but shorter course was organized in Turkey at the Social Sciences University of Ankara (ASBU) for Syrian and Turkish professionals working with Syrian refugees in the country.

For the background and the structure of the course, read the introduction of this [publication](#).

For the description of the modules and a sense of the background and professional affiliations of the participants, see this [video](#).

For the description of the main themes of the fieldwork of the two editions of the programme in Lebanon, read [here](#).

To read the best 4 fieldworks of students of the course in Ankara, read the dedicated section of the number of the review Intervention hypelinked [here](#).



15.6. CHALLENGES AND CONSIDERATIONS

For technical supervision, if the roles of the supervisor and the manager overlap, issues of power and accountability can prevent a fully free supervisory process. It can help in

facilitating matters to establish a clear set of boundaries at the very beginning of the supervision process, and to tailor contents of the supervisory sessions on the possible related shortcomings. However, as a best practice, the two positions should be kept distinct.

The different roles of manager and technical supervisor, and their respective boundaries, need to be clearly defined and communicated to avoid confusion and overlap.

For both technical supervision and training, programmes may not be funded, or not funded enough, due to donors' rules. Indeed, these are not considered as life saving emergency response activities and therefore may be excluded from funding, no matter the size of the programme. This creates a situation where an agency is asked to respond on a large scale, but will never be able to grant quality and minimum standards of intervention. This problem can be solved by enlarging the pool of donors and stressing the emergency-development nexus, while reducing the costs of training and supervision mapping national and regional trainers.

Another challenge in training is posed by the short duration of emergency programmes and often, the inability of the project manager to foresee incoming funds. This can bring to a fragmentation, that if not probably accounted for in planning can lead to frustrations. It is therefore recommended to plan trainings based on their maximum duration in relation to the life of the programme, and adapt training objectives accordingly.

FURTHER READING

Bragin, M.

2012 So that our dreams will not escape us: Learning to think together in time of war. *Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals*, 32(2):115–135.

Haans, T., J. Lansen and H. Brummelhuis

2007 Clinical Supervision and Culture: A Challenge in the Treatment of Persons Traumatized by Persecution and Violence. In: *Voices of Trauma* (B. Droždek and J.P. Wilson, eds.). Springer, Boston.

Sangath and London School of Hygiene and Tropical Medicine (LSHTM)

2013 *The Premium Counselling Relationship Manual*. LSHTM, London.

For other references, see the full bibliography [here](#).



16. MONITORING AND EVALUATION



➔ 16.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Monitoring and evaluation, currently conceptualized as monitoring, evaluation, accountability and learning (MEAL) (Sphere Project, 2015), are integral to any community-based MHPSS programme in emergencies. A community-based and participatory MEAL process brings programme managers, staff, community leaders and programme participants and clients together to ensure effective programme performance. It strengthens the ability of MHPSS programme managers to reflect thoughtfully on their work, to be sure that it is completed as intended, and to be clear as to whether and how it met expectations to improve MHPSS in affected communities. This process should allow for changes in activities and programmes, and support community learning about effective interventions for MHPSS, during the emergency and afterwards. Such a process creates additional opportunities for community ownership and accountability to accompany institutional learning at the design and implementation levels.

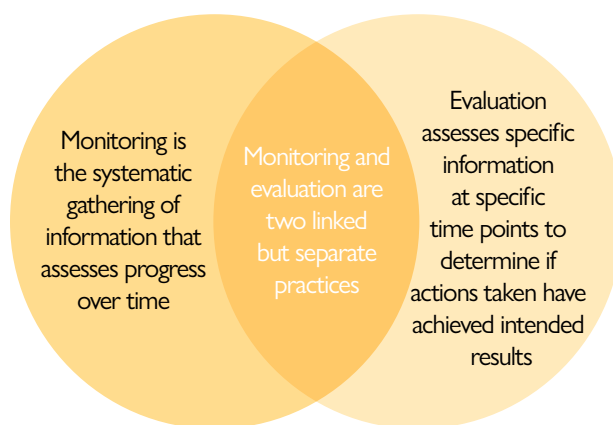
 The aim of this chapter is to introduce the concept of **community-based** and **participatory** monitoring and evaluation in MHPSS programming, and clarify its essential role in reviewing needs, resources, socially and culturally adequate strategies of implementation, and objectives in the rapidly changing environment of humanitarian emergencies, taking into account that communities are not **homogeneous**.



Monitoring and evaluation are distinct but interrelated processes. In *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007), they were identified as an essential part of MHPSS programming in emergencies. Action Sheets 2.1 and 2.2 should be read along with chapter 3 on **Assessment and mapping** of this Manual as an introduction to this chapter.



Figure 15: Monitoring and evaluation



Source: IASC (2017).

Monitoring and evaluation is applied to the following project components:

- Project inputs: Funds, materials, equipment, staff and other resources “put in” to carry on project activities.
- Project outputs: The activities achieved or “put out” in the process of implementing a project (such as training session for staff or improved access to services or facilities) that show that operational plans are on track.
- Project outcomes: What “comes about” during the course of a project as a result of the achieved outputs.
- Project impact: A lasting change in individuals, families and communities that results as a consequence of the project.

16.1.1 What monitoring is

Monitoring is the systematic gathering of information that assesses programme progress over time (IASC, 2017). Monitoring compares intention to results (Sphere 2018). During a humanitarian emergency, even the best assessment and programme design cannot perfectly predict emergency-related changes in circumstance, the difficulties of implementation in specific places,

or any other complications in programme actualization. Community-based and participatory monitoring provides the mechanism for learning, contextualization and adapting programmes throughout the implementation (Sphere, 2018).

16.1.1.2 Why monitor MHPSS programmes

We monitor for two things; process (are we implementing correctly in the specific circumstances?) and results, (is what we are doing working?) In addition, people implementing programs will want others to witness and recognize their work, and help make corrections when needed. Programs can then be modified to be sure that they do in fact address the issues at hand, as experienced in the local context.

16.1.1.3 When to monitor MHPSS programmes

Monitoring is an ongoing process, but a good rule of thumb can be to monitor after 30 days to learn whether and how implementation is possible, and what needs to be addressed; 60 days to see if things have begun and again what issues need addressing, and then at 90 days and every additional 90 days until the program's end.

16.1.1.4 Community-based participatory monitoring

Monitoring can occur through a method called community-based participatory monitoring and evaluation, which provides the mechanisms for learning, contextualizing, and adapting programmes throughout implementation (Sphere 2018). This process can include the following activities:

- Discussions with project management and staff;
- Observing the project activities while they are happening;
- Listening to programme participants about

their experience of the programme in focus group discussions;

- Engaging with community representatives in focus group discussions;
- Seeking out community representatives of groups who may not be participating to be check on inclusion and exclusion;
- Developing a monitoring “grid” complete with indicators for each project objective and and holding a meeting with beneficiaries at each point to chart progress.

Click [here](#) for an example of one such chart. After charting the results, the participants can evaluate for themselves whether the group is “on the right track.” Are the actions they are taking really improving their sense of psychosocial well-being? Are these changes having any negative effects on their well-being? If so, can they be corrected?



16.1.1.5 Questions addressed by community-based participatory monitoring

Community-based and participatory monitoring addresses the following questions:

- Is the programme being implemented as planned after the participatory assessment?
 - o If not, what are the obstacles?
 - o How should they be addressed? Need the programme be further contextualized?
- Are all of the intended affected populations being reached?
 - o Who is being excluded? Why?
 - o How can the programme bring in additional marginalized populations?
- Have the circumstances of any given population changed significantly?
 - o What adaptations are needed to operate in these new circumstances?
- Are the needs, resources and methodology of intervention identified at assessment still relevant to the psychosocial well-being of the affected

individuals and communities?

