UKRAINE TASK FORCE WORK ON OPERATIONALIZATION OF THE IASC GUIDELINES ON MHPSS DURING 2016-2017:

Guidance Notes, International Best Practices, and Case Studies from Ukraine

ANNEX TO IASC GUIDELINES

Kyiv - 2017
**Acknowledgements**

IMC is grateful for the commitment and dedication of the members of the Interagency Task Force on Operationalization of the IASC Guidelines of Mental Health and Psychosocial Support in Emergency Settings in Ukraine, the commitment and dedication of its local partners, and for the collaboration with members of the MHPSS sub cluster.
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Abbreviations and Acronyms

1. CF  Charitable Fund
2. DRC  Danish Refugee Council
3. GN  Guidance Note
4. IASC  Inter-Agency Standing Committee
5. ICRC  International Committee of the Red Cross
6. IMC  International Medical Corps
7. INGO  International non-governmental organization
8. M&E  Monitoring and evaluation
9. MDM  Médecins du Monde
10. MSF  Médecins Sans Frontières
11. NaUKMA  National University of Kyiv-Mohyla Academy
12. NGO  Non-governmental organization
13. MHPSS  Mental Health and Psychosocial Support
14. PFA  Psychological First Aid
15. PIN  People in Need
16. PSS  Psychosocial Support
17. SDC  Swiss Humanitarian Aid
18. TF  Task Force
19. UN  United Nations
20. UNHCR  United Nations High Commissioner for Refugees
21. UNFPA  United Nations Population Fund
22. USAID  U.S. Agency for International Development
23. WB  World Bank
24. WHO  World Health Organization
INTRODUCTION

From 2015 – 2017 International Medical Corps, supported by USAID and John Snow International, worked together with several partners on the project “Improving MHPSS for Conflict-Affected Populations in Eastern Ukraine through Increased Capacity for Psychosocial Support Activities and Services Aligned with IASC Guidelines among National actors, Organizations and Agencies”.

THE PROJECT

Objectives
The project had three objectives:

1. Strengthen the provision of mental health and psychosocial support in Ukraine in line with international principles such as the IASC Guidelines for MHPSS in Emergencies.
2. Strengthen the capacity of relevant local organizations to apply IASC Guidelines through capacity building and training.
3. Strengthen capacity to link psychosocial support to evidence-based mental health services for conflict-affected populations in at least one city in Eastern Ukraine.

Partners

Task Force
IMC collaborated with a Task Force comprised of government ministries, educational institutions, NGO and INGO representatives. The aim of the Task Force was to strengthen the development of an integrated mental health and psychosocial support system in Ukraine by promoting awareness and understanding of the Inter-Agency Standing Committee «Guidelines on Mental Health and Psychosocial Support in Emergency Settings» (IASC Guidelines) at national, regional, and local levels.

Local NGO Partners
IMC worked on building the capacity of 5 local partner organisations to facilitate appropriate psychosocial support activities for affected communities in line with the IASC Guidelines.

Partners include:

- A local media organisation to create radio programmes designed to reduce stigma and negative preconceptions around mental health in the country.
- A local university to train social workers and volunteers in ways to enhance psychological resilience as part of their education and practice.
- Three community based organizations who provide community based psychosocial support to conflict-affected populations including war veterans and their family members, internally displaced persons and host communities.
Coordination and mapping
To help coordinate MHPSS in Ukraine, IMC also leads the MHPSS sub cluster coordination group. In line with the IASC Referral Guidance Note for MHPSS and the IASC 4Ws (Who is doing What, Where and until When) Activity Codes, IMC completed and disseminated a service mapping in Zaporizhzhia and continues to support coordination meetings to further strengthen referral pathways.

International Medical Corps has also performed mapping of services in Kramatorsk, Bakhmut, Druzhkivka, and Zaporizhzhia with a view to strengthening quality referral pathways; there has been conducted a workshop in Severodonetsk to disseminate the mapping methodology. Mapping outcomes are available at http://ngomap.org.ua/, which is a Ukrainian mapping tool. Results of the above mentioned mapping may also be found at MHPSS.net, which is an international psychosocial services mapping tool in line with the Intervention Pyramid from the IASC Guidelines on MHPSS in Emergency Settings.