- o Do the proposed activities still seem likely to improve their psychosocial well-being and social relations?
- What are the unintended negative consequences to date?
 - o How do they affect the populations' well-being?
 - o How will the programme address these?
 - o Is there a functioning and transparent grievance mechanism?
- Is inter-agency coordination proceeding as planned?
 - o If not, what adjustments are necessary?
- Are staff members performing according to standards, and are self-care programmes and measures available?
 - o If not, what adjustments are needed?
 - o Recognize and support the positive efforts of staff, participants, and community members.

With these questions answered, monitoring information can guide programme, project, or intervention revisions, verifying target criteria, and confirm that the intervention is reaching the people who need it (Warner, 2017).

16.1.2 What evaluation is

Evaluation is a systematic and objective assessment of the design, implementation and results of an ongoing or completed intervention, project, programme or policy (Sphere, 2017). Evaluation refers to the process of examining a programme at specific points in time, minimally at the beginning, then at the middle (if possible), and after completion to see if it achieved the desired results as determined in the assessment. Engaging community members and programme participants in the evaluation process ensures their inclusion in learning. In MHPSS programmes, IOM, from a technical perspective, evaluates outcomes and, when possible, impact:

- Outcome evaluations assess the effectiveness of a programme in producing change.

They ask what happened to programme participants and how much of a difference the programme made for them. They are conducted at midterm and again at the end of a project of intervention.

- Impact evaluations attempt to measure if the project promoted lasting positive changes in the participants' mental health, psychosocial well-being, attitudes, behaviours and social relationships.

Box 71

Questions that IOM evaluations of MHPSS programmes try to answer

- How was the programme delivered? Which processes contributed to positive and negative effects?
- Which internal and external factors intervened to affect (positively and negatively) the impact of the project?
- Was the integration of specialized services provided by the project effective in stabilizing, treating and preventing mental, neurological and substance use disorders?
- Did the project improve and activate resilience, promote inclusion, facilitate positive human connections, and restore agency, self and community efficacy, and hopefulness to individuals, families and groups at each targeted level of the pyramid?
- Did the project enhance the protection of persons in institutions or segregated at home, in tents or in camps?
- What are the most relevant good practices, innovations and lessons learned in implementation, monitoring and evaluation of the project?
- What structural and ongoing changes have been made to the lives of the individuals, families and communities who participated in the project?

16.1.3 Understanding indicators

Indicators are the measurable information used to help, ask and answer the questions identified in the monitoring and evaluation plan. The choice of indicators informs the rest of the monitoring and evaluation plan, including methods, data analysis and reporting. Indicators can be quantitative or qualitative. Participatory indicators are those that are developed together with stakeholders, especially community members and participants, that help all of those concerned to be precise about whether the programmes are succeeding to improve mental health and psychosocial well-being in the community. Strong indicators are referred to as SMART – specific, measurable, attainable, relevant and time-bound.

- Input indicators: These measure the contributions necessary to enable the programme to be implemented (such as funding, staff, key partners and infrastructure).
- Output indicators: Many programmes use output indicators as their process indicators; that is, the production of strong outputs is the sign that the programme's activities have been implemented. Others collect measures of the activities and separate output measures of the products/deliverables produced by those activities.
- Outcome indicators: Measure whether the programme is achieving the expected effects/changes in the short, intermediate, and long term.
- Impact indicators: Because outcome indicators measure the changes that occur over time, indicators should be measured at least at baseline (before the programme/project begins) and at the end of the project. Long-term outcomes are often difficult to measure and attribute to a single programme.

For specific examples of how these questions can be addressed for CB MHPSS programs see 16.1.4 and the linked material in the section.

16.1.3.1 Goals and indicators supplied by the common framework

The IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings has created the *IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings* (IASC, 2017). This document presents a consensus on the goals, objectives, indicators and actions for the monitoring and evaluation of MHPSS programmes in emergencies. The full document can be found [here](#). Its key elements as they relate to CB MHPSS are summarized here. The document enumerates a five-step process for conducting monitoring and evaluation on MHPSS programmes:



1. Assessments of MHPSS proceed as usual. The beginning of an MHPSS programme design is initiated to meet assessed needs (see chapter 3).
2. The organization considers its own programme outcomes and outputs as they relate to the programme design. Each organization considers how its project will contribute to the goal in the common framework.
3. During the design phase, practitioners/implementers are encouraged to review the common framework to see how it aligns with their own proposed intervention(s).
4. The programme takes (at least) one goal impact indicator and at least one outcome indicator from the common framework. The programme also includes output indicators unique to the programme design.
5. The organization explores possible means of verification to measure impact and outcome indicators. These may be measures previously used by them or other organizations.

The common goal identified for MHPSS programmes is “to reduce suffering and improve mental health and psychosocial well-being”. The framework describes two types of outcomes:

- Community-focused outcomes;
- Person-focused outcomes.

Box 72

How do monitoring and evaluation combine with accountability and learning to complete a MEAL?

Accountability to affected populations (AAP) is an integral part of the humanitarian programme cycle, which includes monitoring and evaluation, accountability and learning in its areas of concern.

AAP requires communities to be engaged in programme assessment, design, monitoring and evaluation. AAP requires that, as programmes are amended and adapted based on community feedback, there is a mechanism in place to report back to the community the changes being made and how to make use of newly adapted services. As participatory monitoring is an ongoing process, there are many opportunities to return to community members with the results of any adaptations. In low-resource settings, this information can be disseminated in focus groups, community meetings and activity groups, such as those mentioned earlier in this Manual. In higher resource and urban settings, these methods of dissemination are also useful, but they will require the addition of social media and radio communications in order to be effective.

The IASC toolkit on AAP provides detailed advice on how to implement this process and can be found [here](#).

Participatory monitoring and evaluation invite reflection and learning as managers, staff, community leaders and programme participants work together to evaluate programme effectiveness. Learning conferences that include evaluation reports allow participants – who have participated in the entire process, from assessment and implementation to monitoring and evaluation – to consider next steps.

What about the evaluation was surprising? Anticipated? What experiences were pleasant but yielded few results? Such learning conferences and, to the extent that resources allow, their publication on interactive social media sites and through community organizations, ensure that there is a longer-term effect that communities can use to improve well-being going forward.

Some important questions to ask for reflective practice:

- What actions were taken during monitoring and evaluation to ensure that opportunities were created for reflection and learning?
- To what degree did participant perspectives influence these activities?
- How were issues identified in the process documented, acted upon and reflected in the evaluation?

To link these practices to AAP requirements, click [here](#).



These reflect MHPSS programmatic activities at the community, group, family and individual levels.

The framework identifies five main common outcomes for any MHPSS project in an emergency, and provides a set of 49 indicators to measure impact and achievements. The Guide also encourages, along with the overall goal, to include at least one outcome and related set of indicators to monitor and evaluate each MHPSS project. For easy reference, Table 12 highlights three key indicators for each outcome, chosen among the ones that most relate to community-based MHPSS practices and the IOM approach; however, it is highly recommended to refer to the publication in its entirety for the full complement of indicators and details on implementation.

Table 12: Key indicators for community-focused and person-focused outcomes

Outcomes			
Community-focused	Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable.	People are safe and protected, and human rights violations are addressed.	Family, community and social structures promote the well-being of all of their members.
Person-focused	Communities and families support people with mental health and psychosocial problems.	People with mental health and psychosocial problems use appropriate focused care.	

Source: Based on IASC (2017).

Table 13 provides a sample of key outcomes and indicators, again chosen among the ones that better serve CB MHPSS programmes and the IOM approach.

Table 13: Key outcomes and indicators

Outcomes	
1. Emergency responses do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable.	• O1.1: Percentage of affected people who report that emergency responses (a) fit with local values, (b) are appropriate and (c) are provided respectfully. • O1.3: Percentage of target communities where local people have been enabled to design, organize and implement emergency responses themselves. • O1.4: Percentage of staff trained and following guidance (for example, the IASC Guidelines) on how to avoid harm.
2. People are safe, protected, and human rights violations are addressed.	• O2.1: Number of reported human rights violations. • O2.2: Percentage of target communities with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women, people with severe mental disorders). • O2.6: Percentage of target group members (such as the general population or at-risk groups) who feel safe.

3. Family, community and social structures promote the well-being and development of all their members.	• O3.2: Extent of parenting and child development knowledge and skills among caregivers. • O3.5: Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups). • O3.6: Percentage of target communities where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development.
4. Communities and families support people with mental health and psychosocial problems.	• O4.1: Number of people with mental health and psychosocial problems who report receiving adequate support from family members. • O4.2: Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information, and resources needed to access care). • O4.4: Perceptions, knowledge, attitudes (including stigma) and behaviours of community members, families and/or service providers towards people with mental health and psychosocial problems.
5. People with mental health and psychosocial problems use appropriate focused care.	• O5.4: Number of women, men, girls and boys who receive focused psychosocial and psychological care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or other psychological interventions). • O5.6: Number of people per at-risk group (for example, unaccompanied and separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (case management, psychological counselling, psychotherapy or clinical management of mental disorders). • O5.8: Level of satisfaction of people with mental health and psychosocial problems and/or their families regarding the care they received.

Source: Based on IASC (2017).

It should be noted that a group of IASC partners and Johns Hopkins University are currently identifying recommended means of verification for each of the indicators. The resulting publication will be added to the online version of this Manual once ready. A UNICEF manual on methods of monitoring and evaluation particularly tailored to children can be found [here](#).



16.1.3.2 Developing and using participatory indicators.

Many IOM MHPSS programmes, as described in this Manual, while providing a referral system for people with psychological problems, focus on the re-establishment of community protective systems, such as social cohesion and the activation of agency among groups within the population, using terms defined by the participants themselves. These activities contribute to the same overall goals as all other MHPSS programmes, but require specific indicators to represent results to be evaluated, in addition to the ones reported in the IASC Guide. In a community-based approach, it is fundamental to involve affected populations in the identification and development of the indicators used in monitoring and evaluation

16.1.4 The SEE_PET

The SEE_PET is a rapid participatory method that can be used to develop indicators of psychosocial well-being in a specific cultural context with concerned social groups. It can be used to develop indicators of MHPSS programme effectiveness, against which staff and participants can evaluate success and discard ineffective practices. Derived from the methodology of a three-country study of conflict-affected women's perceptions of psychosocial well-being (Bragin et al., 2014), it has been adapted for use with children and male adults, as well as IDP settings. The SEE_PET is used to engage community members in defining and operationalizing the components of psychosocial well-being in their own language and thinking, turning those operational definitions into SMART, contextual indicators. The method facilitates participants, community members and programme staff in the use of these indicators to monitor and evaluate the psychosocial components of emergency MHPSS programmes. It provides participants with a moment to reflect on both needs and resources in the midst of crisis, enabling them to articulate and work toward the life that they envision for themselves and their children, now and in the future. This method has subsequently been used by IOM in emergencies in different low-resource contexts, such as in South Sudan and Nigeria.

- For specific step-by-step instructions on how to use the SEE_PET, click [here](#).
- To create and chart specific indicators for adults, click [here](#).
- To create and chart specific indicators for children and adolescents, click [here](#).
- For an illustrative IOM case study, click [here](#).
- For the context and follow-up of the study, click [here](#).

SEE_PET can be community-led but it is typically a process facilitated by trained experts.

Box 73

Developing participatory indicators supporting referral for treatment of mental, neurological and substance use disorders

In some settings, IOM will be called upon to identify people with mental, neurological and substance use disorders, who require specific referral and follow-up care. In some low-resource settings, community members may not have ever had a proper system of locally available mental health care. In those instances, recent studies show that community members are aware of symptoms they associate with mental illness, neurological disorders and response to substance abuse. Such communities often have ways of identifying and differentiating people whose behaviours represent the results of grief and exposure to violence from those with ongoing issues requiring psychiatric care (Ventevogel et al., 2013).

Organizing focus group discussions supplemented by meetings with key informants – such as health-care providers, traditional healers, community leaders and psychiatric personnel who may be available – can produce positive identifications of people requiring specialized referral.

In this case, rather than asking questions regarding psychosocial well-being, focus group discussion questions might ask about persons with behavioural and emotional problems and the optimal way to care for them (Ventevogel et al., 2013). For case examples and a careful description of how to develop and analyse the results of such focus groups, see the referenced article [here](#).



➔ 16.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

Nine steps to start the monitoring and evaluation process are listed below. It is important to note that each emergency is unique and that the steps may be omitted or modified based on circumstances.

1. Sites and locations: Focus on three different sites (such as camp, transit centres and host community), or three different locations in the same area (such as camp sections, nearby villages and neighbourhoods).
2. Mapping: Carry on at least three different participatory exercises, such as transect and well-being walks, social networks diagrams (see [INTRAC website](#)) for resources and free online related publications ([here](#)), and [community scoring cards](#); and see MHPSS.net for an array of downloadable and practical tools and instructions on how to use [them](#).
3. Affected population: Purposive sample of approximately 30 informants for each site/location, including men and women, GBV survivors, persons with disabilities, the elderly and people from marginalized groups. If children are to be included in the programme, there should be separate groups for children and adolescents.
4. Stakeholders and gatekeepers: Identification of four key informants for each site/location – teachers, health-care workers, local and religious leaders, and camp managers – to be interviewed.
5. Indicators: Identification of at least two SMART, qualitative and quantitative indicators for each activity, output and outcome.
6. Tools: Selection of at least three tools – such as activity monitoring forms, participant satisfaction questionnaires and focus group discussions – for each indicator.
7. Timing: According to the operational plans but as regularly as possible, including weekly activity monitoring data, monthly participant satisfaction questionnaires and quarterly focus groups.
8. Staff: Identification of dedicated staff with appropriate language and cultural competence to be trained in data collection and data management, including field team leaders, data entry assistants, IT managers and project officers.
9. Data management: Identification of available platforms to store information (such as spreadsheets, online databases and Word documents) and reporting forms to graphically share data (such as monthly and quarterly).



➔ 16.3. CHALLENGES AND CONSIDERATIONS

Challenges include the following:

- Special care must be taken to ensure that all community subgroups are represented in the monitoring and evaluation process. This requires a specific effort to prevent obstacles to participation such as language, education, cultural norms, accessibility, social and gender discrimination, power struggles, political interests and open conflicts.
- Cultural acceptance of methodologies and tools of community-based monitoring and evaluation

might not be taken seriously by stakeholders and affected populations themselves in emergency contexts. It is important to make them part of a larger effort to engage communities.

- Subjective changes and self-perceptions of well-being are also determined by external concurrent factors, such as conflict dynamics, displacement stages, cultural interpretations of illness, social conditions and political narratives that might rapidly change in a typical emergency scenario. This all needs to be considered when analysing the results of monitoring and evaluation.
- Community-based activities – such as public gatherings, awareness campaigns, religious celebrations, sport tournaments, skill training and livelihood promotion – require a set of specific indicators and tools to measure the actual impact on psychosocial well-being of affected populations. These are signalled, when relevant, in the relevant chapters.
- Positive and lasting impact in MHPSS might require more time than the usual short operational frame of an emergency intervention. Therefore, indicators and evaluation tools should be accurate enough to measure trends and attitudes instead of consolidated achievements and lasting changes.
- Budgets often fail to allocate sufficient resources for dedicated and qualified human resources to attend to MEAL. When resources lack, they should be included in the job descriptions and related competencies of core staff. These activities will therefore not represent added burdens, but rather a part of regular duties.