Materials


- IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Ukrainian and Russian)
- IASC Guidelines on Mental Health and Psychosocial Support in Emergency Setting: Checklist for Field Use (Ukrainian and Russian)
- Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings (Ukrainian)
- Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes (Ukrainian)
- IASC Reference Group Mental Health and Psychosocial Support Assessment Guide (Ukrainian)
- Psychological First Aid: Guide for Field Workers (Ukrainian)
- Psychological First Aid: Facilitator’s Manual for Orienting of Field Workers (Ukrainian)
- IASC Referral Guidance Note for MHPSS (Ukrainian)
This document consists of a summary of the results of the National Conference that took place on June 14 and 15, 2017 in Kyiv. The conference brought together actors working on mental health and psychosocial support to people affected by the conflict in Eastern Ukraine. It also includes a summary of minutes from the Task Force meetings. Furthermore, the document includes IASC Guidelines on MHPSS Operationalisation and Guidance Notes on Coordination, Health Services, Community Mobilization and Information Dissemination, as well as case studies prepared by local NGO partners.
PART 1. TF meetings. Summary
Task Force for the Operationalization of the IASC Guidelines on Mental Health and Psychosocial Support in Emergencies Settings to Ukraine

BACKGROUND
As part of the project “Improving Mental Health and Psychosocial Support (MHPSS) for Conflict Affected Populations in Eastern Ukraine through Increased Capacity for Psychosocial Support Activities and Services Aligned with IASC Guidelines among National actors, Organizations and Agencies,” a Task Force was established on May 23, 2016.

The Task Force is a platform to enable operationalization guidance for the IASC Guidelines on Mental Health and Psychosocial Support, and to have a facilitating role in the collaboration between different actors in Ukraine (such as civil society, governmental bodies, international NGOs). IMC facilitated this platform. Task Force members include state actors, academic institutions, international and local non-governmental organisations working in the field of psycho-social support to affected populations.

Establishment of the Task Force
During the first two meetings an orientation to IASC Guidelines for MHPSS in Emergency Settings was provided. The Task Force members assessed the relevance of the IASC MHPSS Guidelines for the Ukrainian context for their own work (Annex 1), and they agreed on the mission, the objectives and key activities of the Task Force.

MISSION
To strengthen the development of an integrated mental health and psychosocial support system in Ukraine by promoting awareness and understanding of the Inter-Agency Standing Committee «Guidelines on Mental Health and Psychosocial Support in Emergency Settings» (IASC Guidelines) at national, regional, and local levels.

OBJECTIVES
1) Operationalization of the IASC Guidelines for MHPSS in Emergencies in the Ukrainian context
2) Raising awareness of policy makers and service providers (gov. and non-gov.) about the IASC Guidelines for MHPSS in emergencies and relevance for services for conflict-affected populations in Ukraine
3) Facilitating endorsement of Guidelines by relevant stakeholders, including possible adoption of guidelines into Ukrainian legislation and/or educational system

RESULTS
The results of the Task Force activities are presented below, following to the above-mentioned three objectives.
RESULTS OBJECTIVE 1: OPERATIONALIZATION OF THE IASC GUIDELINES FOR MHPSS TO THE UKRAINIAN CONTEXT

a. Translation of the IASC MHPSS Guidelines translations to Ukrainian and Russian
Chapters of the initial translation of the IASC Guidelines were reviewed and proofread by the Task Force members and UKR terminology/glossary agreed on. It was agreed that the Ukrainian Catholic University (UCU) would work as an independent editor of the final Ukrainian IASC MHPSS Guidelines version. The Ukrainian version of the IASC Guidelines was published.

b. Application of Guidelines to the Ukraine context: Guidance Notes development

Priority domains for Guidance Notes
TF members decided on priority domains to develop Guidance Notes (GN) (see the table below).