Depending on the size and characteristics of the emergency, a full participatory identification of indicators may be difficult to achieve in the very initial phase of the response. Communities and the programme can achieve this capacity later in the process. In those cases, a SEE_PET or other processes can also be initiated at a later stage, since they can still impact programme outcomes and learning.

→ FURTHER READING

Ager, A., L. Stark, T. Sparling and W. Ager

2011 *Rapid Appraisal in Humanitarian Emergencies Using Participatory Ranking Methodology (PRM)*. Program on Forced Migration and Health, Columbia University Mailman School of Public Health, New York.



Augustinavicius, J.L., M.C. Greene, D.P. Lakin and W.A. Tol

2018 Monitoring and evaluation of mental health and psychosocial support programmes in humanitarian settings: a scoping review of terminology and focus. *Conflict and health*, 12(1):9.



Bragin, M., K. Onta, J. Taaka, D. Ntacobakinvuna, K. Adolphs, J. Bolen, N. Tammelleo and T. Eibs

2013 *To be well at heart: Perceptions of psychosocial well-being among conflict affected women in Nepal, Burundi, and Uganda*. CARE Österreich, Vienna.



Eggeman, M. and C. Panter-Brick

2011 Fieldwork and Research Process and Community Engagement: Experiences from the Gambia and Afghanistan. In: *Centralizing Fieldwork: Critical Perspectives from Primatology, Biological and Social Anthropology*. Studies of the Biosocial Society, (4). Berghahn, New York.



International Federation of Red Cross and Red Crescent Societies (IFRC)

2017 *Monitoring and evaluation framework for mental health and psychosocial support in emergency settings: Guidance and Overview*. IFRC, Geneva.



International Organization for Migration (IOM)

2018b *OIG Strategy for the Management of its Evaluation and Monitoring Functions, 2018–2020*. Office of the Inspector General, IOM, Geneva.



Rogers, P.

2014 *Theory of Change: Methodological Briefs – Impact Evaluation No. 2*. UNICEF Office of Research, Florence.



For other references, see the full bibliography [here](#).



ANNEX 1

INTER-AGENCY COORDINATION



→ 1. INTRODUCTION

Coordination is an important component of successful MHPSS programme implementation. It is included as an annex in this Manual not because it is deemed less important than other programmatic aspects, but for the following reasons:

- Coordination and partnership with different actors, community members, civil society organizations, stakeholders, affected populations and clients, leaders, religious leaders and academia on the overall planning and implementation of an MHPSS programme, and with other humanitarian organizations to optimize assessment efforts and define common monitoring and evaluation frameworks, are already mainstreamed—described throughout the Manual. This annex covers issues related to inter-agency coordination, which are essential knowledge for managers, but are not necessarily a part of a community-based approach.
- The differential role that IOM plays or can play in inter-agency coordination of MHPSS efforts is essential knowledge for IOM MHPSS managers, but not necessarily relevant for readers from other organizations.

The chapter will discuss how IOM PMs should coordinate inter-agency MHPSS activities and how to facilitate community engagement, to the possible extent, within country level MHPSS working groups (MHPSS WGs).

Inter-agency coordination is an essential component of the emergency response at any stage of its cycle – including preparedness and recovery – to ensure:

- Accurate information-sharing and reliable channels of communication;
- Identification of common strategies and priority of interventions;
- Even allocation of available resources according to needs, locations and partners' operational capacity;
- Adherence to humanitarian principles and minimum standards;
- Adherence to identified minimum technical and **ethical standards**;
- Promotion of joint training sessions and advocacy actions.

IOM's Principles for Humanitarian Action (2015b) clearly commit the organization to the IASC's procedures and guidelines, along with other United Nations coordinating bodies. **IOM's Migration Crisis Operational Framework (2012a)** recognizes the importance of external coordination with concerned States, IASC and United Nations agencies; particularly with UNHCR.

A joint IOM–UNHCR letter addresses the coordination between the two **agencies**.



2. COORDINATION OF MHPSS IN EMERGENCIES

Globally, a Reference Group on Mental Health and Psychosocial Support in Emergency Settings is an IASC-associated inter-agency entity. It was established in 2007, immediately after the launch of *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings*, (IASC, 2007), with the aim to:

- (a) Facilitate integration of the core principles of the Guidelines into all sectors or clusters of emergency response;
- (b) Foster collaboration among agencies and diverse stakeholders (such as governments and communities) for MHPSS in emergencies;
- (c) Support inter-agency coordination and activities for MHPSS at the global, regional and national levels;
- (d) Develop relevant tools linked to the Guidelines and actively disseminate these with relevant actors in the field;
- (e) Encourage individual agencies to institutionalize the Guidelines;
- (f) Promote and support ongoing capacity development to enable effective use of the Guidelines and related tools;
- (g) Share experiences of implementation of the Guidelines among MHPSS actors;
- (h) Interface with the United Nations Cluster System, refugee and migration coordination systems to include MHPSS in policies, tools, capacity-building and planning processes;
- (i) Facilitate language translations, printing and dissemination of the Guidelines.

Box 1

Actors and bodies of humanitarian coordination

IASC serves as the primary mechanism for inter-agency coordination, and acts in an action-oriented manner on policy issues related to humanitarian assistance, and for formulating a coherent and timely United Nations response to major and complex emergencies. **IOM** is among the 19 permanent members (Principals) of IASC.

The United Nations Office for the Coordination of Humanitarian Affairs (OCHA), at the global, regional and country levels, convenes humanitarian partners for the coordinated, strategic and accountable delivery of humanitarian **action**. OCHA is mandated to support humanitarian efforts in complex crisis and internal displacement. UNHCR remains the lead agency with the mandate to support refugee response and refugee coordination, with IOM leading on migration.

The Humanitarian Coordinator (HC) and the Humanitarian Country Team (HCT), made up of the operational United Nations agencies involved in the emergency response, represent the main coordinating body in countries affected by complex humanitarian crises related to internal displacement (note not refugees and migrants).

Eleven Global Clusters coordinate the different sectors of any emergency:

- Camp Coordination and Camp Management (CCCM);
- Early Recovery;
- Education;
- Emergency Telecommunications;
- Food Security;
- Health;
- Logistics;
- Nutrition;
- Protection, which includes: Child Protection, Mine Action, Housing Land and Property and Gender-Based Violence Areas of Responsibility (AoR);
- Shelter;
- Water, Sanitation and Hygiene (WASH).

For each cluster, IASC designated a lead agency (including WHO for Health, UNHCR for Protection, and IOM for CCCM in displacement due to natural disasters) to be supported by co-lead organizations, usually an international NGO (such as Save the Children and UNICEF as lead agencies of the Global Education Cluster). The Global Clusters have a permanent nature and yearly plans, aiming at setting and disseminating standards, practices and knowledge. When a humanitarian intervention starts, the same clusters are established at country level, based on needs, number of actors and the specific request from the host Government declaring which clusters should be activated. Sometimes clusters merge (for example the Health and Nutrition Cluster in the NE Nigeria response) and sometimes the clusters are labelled slightly differently based upon the host Government's request. MHPSS is cross-cutting in potentially all clusters, and is a particularly relevant theme in CCCM, Education, Health, Nutrition, Protection (and its AoRs), Shelter and WASH.

The Humanitarian System-Wide Scale-Up seeks to reinforce focused collective and time-bound emergency procedures. Scale-Up activation is time-bound and limited to six months, and can only be extended once, for an additional three months, in exceptional **circumstances**.



The group has produced a wealth of additional operationally focused documents, tools and guidance that have been quoted and referred to throughout the Manual. The entire list of publications can be found [here](#). Particularly relevant for this Manual is *Community-Based Approaches to MHPSS Programmes: A Guidance Note* (IASC, 2019a).

Particularly relevant for IOM staff is the booklet *IASC, Mental Health and Psychosocial Support in Emergency Settings: What should Camp Coordinators and Camp Manager Actors Know?* (IASC, 2014c), because it is addressed to actors of the cluster that IOM co-leads globally and at the country level.