<table>
<thead>
<tr>
<th>Topic</th>
<th>Priority ‘Votes’</th>
<th>TF Member</th>
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<td>Assessment, M&amp;E</td>
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<td>Ministry of Health, Krym-SOS, Ukrainian Association for overcoming of traumatic event consequences</td>
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Additional topics for consideration proposed by Task Force (TF) members:
- Preparation of guidance for mass media representatives in their approaches to and communications with affected people, and especially children
- The need for guidance for volunteers not belonging to any organization on how to exchange information with them
- To agree on the understanding of the definitions “MHPSS” and “emergency situation” in Ukraine.
**Guidance Note goal**
The TF agreed that Guidance Notes envisage application of the Guidelines to the Ukraine context and become a platform for determining ACTION to be considered and taken by the Task Force members in the future.

**Guidance Note Structure**
Task Force sub-working groups per selected domains formed to work on the prioritized topics, the structure of the Guidance Notes and an action plan and timeline was agreed on.

1. **Summary:** Paragraph summarizing the IASC Guideline of focus
   Background: Current status of issue in Ukraine, historical context including effects of conflict over last 2 years: strengths and gaps/challenges
2. **Recommended actions:** Recommendations for next steps to address gaps/challenges
3. **Key messages:** Brief messages to summarize takeaway points – for easy dissemination
4. **Key terminology:** Ukrainian terms relevant to this section and definitions
5. **Examples/case studies from Ukraine:** Should demonstrate a challenge and a solution
6. **Resources:** Relevant organizations, agencies; materials, articles, guidelines, tools, etc.

**Guidance notes should take into account the core principles:**
1) Human rights & equity, 2) Participation, 3) Do no harm, 4) Local resources, 5) Integrated services, 6) Multi-layered approach (pyramid).

**HEALTH GUIDANCE NOTE**
The GN was developed based on the 2-year experience of the WHO assisting the mobile emergency primary health care teams in delivering mental health support in the east of Ukraine.
The GN represents the Ukrainian context, problems and obstacles for IASC Guidelines implementation, i.e. staff qualification, legal barriers, stigmatization, no clear referral pathways, a communication gap between the public and the civil sector, regional and national levels of mental health support.

**The key Comments from the TF on the Health Guidance Note are as follows:**

- “Specialized groups” can have a negative meaning for clients. Clients may therefore refuse mental health care. It is proposed to refer to the “specialized groups” in the context of the social service system of Ukraine;
- Official referral protocols are absent in the mental health sphere of Ukraine;
- To consider how much the centralized system can ensure confidentiality in referral processes; it is proposed to develop a referral methodology of interaction with governmental bodies.
**COORDINATION GUIDANCE NOTE**

During the development of the Guidance Note on MHPSS Coordination, the Task Force members shared their observations and suggestions about the MHPSS Coordination efforts made in Ukraine by different actors since the start of the conflict in Ukraine. The key ones are as follows:

- NGOs’ potential for MHPSS coordination is not used beyond emergency situations (i.e. during emergency preparedness or comprehensive response).
- There is a big gap between cluster operations conducted in Kyiv and the regions. There is a lack of outreach to the regions.
- There is a need to establish knowledge – sharing systems for exchange of information\ methodological\ training materials between the stakeholders working in MHPSS programs open and accessible to all MHPSS actors in Ukraine.
- There is a need for a formal regulation of relationships between the state and civil society organizations, on MHPSS service providing.
- There is a need for the State to perceive its status as an ordering party for MHPSS services.

**COMMUNITY MOBILIZATION GUIDANCE NOTE**

The Guidance Note on Community Mobilization in Ukraine was developed in close coordination with the Task Force members, and with input from international experts in this field. The key considerations related to Ukraine Community Mobilization are as follows:

- The state sector has experience in community mobilization in response to natural or technogenic disasters. This helps with responding to coordination in a conflict situation. At the same time however, the necessity to coordinate actions with the civil society, and collaborate with the affected populations in a rapidly changing environment became clear.
- When developing state and regional emergency action plans it is important to delineate clearly roles of all actors.
- To consider the following experiences on in community mobilization that are available in Ukraine:
  - System level surveys, evaluations of the MHPSS initiatives of the international organizations;
  - The adapted international practices of providing MHPSS in a military conflict (PFA, treatment of trauma, recovery skills etc.);
  - Available methodological materials for arranging MHPSS to different populations affected by the conflict;
  - Formed network of professional service providers ready to meet the needs in MHPSS of the state and civil society sectors;
  - There is a need in trainings for community members to strengthen community overall capacities.
GOOD PRACTICES of application of the IASC Guidelines per domains on COORDINATION and COMMUNITY MOBILIZATION

The Task Force decided to complete the draft GNs on Coordination and Community Mobilization with the good practices of IASC Guidelines application in other countries, such as Belgium, Canada, Denmark, England, Finland, Georgia, Greece, Hungary, Japan, Norway, Spain, and Turkey.