The MHPSS Reference Group has advocated for the establishment of MHPSS Working Groups at the national and subnational levels, as the best way to coordinate the various actors engaged in the different sectors of the response, particularly in order to avoid fragmentation among humanitarian actors traditionally associated with the Health (clinical mental health) and Protection (community-based psychosocial support) Clusters. The MHPSS Working Group should collaborate with the relevant clusters and be proactive in mobilizing resources through the Consolidate Appeals Process, drafting policies and promoting joint advocacy actions. What is at stake is not only the coordination of the operational capacities of different service providers, but the coherence of the integrated programme approach of MHPSS services (the four layers of the pyramid) throughout the whole humanitarian response.

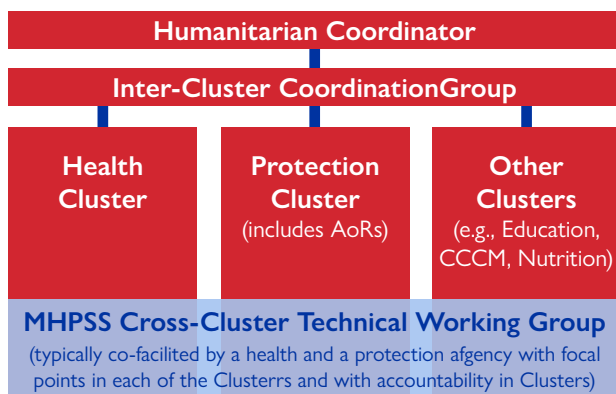
Preferably, the MHPSS Working Groups should be established at the national and subnational levels at the early onset of the crisis. MHPSS WGs should never be attached to any single cluster, but be kept inter-cluster (meaning a floating body that supports all relevant clusters – CCCM, health, education, nutrition and protection). Each participating organization can then be tasked to link to the cluster to which their organization is more related to in terms of programming.

Box 2

IOM and the IASC RG on MHPSS

IOM has been a member of the group since its inception, and has institutionalized the use of the Guidelines in internal guidance notes; in its internal trainings for MHPSS, Protection, Health and Emergency actors; external trainings for MHPSS actors; and in recruitment processes for MHPSS staff.

Figure 16: Generic humanitarian response mental health and psychosocial support (MHPSS) coordination structure for large emergencies with numerous MHPSS actors - to be adapted locally -



IOM is among the organizations that usually take the leadership in establishing and co-chairing the country-level MHPSS Working Groups. It has chaired or co-chaired the groups in different countries and emergencies worldwide, including in Myanmar, Haiti, Nigeria, South Sudan, Libya, Iraq and many others.

When the size and scope of the project allows, IOM appoints a full-time MHPSS inter-cluster coordinator (South Sudan, Nigeria, Haiti), which is the preferred option. The coordinator is managerially attached to the IOM MHPSS manager, but can technically refer to the global Co-Chairs of the IASC MHPSS Reference Group for guidance.

If resources or the scope of the programme do not allow for a dedicated position, part of the MHPSS programme manager's and/or MHPSS officer's working time will be dedicated towards supporting the MHPSS Working Groups, either co-chairing, or as active members. Typically, in this case, at the minimum, IOM MHPSS staff will act as a link between the MHPSS Working Group and the CCCM Cluster.

If a cross-sectoral MHPSS Working Group cannot be established, it would still be important that MHPSS's focal points sit in the relevant clusters and sub-cluster working groups to ensure that the following minimum coordinated actions still occur:

- Share information on the context of operations and documents, such as MHPSS needs assessments, indicators, data collection tools, advocacy reports and plans of action.
- Create and constantly update a mailing list of concerned organizations to quickly disseminate information, materials and schedules (meetings, workshops and events).
- Conduct joint MHPSS needs assessments and surveys.
- Provide regular updates on each organization's programme, highlighting constraints and opportunities for collaboration.
- Compile and regularly update MHPSS 4Ws mapping of service providers (Who is Where, When and doing What).
- Search for synergies and integration of services with local organizations, including State and private mental health providers, schools, clubs, cultural centres, civil society organizations, women's association and faith-based organizations.
- Promote local organizations' participation in cluster and inter-cluster working groups' and sub-working groups' meetings.
- Set-up an inter-agency referral system.
- Address minimum standards, harmful practices and codes of ethics through joint monitoring exercises and reports.
- Mainstream MHPSS Guidelines in relevant sectors of the emergency response.
- Provide training sessions to humanitarian staff on MHPSS basic response (such as PFA) and on the MHPSS Guidelines.

- Promote joint advocacy campaigns on MHPSS in the affected groups and communities of concern (such as posters, leaflets, brochures and radio programmes in the relevant languages).
- Promote awareness on MHPSS' needs and opportunities at OCHA, and the Humanitarian Coordinator and Humanitarian Country Team level (such as funding requirements).
- Participate in the preparation of the annual Humanitarian Needs Overview (HNO) and related Humanitarian Response Plan (HRP). Note that some HRPs may run for 2 years.
- Identify approximately 5 MHPSS related indicators (**see Common Monitoring and Evaluation Framework as a guide**) that agencies can report against. These inter-agency MHPSS indicators can also feed into the relevant cluster chapters of the HNO and HRPs.
- Support the regular update of humanitarian information systems (such as the Displacement Tracking Matrix) and cluster database (for example, ActivityInfo) as far as MHPSS data are concerned.
- Draft terms of reference for consultancies on specific topics (research, training, advocacy, policies) jointly promoted by the MHPSS inter-cluster Working Group and other relevant clusters/AoRs (such as Health, Child Protection, Mine Action and GBV).
- Support government and private mental health institutions with technical guidance and ad hoc capacity-building initiatives (workshops, seminars, conferences, training sessions, internships and scholarships).
- Support relevant government bodies at the national and local levels to draft emergency strategies, operational plans and MHPSS policies.



In addition, when IOM chairs the country-level CCCM clusters, the MHPSS managers should touch base with the CCCM team to support the following actions:

- Train CCCM actors in PFA and basic MHPSS.
- Teach the psychosocial modules of the core CCCM training.
- Disseminate the booklet IASC, Mental Health and Psychosocial Support in Emergency Settings: What Should Camp Coordinators and Camp Manager Actors Know? (IASC, 2014c).
- Participate in the cluster meeting to identify MHPSS needed to refer to the MHPSS Working Group, and report requests for support and troubleshooting from MHPSS actors operating in camps.

Box 3

List of members of the IASC RG on MHPSS

ACT Alliance	International Medical Corps
Action Aid International	International Rescue Committee
Action Contra La Faim	IOM/ UN Migration Agency
Africa Psychosocial Support Institute	IsraAID
Americares	Jesuit Refugee Service
American Red Cross	Medair
Antares Foundation	Medicin du Monde (France)
Care Austria	Medicine du Mondo (Spain)
CBM International	Mercy Corps
Centre for the Victims of Torture	MERCY Malaysia
Child Fund	MHPSS.net
Church of Sweden	OCHA
COOPI	Oxfam GB
DIGNITY	Plan International
GIZ - Gesellschaft für Internationale Zusammenarbeit	Red-R
Global Practice Group	Refugee Education Trust
Global Psychosocial Training Institute-Cairo	Save the Children International
Health Right International	Terre des Hommes
Health Works	TPO Nepal
Heartland Alliance International	TPO Uganda
Hebrew Immigrant Aid Society (HIAS)	UNFPA
Humanity & Inclusion	UNHCR
ICVA	Unicef
IFRC and ICRC (Special status - Standing Invitees to the IASC)	UNRWA
INEE	War Child Holland
InterAction	War Trauma Foundation
International Catholic Migration Commission	WHO
	World Vision International

ANNEX 2

ETHICAL CONSIDERATIONS



Applying ethical principles to Community-Based MHPSS is necessary to avoid risky practices and grant communities' safety. Generally, ethical guidelines in MHPSS respond to two principles:

- Non-maleficence or “do no harm”.
- Quality and effectiveness of intervention.