The key observations on Coordination good practices from the mentioned above countries:

- Coordination of emergency response is decentralized, coordination structures include MHPSS component and act as agents of local authorities in exercising local authorities’ powers/ duties
- INGOs are always part of any coordination structure with their roles/ responsibilities clearly defined
- Emergency plans of national, regional and municipal levels envisage MHPSS interventions as an obligatory component of any emergency response
- Information sharing is supported via close cooperation between private sector and local self-governments.

For more detailed information on good practices of IASC Guidelines application see Annex “Good Practices” in Guidance Note on “Coordination”

The key observations on Community Mobilization good practices in the mentioned above countries:

- Emergency management professionals of municipal level are the core of community mobilization
- Augmentation of media ties into emergency operations to support self-help and community involvement in the emergency response
- Augmentation of private sector preparedness by municipalities
- Regulation of volunteering by signing agreements of intent with NGOs

For more detailed information on good practices of IASC Guidelines application see Annex “Good Practices” in Guidance Note on “Community Mobilization”

INFORMATION DISSEMINATION GUIDANCE NOTE

The GN was developed based on the 3-year experience of the international and local NGOs responding to the needs of the conflict-affected populations in the East of Ukraine. The GN represents the Ukrainian context and challenges for IASC Guidelines related to information dissemination in Ukraine, i.e. limited or no access to information, sources of information to be trusted, specific sub-groups of target audience, no clear referral pathways etc. The document also includes a summary of recommendations for information dissemination in Ukraine. The key actions have been adapted from the IASC MHPSS Guidelines information dissemination action sheets and related generally to:

- access to existing information resources and gaps
- community participation in developing, validating and disseminating information
- development of accessible, culturally relevant information and its adaption for different subgroups
- coordination and consistent distribution of information on positive coping.
RESULTS OBJECTIVE 2: RAISING AWARENESS OF SERVICE PROVIDERS AND POLICY MAKERS ABOUT THE IASC GUIDELINES ON MHPSS

Raising awareness about the IASC Guidelines by TF members at system level launched

a. Information sharing plan on IASC Guidelines by TF members was agreed on
b. A model of an info sharing and gathering session delivered
c. Information sessions on 3 prioritized domains of the IASC Guidelines delivered

Dissemination of the Ukrainian version of the IASC Guidelines and GNs coordinated and delivered

- Information sessions on IASC Guidelines and the M&E domain were delivered by TF members in Kharkiv by Ministry of Education for heads and methodologists of regional centers of social work in the education system of Ukraine (representing Donezk, Dnipro and Kharkiv regions) and for the representatives of the Kharkiv University of Internal Affairs
- Information sessions on IASC Guidelines and the Coordination and Community Mobilization domains were delivered in Zaporizhzhia by and for the State Agency on Emergency Issues represented by 25 heads of psychological centers from 18 regions throughout Ukraine

RESULTS OBJECTIVE 3: FACILITATING THE ENDORSEMENT OF THE GUIDELINES BY RELEVANT STAKEHOLDERS

Coordination between policy-level and service-providing actors was initiated to facilitate endorsement of the IASC Guidelines. The coordination between the State and Civil Society sectors was facilitated through a joint meeting between the Task Force and the IMC five NGO partner organizations delivering PSS services to the conflict affected population in the east of Ukraine following the IASC Guidelines. During the joint meeting, the five NGOs presented their case studies to be considered by TF members as potential “examples” to be incorporated into the GNs associated with the UKR version of the IASC Guidelines. Discussion of the statistical data available at the NGOs as PSS service-providers was discussed with the representative of the Ministry of Social policy.