Ethical standards for humanitarian programmes are defined and enshrined in a series of guidelines, which apply to MHPSS programmes as well, including:



- **International Federation of Red Cross (IFRC), Code of Conduct in Principles of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programmes, 2007.**



- **Core Humanitarian Standard on Quality and Accountability in The Sphere Handbook, CHS, 2018.**



- **The 6 core principles of the IASC Guidelines on MHPSS in Emergency Settings, Core Principles, IASC (2007), Geneva, 2007**, p. 9. In particular, when promoting a CB approach to MHPSS it is paramount that:
 - o The needs, best interests and resources of the emergency-affected population must be of primary consideration when planning and implementing interventions, not only the agenda of the provider or donor.
 - o Care must be taken that all those engaged in any aspect of CB MHPSS are aware of the ethical prohibition against sexual exploitation and abuse, sexual activity with programme participants or any other potentially exploitative “dual” relationships. See the UN website on Preventing Sexual Exploitation and Abuse (PSEA) [here](#).
 - o Confidentiality must be maintained. This includes providing services in such a way that vulnerable groups can receive services without being specifically identified by their vulnerabilities (**IASC, 2019a**). If a person of concern discloses confidential information during a community-based



activity, they need to have the same level of trust as when MHPSS specialized services and be referred to further MHPSS resources when needed.

In addition

- **Be careful to avoid exacerbating marginalization/discrimination/stigmatization**

There are many possible ways in which exclusion can take place within a community. At times, paying close attention to one group of concern can lead to the needs of another group of concern being overlooked or neglected, potentially making people feel discriminated against. Marginalization can also be caused by drawing attention to survivors in certain circumstances, especially when their experiences are likely to attract social stigma. It is therefore important to be aware of community dynamics and power structures, and to aim for an approach that is inclusive while also being responsive to the needs of different subgroups. A gender analysis can also be a powerful tool to identify power dynamics in a community. Programme methodologies may have to change to reach different subgroups, even if the outcome is the same. Examples include conducting awareness-raising sessions at household level and at a community centres, to ensure that women, persons with disabilities or others with movement limitations outside of the home also have access to information. One should also be mindful of inadvertently reinforcing power imbalances or subverting existing power balances in a way that creates tensions and further oppression. Therefore, when providing humanitarian relief and facilitating community participation, it is critical to understand the local power structures and patterns of community conflict, to work with different subgroups and to avoid privileging particular groups.

- **Do No Harm**

When terrible things happen in a community, particularly following mass violence or during armed conflict, the existence and espousal of different narratives can intensify feelings of rage and hatred. Participatory needs assessments and tools can invite the above-mentioned feelings. In turn, these narratives can marginalize those with conflicting views or those who have family members on the “other side”; and may be used to organize retaliatory violence. It is important to be mindful of group composition (e.g. differences in gender, political affiliation) and the types of questions asked. The content of discussions needs consideration as does the most suitable time to carry out a focus group discussion, separate discussions among specific groups (for example women only) or one on one (key informant) interviews.

- **Respect traditions and promoting change**

Cultural traditions and identities are in a constant evolution. Some traditions entrench unequal power relations, are a source of rights violations, or incite social violence. As important as it is to support existing traditional support systems, community based MHPSS should also include actions that can shed light on harmful and exclusionary practices, thereby allowing positive traditional aspects to develop and negative ones to be left aside (Bragin, 2014). In the case of specific vulnerabilities, a MHPSS worker should exercise extra caution in identifying the most fruitful community-based mechanisms to activate.

- **Obtain consent**

In the case management system, informed consent should always be explained and signed by the client. In the case of minors, a parent or guardian must receive information and sign on their behalf. It is important that people of concern understand the limits of the programme from the start; knowing what the organization can do and cannot do for them. This will help to avoid unrealistic expectations, distress and distrust in future

programmes. People of concern must also be informed of the practicalities of what will happen during the time they receive services in an adequate way, in order to avoid misunderstandings.

- **Recognize competence**

Staff must recognize the limits of their professional competence and not attempt to provide services beyond their expertise. When a staff member does not have the required expertise to support a person of concern, a referral should be made to other team members with the adequate knowledge or to local MHPSS resources.

- **Avoid conflict of interest**

MHPSS staff must keep the best interest of people of concern in mind. When donor visits are organized, staff must consider the impact of the visits and receive consent from people of concern. This kind of exposure can be exploitative, people of concern might feel they are obliged to give consent, and it might be a trigger for distress. Staff must think of power dynamics they might be recreating. Steps to eliminate conflict of interest situations must be in place to follow when a situation arises.

- **Avoid grossly unethical behaviour**

Behaviours such as fraud, exploitation, abuse, criminal behaviour, etc., further amplify unbalanced power dynamics. A code of conduct must be signed by all staff. Both staff and people of concern should receive information on unethical behaviour and safe reporting mechanisms.

This annex has been partially copied from the document **Community-Based Approaches to MHPSS Programmes: A Guidance Note** and the video **Restoring Livelihoods with Psychosocial Support** by Dr. Adeyinka Akinsulure-Smith. For additional information on ethical considerations within IOM MHPSS programmes you can contact the IOM MHPSS and Intercultural Communication Global Section: contactpss@iom.int.



ANNEX 3 GBV CONSIDERATIONS



→ INTRODUCTION

Gender-based violence (GBV) is a human right infringement rooted in gender inequalities and discrimination. All GBV survivors have the right to receive high quality, compassionate care and support that addresses the harmful consequences of violence, including MHPSS.

MHPSS is a key component of referral pathways for survivors of GBV, but the capacity to address the issues at stake remains limited, especially in remote locations and in the immediate aftermath of an emergency. This annex tries to describe how the specific needs of GBV survivors can be addressed through IOM's MHPSS interventions in a safe manner, noting that GBV survivors will likely require the same level of support as other members of the population suffering from distress and other negative psychological reactions. As for other groups, some GBV survivors may be in need of specialized mental health care for needs either pre-existing and exacerbated, or resulting from, their experience of GBV.

→ WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

What is Gender Based Violence (GBV)?

GBV is defined by the IASC as “*any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females.*”

GBV can affect everyone, but women and girls are disproportionately impacted by this violence. IOM categorizes GBV into six core types of harmful acts:

- Rape
- Sexual assault
- Physical assault
- Psychological/emotional abuse

- Forced marriage
- Denial of resources, opportunities and services

While inequitable power dynamics and gender inequality lie at the root of GBV, there are many factors that can make people more or less susceptible to experiencing it. Crisis settings in general contribute to exacerbated risks.

While the psychological and psychosocial impact of GBV will differ among individuals; contexts, types of violence, magnitude and duration of the violent acts, and negative psychological and social reactions are common among GBV survivors, to varying degrees of severity. In addition, the consequences of a GBV incident may lead to other harmful consequences, like the loss of socioeconomic opportunities, which can add to or reinforce the psychological burden of the survivor, in a vicious cycle.

→ WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

A MHPSS manager should make sure that:

- a) MHPSS programmes adhere to the principle of do no harm and aim to mitigate the risk of GBV.
- b) MHPSS programmes are inclusive of GBV survivors in a safe manner.
- c) MHPSS teams are trained in safety measures, and counsellors on specific therapeutic approaches for GBV survivors.

1. MHPSS programmes contribute to GBV prevention programming through coordinating with GBV actors

GBV prevention programming is to be carried out by GBV specialists to ensure appropriate approaches, activities and messaging in a given context. MHPSS programmes should therefore

coordinate with GBV actors when present, both within and outside of IOM, in order to contribute to GBV prevention programming.