The NGO “Dopomoga Dnipra”, addressed the TF to jointly agree on assessing and joint development of the response plan to the following issues:

- There is still a situation of absence of clear regulations as for administering places of IDP compact residence;
- The administrative responsibilities for security /safety system around the cases of increased risk of doing harm to oneself and others for the settlements are not always clear;
- The absence of unified patients’ health records databases, and no access to the data
from Non-government controlled area makes it difficult to detect mental as well as other illnesses jeopardizing safety of other members within the community.

In response to the inquiry from the NGO “Dopomoga Dnipra” IMC jointly with the TF members facilitated Ombudsman Feedback on the matter. The Ombudsman’s mission in Ukraine is to ensure “adherence & protection to/of human rights” in cases of psychiatry problems. The feedback was based on the reference to the Law of Ukraine “Law on Psychiatric Assistance” focusing on the “presumption of sane mind” and being the grounds for calls for a mobile “psychiatric crews” per Part I, Article 7-8; Part II Grounds and Procedures for Psychiatric Assistance of the Law. The Ombudsman Offices in the East of Ukraine are operational in Zaporizhzhia, Luhansk, Dnipropetrovsk.

Strategic coordination between different actors of the humanitarian response in Ukraine to facilitate endorsement of the IASC Guidelines on MHPSS was enabled at the National Conference organized in Kyiv in June 2017. The National Conference created a platform for Ukrainian MHPSS sphere stakeholders: state bodies, INGOs, and national NGOs to coordinate and build potential next steps for joint actions in line with IASC Guidelines on MHPSS in Emergency Settings in Ukraine.

The conference facilitated:

- informing about the IASC Guidelines and advocating for its application in practice;
- sharing the Ukrainian practice, outcomes, achievements, and challenges relating to the operationalization of the IASC Guidelines in Ukraine;
- collecting suggestions on further steps on operationalization of the IASC Guidelines on MHPSS in Emergency Settings in Ukraine.

The National Conference resulted in a raised awareness of the Ukraine MHPSS stakeholders about the IASC Guidelines and their operationalization by different MHPSS actors in the context of the conflict in Ukraine.

Participants of the National Conference:

- NGOs and government agencies which provide psychosocial support to conflict-affected populations
- The Interagency Task Force on operationalization of the IASC Guidelines of Mental Health and Psychosocial Support in Emergency Settings in Ukraine
- Global IASC MHPSS Reference Group
- UN Agencies: UNHCR; WHO; UNICEF; UNFPA
- USAID; SDC; WB
- MDM; DRC; Caritas Ukraine; ICRC; MSF; PIN; Malteser International and others

For more detailed information on the National Conference see Part 4 “National Conference Summary”
ANNEX 1
Assessment of the Relevance of the IASC Guidelines for Ukraine context among TF members

ANNEX 2
Expectations of TF Members from TF Activities:

- Systematization (theoretical) of existing knowledge on the organization of Psychosocial Support and its introduction into the Ukrainian practical structure
- Introduction of IASC Guidelines for MHPSS in Emergencies in Ukraine while taking into account the existing experience
- Get the information for the operationalization of the IASC Guidelines for MHPSS into the procedures for Emergency response in Ukraine
- Coordination of Psychosocial Support programs, facilitation of MHPSS coordination
- Creation of conditions for the PSS systematization, share of experience, networking

ANNEX 3
Materials shared with TF for use in their IASC Guidelines operationalization activities

- 4 Ws in MHPSS sphere; manual on coding different types of activities
- Recommendations on ethical assessment in the sphere of MHPSS in emergency settings
- “Inter-Agency referral form and Guidance Note”
- “IASC MHPSS Guidelines in emergency Settings: Checklist for Field Use"
PART 2. IASC Guidelines Operationalization and Guidance Notes
SUMMARY

To strengthen the development of an integrated mental health and psychosocial support system in Ukraine by promoting awareness and understanding of the IASC MHPSS Guidelines in Emergency Settings at national, regional, and local levels International Medical Corps (IMC) has facilitated the establishment of the Ukraine Interagency Task Force to operationalize the IASC Guidelines for MHPSS in Emergencies in the Ukrainian context of protracted conflict and to develop adapted IASC-related materials specific to Ukraine.