Risk mitigation is the process of ensuring that all crisis programming interventions:

- Avoid any unintended negative effects which may result in an increased risk of GBV occurring (e.g. through locating services in an unsafe location).
- Ensure women and girls are included in a safe and meaningful manner in all interventions.
- Ensure that all staff knows how to safely and ethically respond if a survivor discloses an incident of GBV, to avoid further harm.

Contributing to GBV risk mitigation efforts is the responsibility of all programmes, and MHPSS managers must commit to reducing the risk and safeguarding survivors from harm through their programming.

Examples of GBV Risk Mitigation efforts in MHPSS programmes:

- Ensuring safe and accessible locations of MHPSS activities for women, girls, men and boys. This may include facilitating women support groups in facilities or centers that proved to be both accessible and safe for women.
- Making sure that MHPSS activities do not put women and girls at unintended risk of intimate partner or family violence. This can be resolved by including a risk analysis in the initial **assessment** to guide programme design. Assessment questions on the prevalence of GBV incidents are not recommended, and safety concerns relating to specific interventions (e.g. income generating activities) should be obtained through **proxy questions if necessary**. If negative community perceptions of women and girls engaging in such interventions exist, proactive measures can be taken to promote

and improve safe access. For instance, having an open day, in which families can join and observe MHPSS activities, may mitigate rumors and facilitate women's ability to participate.

- Many MHPSS group activities, including those related to creative expression, support groups, discussion groups and others, may elicit survivors to recount their experiences of GBV. It is therefore important that relevant MHPSS staff is trained in managing those situations, so that the survivor does not share identifying information or anything that could put them at risk, while respecting the survivor's right to tell their own story. In creative expression workshops, it would be essential that staff are trained in how to maintain the communication **metaphorical and avoid asking any direct questions related to GBV**.
- Any individual referred by an agency known to focus on GBV activities should not be directly asked if they are a survivor or asked to 'tell their story' as a way to access the programme or initiate the help path. Information on available services should be provided together with assistance to access the services, if requested by the survivor.
- MHPSS staff may be requested by a survivor to accompany them to a health facility or another type of response service. If possible and safe, agency visibility should be limited to the maximum extent and travelling in a non-humanitarian vehicle considered the norm, to mitigate the associated risks to survivors.

If survivors withdraw from the MHPSS activity, unlike in other cases, they should not be sought out due to risks of being identified as a survivor of GBV.



Box 1

Survivor-centered approach/client-centered approach

MHPSS programmes are all informed by the logic of a client-centered approach. This means that programmes grant respectful, safe, confidential, non-discriminatory support that is centered on the client's agency. The same applies to GBV programming, in which the same approach is called survivor-centered. In practice, the survivor/client-centered approach places the survivor/client themselves as the decision maker in all issues affecting them; it is the survivor's or client's choice to seek medical, legal, psychosocial or other services available to them. The survivor/client should never be forced to report or seek services when they do not want to.

- Make sure that MHPSS teams are diverse in terms of gender composition to allow survivors to choose the gender of the MHPSS staff member they want to interact with. Survivors of GBV may feel more safe talking to MHPSS support staff of their same gender, even though that is not always the case and the survivor, wherever possible, should be given a choice.
- Train staff of the GBV sector (caseworkers/others) in basic MHPSS, including communication skills and tools to identify which cases to prioritize for referral to MHPSS services and to which services.

2. MHPSS programmes know how to be inclusive of GBV survivors in a safe manner

It is important to notice that MHPSS programmes should never target ONLY GBV survivors or seek them out in the community as this can lead to retaliation or stigmatization. However, MHPSS programs should be able to respond to the needs of GBV survivors. This can be done as follows:

- Establish specific activities for women and girls that can lead to the referral of survivors who disclose a GBV incident to MHPSS teams.
- Establish trusted mechanisms that can enable survivors to self-disclose their need for specific support in relation to their GBV experiences if they wish.
- Since MHPSS is included in referral pathways for GBV support, communicate clearly with the GBV sector on which capacity exists in the MHPSS programme and in the country, to avoid misunderstandings. See box 4.

Box 2

MHPSS for men and boys

While men and boys can also be survivors of GBV, fear of stigmatization and social norms around masculinity might deter them from seeking support. Following a community-based approach, it is the responsibility of all MHPSS actors to be aware of such gendered realities associated with GBV and ensure that service provision is inclusive.

Various resources provide more information on the need for MHPSS for male survivors of GBV, like this [guidance note](#) on *Responding to Sexual Violence Against Males and Engaging Men and Boys in Preventing Sexual and Gender-Based Violence*, [this report](#) on *Caring for Boys Affected by Sexual Violence*, [another report](#) on sexual violence against men and boys in the Syria crisis, and [this guidance](#) on *Working with Men and Boy Survivors of Sexual and Gender-Based Violence in Forced Displacement*.

Box 3

MHPSS for LGBTQI+

Marginalization of LGBTQI+ people is often reinforced during a crisis and can extend to exclusion from humanitarian response/aid. Given the lack of awareness over their needs, MHPSS programmes can tend to overlook the risks and violence faced by them, especially in countries or communities where not adhering to traditional gender norms might be punished by law or is culturally unacceptable, making them seem invisible. LGBTQI+ people might be at enhanced risk of GBV, including practices such as corrective rape or conversion therapy. MHPSS teams must therefore consider the barriers that LGBTQI+ people face in accessing services and ensure that their support is non-discriminatory and follows a survivor/client-centered approach, that does not expose them to stigma or harm.

3. MHPSS teams are trained in safety measures, and counsellors on specific therapeutic approaches for GBV survivors.

It is vital to train all MHPSS teams in basic safety measures and disclosure management methods. Survivors may disclose an incident to a trusted MHPSS staff, or during activities conducive of emotional venting or storytelling. As such, it is important that all MHPSS staff are trained on how to handle a disclosure in a safe and **ethical manner** and have up to date information on GBV and other services available. They should use the referral pathways to inform survivors of available services and seek informed consent to refer to GBV actors. In case of rape, it is important to inform the survivor of the importance to seek medical treatment at their earliest possible convenience and within 72 hours, and eventually facilitate access, noting that

it is ultimately the survivor's decision whether they seek out medical support or not. Capacity and procedures to do so should not be left to the initiative of the individual staff member but programmed by the managers.

Likewise, it is vital to train a determined number of counsellors who will act as focal points for GBV referrals (Bott et al, 2004). Counsellors must trust survivors' experiences and normalize and validate their reactions, validate survivors to make their own choices, and develop an action plan based on their personal needs. They might use different approaches based on the training they received and the situation of the client. Counselling might include the activation of survivors' resources, strategies to rebuild self-esteem and self-efficacy, decisional balance, and relaxation techniques as well as other positive coping strategies. It must be considered that GBV survivors might have additional concerns during the emergency and displacement that might also require counselling and additional support. Some approaches indicated for GBV survivors include **solution-focused brief therapy (SFBT)** and the **stages of change approach**, which considers precontemplation, contemplation, preparation, action and maintenance phases to support clients. Additional measures, such as peer support, can be considered as complementary services to support the well-being of the client.

More information on recommended steps for counsellors is available in this **manual and report**, in these **Standard Operating Procedures** on psycho-social services provision, this **handbook** on *Counselling Asylum Seeking and Refugee Women Victims of Gender-Based Violence*, and in the *Inter-Agency Minimum Standards on GBV in Emergencies Programming publication*, with particularly relevant guidance from points 4, 5 and 7. Please see also the chapter on **counselling**.

Counselling might also be indicated for **perpetrators as a tool to reduce harm**,



especially in cases of IPV, focusing on building communication skills, expression and management of emotions, problem solving and conflict resolution skills, and sessions could provide practical tools to support healthier relationships.