The process of discussing the application and contextualizing the guidelines has been conducted by the Task Force jointly with the IMC MHPSS Technical Advisors, IASC Consultants and is resulted in a Ukraine-specific set of documents related to the IASC Guidelines document. This compilation includes Ukraine Guidance Notes per Coordination, Health Services, Community Mobilization and Information Dissemination domains of the IASC MHPSS Guidelines document. The information presented in the documents can be used to guide and inform further Ukraine MHPSS coordination, assessments and community mobilization activities at national and regional levels by both state and civil society actors.

IMC would like to thank the members of the Ukraine Interagency Task Force for informing the Guidance Notes.
Guidance Note on Coordination

Introduction:
Coordination among different actors involved in Mental Health and Psychosocial Support (MHPSS) can help ensure effective, complimentary, and appropriate service provision in emergency settings. Proper coordination reduces the risk of actors delivering harmful interventions and creates a more unified approach based on global guidelines and best practice. It is not recommended for actors to begin MHPSS activities without knowing what other service providers are doing. Every actor is responsible for participation in coordination mechanisms within their current context.

As part of the project “Improving Mental Health and Psychosocial Support (MHPSS) for Conflict-Affected Populations in Eastern Ukraine through Increased Capacity for Psychosocial Support Activities and Services Aligned with IASC Guidelines among National Actors, Organizations and Agencies,” a Task Force, consisting of state actors, academic institutions, international organizations and local organizations, has been created to contextualize global IASC Guidelines to Ukraine. The IASC Guidelines on MHPSS in Emergency Settings also provides guidance on MHPSS coordination. Together, the Task Force has reflected over global principles of coordination and their application in Ukraine, covering aspects of coordination groups, mapping of different actors, and creation of referral pathways. The points mentioned in this document are based on discussions during workshops and meetings with Task Force Members from May 2016 to April 2017 regarding the IASC Guidelines section on coordination that intended to explore their existing and potential application in Ukraine. Some examples provided in the document are added by IMC in addition to the Task Force meetings held within the aforementioned time period. To contextualize the IASC Guidelines on MHPSS in Ukraine, the Task Force has reviewed good practices of IASC Guidelines on MHPSS from other countries relating to coordination (See Annex “Coordination. Best Practices. Background to inform the Guidance Note on Coordination”).

Background:
In 2014, an increased number of actors started to provide MHPSS services in response to the conflict. New actors arrived, including recently formed local volunteer organizations and international organizations.

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1 WHO EMRO Facilitator Guide MHPSS in Complex Emergency Training Course
2 Note: In the IASC Guidelines on MHPSS in Emergency Settings, Action Sheets 1.1 describes guidance on how to “Establish coordination of intersectoral mental health and psychosocial support.
3 Source: Task Force Meeting #6, April 6, 2017.
1. MHPSS Coordination Group

Global Guidance on MHPSS Coordination Groups: An MHPSS coordination group is a forum where actors can provide information about existing and planned programs, share global guidelines and advise against potentially harmful practices in mental health service provision (e.g., psychological debriefing). This can help ensure that program planning and implementation are in line with the IASC Guidelines on MHPSS in Emergence Settings, reach emergency-affected communities equitably and in a timely manner⁴ and promote consultation and input of different actors including affected communities.⁵ Coordination group participants typically include representatives from key government ministries (such as ministries of health, social welfare and education), UN agencies, INGOs, professional associations and universities as well as religious or community-based organisations that are active in MHPSS. Coordination groups in humanitarian settings are typically co-led by UN agencies, INGOs, NGOs or government representatives. The MHPSS coordination group is also linked with other coordination groups or clusters.⁶ Global consensus recommends that MHPSS Coordination should be cross-sectoral among other clusters such as Health, Protection, and Education. The MHPSS Coordination Group should interact closely with Health and Protection Clusters, including representatives of emergency services and social services. It is important for the MHPSS to be linked to the Protection Cluster because many Child Protection and Gender Based Violence actors provide psychosocial support services. Protection Actors also engage in advocacy on topics that affect the wellbeing of conflict-affected populations such as access to entitlements. MHPSS Coordination groups also should seek to ensure that actors know about global guidance and best practices to inform their work. This can lead to better quality programs and minimize harm. Specifically, coordination groups should: provide information about the IASC Guidelines, adapt the IASC Guidelines to the local context, develop guidance notes or other documents in line with IASC Guidelines, advocate for use of evidence-based interventions, coordinate information dissemination and share information about services provided by organizations, lessons learned and resources. The coordination group can also be a forum for MHPSS advocacy. MHPSS advocacy seeks to advocate with other actors for MHPSS considerations (e.g., donors, other sectors). Examples of MHPSS advocacy can include to the following: discuss a need for IASC MHPSS guidance with other agencies, produce a brief MHPSS inter-agency statement, translate IASC MHPSS Guidelines into a local language (if it is not already available), disseminate relevant IASC Guidelines, summary sheets or locally produced inter-agency statements and conduct seminars or talks on IASC MHPSS guidelines with different groups (e.g. clusters, donors) and other stakeholders.