It is important to develop tailored interventions for specific population groups such as adolescent pregnant girls if the integration into the general MHPSS programme does not provide the participants with the needed safe space to express themselves and to go through a process that enhances their self-awareness and self-esteem.

It should be noted that facilitating discussions related to GBV and developing any kind of GBV-related messaging requires the expertise of GBV specialists, and MHPSS actors should seek the guidance of GBV actors where available.

Box 4

Referral Pathways

GBV actors, as all non MHPSS actors, tend to read psychosocial support programmes as the provision of counselling, psychotherapy, psychiatric and clinical psychological care. It is therefore extremely important to clarify the capacity existing in the MHPSS programme in terms of level of intervention and depth of skills, to avoid ending up in a situation where survivors in need of focused counselling are referred to programmes that offer only recreational activities, or survivors with supportive counselling needs are referred to psychiatrists, or individuals in need of specific forms of care are referred to programmes where counsellors are under training and can only provide for generic and basic counselling. Accurate information should be included in **multi-sectoral referral pathways**. Addressing the lack of access to services (like focused counselling or specialized mental health care) should always be advocated for all and GBV actors can become powerful allies in this advocacy work.

It is the survivor's decision to be referred to services, including MHPSS at all levels once all the information is clearly explained in advance. Information which must be provided to the survivor before consent can include:

- Quality of the services – if no specialists are available this should be clearly explained to inform the survivor's decision on seeking services
- Availability of counsellors of preferred gender choice
- Average referral waiting times
- What information will be shared and how confidentiality will be maintained
- How MHPSS teams will contact survivors referred – if calling the survivor is not a safe option, a specific time should be agreed on prior to the individual counselling session. Never seek out the survivor if they do not attend an appointment.

This information should be provided by MHPSS managers to the GBV actors of concern.



Box 5

Our referral system is overwhelmed, should we prioritize GBV survivors?

GBV survivors should be supported in a timely, safe and confidential manner. Prioritization will need to be adapted from context to context depending on programming, staffing and capacity. As mentioned, supporting only GBV survivors may draw unwanted attention and rumors, potentially identifying and exposing to further risk of experiencing harm. Considering the significant mental health and psychosocial impacts survivors face after an incident of GBV it is recommended they are included in any prioritization criteria, however, safeguards must be put in place to protect their confidentiality and not be identified as survivors by virtue of participating in MHPSS activities.

→ CHALLENGES AND CONSIDERATIONS

Ensuring a survivor/client-centered approach in community-based MHPSS

While a community-based approach is considered critical for MHPSS, specific safeguards must be employed when working with survivors of GBV. It is not advised to have community led interventions when supporting survivors of GBV due to the particular sensitivities around GBV cases and the risks faced by both the survivor and community group members when handling such cases, unless community members are formally employed and trained.

GBV survivors should not be sought out in the community as doing so may inadvertently identify them and in turn expose them to further harm, including possible retaliation by their perpetrators and stigmatization in the community.

GBV is rooted in cultural and social norms.

MHPSS interventions must acknowledge gender norms and attitudes of one or multiple affected groups and host communities to provide effective **support**. MHPSS teams working closely with the community may be requested to support some harmful practices or community response mechanisms which are not in line with inter-agency guidelines and the survivor/client-centered approach. Some examples may be requests to involve elders and chiefs or to support traditional justice mechanisms which draw much attention from community members and risks identifying the survivor. As always, it is the survivor's choice if they wish to participate. Humanitarian agencies, however, cannot engage or support such practices, and may only facilitate respectful conversation.

→ MEDIATION

Family and couple counselling following interpersonal conflict, at times referred to as mediation, represents a form of support that counsellors can offer to individuals, couples or families. If mediation seeks to address a GBV incident such as intimate partner violence, counsellors should be aware that engaging the perpetrator may place the survivor at even further risk, such as violent retaliation, threats and ostracization from family and support networks. Staff members could be harmed in the process also, highlighting that the risks associated with mediation need to be carefully considered even when survivors specifically request engagement with an abusive partner. For these reasons, GBV specialists advise against mediation interventions with survivors and perpetrators, only informing survivors of available information on mediation and transitional justice mechanisms alongside any safety or security concerns they may reserve. This information will enable the survivor to seek out community mediation services themselves if they still wish to, which is always their choice.

In some scenarios mediation may be deemed as

the only option remaining for practitioners supporting a survivor due to a lack of alternatives. For example, a lack of safe houses for survivors of domestic violence may result in a survivor requesting MHPSS to mediate with their abuser to improve safety. Intervening in such a case through mediation risks worsening the situation for the survivor as the goal of mediation is to restore relational harmony, which in a case of GBV where the survivor and perpetrator do not have equal power in the mediation process, violence could be normalized, tolerated and perpetuated in the long-term; as mediation would involve a third party, the perpetrator could become aggravated by the public nature of the intervention and violence could increase; and as mediation within a violent context could jeopardize the safety and neutrality of MHPSS staff and undermine survivors' trust in staff and GBV service provision, resulting in less GBV survivors coming forward to receive support subsequent to an incident. In these cases, the counsellor should decline intervening in mediation, explaining the potential risks for the client and the institutional reasoning behind it. The counsellor should, however, make clear that individual counselling and other forms of support are still available as before. If the client decides to withdraw from the counselling activity as a result, the counsellor should let the client know they can resume the counselling and/or activity at any time.

GBV Information Management

GBV Information Management is afforded special protections and procedures due to the extremely sensitive nature of the data. When GBV incident data is gathered, how it is stored and secured, and how and why it is shared with other actors, demands thoughtful and careful practices. While it can be challenging to meet the expected ethical and safety standards, IOM is committed to following international guidelines and to mainstreaming this through all programme departments, which is particularly pertinent for MHPSS programmes who often work directly with survivors and sensitive information. MHPSS teams working with survivors must adhere to strict data protection policies and information sharing protocols when supporting GBV survivors. In practice, this encompasses coded case forms when including any specific information related to GBV incidents; omitting any identifying information alongside storing case forms in a secure location only accessible to relevant staff.

FURTHER READING

CIDA and SAT

2008 Counselling Guidelines on Domestic Violence. Southern African AIDS Training (SAT) Programme & Canadian International Development Agency CIDA.



GBV Area of Responsibility (GBV AoR)

n.d Tools and Resources for Mental Health and Psychosocial Support Services



GBVIMS

n.d GBV Information Management System (GBVIMS). Podcasts.



Hillenbrand E, Karim N, Mohanraj P and Wu D.

2008 *Measuring gender-transformative change A review of literature and promising practices*. CARE USA. Working Paper.



IASC

2015 *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*. (specific chapter for **Health**)



International Organization for Migration (IOM)

2018 *Institutional Framework for Addressing Gender-Based Violence in Crises*. (GBViC Framework). IOM, Geneva.



Medina, M., Petra, V., Mimoso, R., Pauncz, A., Tóth, G., Hiiemäe, R., Harwin, N. and Corgrove, S.

2008 *The Power to change: How to set up and run support groups for victims and survivors domestic violence*.



Raising Voices

n.d SASA, groundbreaking community mobilization approach developed by Raising Voices for preventing violence against women and HIV.



The United Nations Population Fund (UNFPA) and GBV Area of Responsibility (GBV AoR)

2019 *The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming*. (Standard 4 – Health Care for GBV Survivors and Standard 5 – Psychosocial Support)



UNFPA

2008 *Engaging Men and Boys in Gender Equality and Health. A global toolkit for action*. Promundo, UNFPA and MenEngage.



2019 *The Inter-Agency Minimum Standards for Gender-Based Violence Emergencies Programming*. UNFPA.



For other references, see the full bibliography [here](#).



MANUAL ON COMMUNITY-BASED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCIES AND DISPLACEMENT

© 2021 International Organization for Migration (IOM)

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise without the prior written permission of the publisher.