Coordination Groups in Ukraine as of May 2017: Factors creating good conditions for MHPSS Coordination included the start of the cluster system, coordination groups, inter-agency working groups, state initiatives and meetings among local volunteers.

⁴ IASC Guidelines on MHPSS in Emergence Settings, p. 33, 35
⁵ IASC Guidelines on MHPSS in Emergency Settings, p. 34
⁶ See the key terminology section for a description of the Cluster System.
Coordination Mechanisms Existing in Ukraine:

- **Health Cluster, Kiev and regional level:** The Health Cluster started sub-national Health cluster coordination meetings in Severodonetsk, Donetsk and Luhansk regions.\(^7\)

- **Protection Cluster, Kiev and regional level:** The Protection Cluster holds meetings in Kyiv. The Gender Based Violence Sub Cluster facilitates meetings in Kiev and Gender Based Violence Working Groups in Donetsk, Luhansk, and Zaporizhzhia regions. The Child Protection Sub Cluster meets in Kiev and facilitates Child Protection Working Groups in Kharkiv, Kramatorsk, and Zaporizhzhia.\(^8\)

- **MHPSS Sub-cluster, Kiev (only):** In Ukraine, the Health Cluster began its work in November 2013. Within these initial meetings, the need for an MHPSS Sub-Cluster emerged. WHO led the Sub-Cluster and International Medical Corps co-chaired. Currently, the meetings are held monthly in English and Ukrainian/Russian which allows more Ukrainian actors to actively participate.


**Local NGO Coordination:** Coordination between local NGOs through networking as well as between NGOs and state actors has proven its effectiveness at the beginning of the conflict starting in 2014.\(^9\)

Challenges with Coordination Groups in Ukraine: Reported barriers to implementing key actions on coordination in line with the IASC Guidelines include:

- Difficulties to ensure participation of various actors in the same coordination mechanism (e.g., state actors, NGOs, INGOs and volunteers).\(^10\)

- Gaps in communication between the clusters represented in Kyiv (central level) and in the regions.\(^11\)

- Barriers for state actors and other local actors to participate in the cluster.

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\(^8\) Protection Cluster Meetings Notes. April 20, 2017.

\(^9\) Source: Task Force Meeting #6, April 6, 2017.

\(^10\) Source: Summary of comments from December Information Gathering Session and Task Force Meeting #6, April 6, 2017

system such as language and lack of accessible information in Ukrainian and Russian about coordination mechanisms such as clusters and their coordination tools such as mapping.  

- Coordination among INGOs in Kyiv (e.g., in the cluster system) lacks sharing of information about assessments and mapping at the central and regional level.
- When the conflict in Ukraine protracted, local NGO coordination proved to lack sustainability.

**Recommended Actions for Coordination Groups in Ukraine:**

- Ensure that all types of actors are able to participate in the cluster system or other local existing coordination mechanisms (e.g., international organizations, state actors, local organizations, volunteer organizations) by making coordination accessible (e.g. language translation, orienting national actors about the cluster system and ways to contribute to and participate in coordination).
- Continue to clarify actions and roles for MHPSS coordination among various actors (e.g., NGOs, INGOs, state actors and volunteers). For example, determine who is responsible for leading or co-leading MHPSS coordination in a long-term and sustainable way.

- Hold coordination meetings between state oblast administrations, NGOs and INGOs in each oblast and ensure communication between regional and national level of such coordination.
- Use coordination groups as a forum to discuss evidence based practice and global guidelines (e.g., IASC Guidelines on MHPSS in Emergency Settings).
- Ensure that the exchange of information, methodological and training materials among stakeholders working in MHPSS programs is accessible to all actors in Ukraine.
- Deliver practical trainings on coordination based on the IASC Guidelines on MHPSS in Emergency Settings.

**Resources for MHPSS Coordination Groups**

12 Source: Task Force Meeting #6, April 6, 2017.
13 Source: Task Force Meeting #6, April 6, 2017.
14 Source: Task Force Meeting #6, April 6, 2017.
15 Source: Task Force Meeting #6, April 6, 2017.
16 Source: Task Force Meeting #6, April 6, 2017.
17 Source: Task Force Information Gathering Session.
18 Source: Task Force Meeting #6, April 6, 2017.
19 Source: Task Force Meeting #6, April 6, 2017.
21 Source: Task Force Information Gathering Session.
22 Source: Task Force Meeting #6, April 6, 2017.
2. Mapping

Global Guidance on Mapping: MHPSS mapping seeks to map existing MHPSS services, activities and actors. In many emergency settings, it is difficult to know “Who is Where, When, doing What (4Ws)” in mental health and psychosocial support; however, this knowledge is critical for effective coordination and provides an overview of the existing response and gaps in services which is important to avoid duplication and ensure an effective use of resources. This information is also critical to developing programs that align with needs and existing initiatives. A 4Ws tool can be used to map actors across a large region and can help identify relevant state, international, and local actors, as well as services that existed before the emergency. The IASC Reference Group for MHPSS has created a 4Ws tool and guidance specifically for MHPSS mapping (see reference section below). The IASC Reference Group for MHPSS has also created an excel sheet for 4W’s MHPSS data collection. The 4Ws MHPSS mapping tool describes steps to conduct, analyze and share the 4Ws MHPSS mapping. The tool also includes MHPSS activity codes in line with the IASC Guidelines on MHPSS and examples of 4W’s MHPSS mapping from other countries. The activity codes create a common language used to describe and map MHPSS interventions and activities.

Mapping in Ukraine:

- **Mapping conducted by State Agencies:** Different state agencies, including the State Service on Emergency Issues, completed an internal mapping of psychosocial support services provided as of 2015. In particular, the State Service on Emergency Issues collected a list of psychosocial support services and trainings provided throughout Ukraine as of 2015. The mapping data is for the internal use of the agency.

- **Mapping conducted by clusters:** Health and Protection Cluster mappings

Source: Task Force Meeting #5 and #6
include Mental Health and Psychosocial Support activities. The Ukraine Protection Cluster map is available online at

A Ukraine Gender Based Violence Sub Cluster map is available at: http://reliefweb.int/map/ukraine/gender-based-violence-sub-cluster-ukraine-3w-operational-presence-map-november-2015

• Mapping conducted by the NGO Forum: In 2017, the “NGO Forum” will roll out an interactive map of Ukrainian NGOs in the Eastern region. This mapping includes actors providing psychosocial support services. The “NGO Forum” also plans to expand the map of NGO service providers throughout Ukraine. The “NGO Forum” consolidates data about INGOs in Ukraine.

• Mapping completed by IMC: IMC conducted a pilot MHPSS mapping in Zaporizhzhia based on the intervention pyramid. To conduct the mapping, IMC gave service providers information about the IASC Guidelines on MHPSS in Emergency Settings and explained different levels of the intervention pyramid. This helped service providers understand the scope of their services in the context of the intervention pyramid.

Challenges with Mapping in Ukraine:

• Lack of a mapping tool that would be unified and agreed by and between state and cluster actors as well as international organizations in order to avoid gaps or overlapping in data collection and ensure comprehensive mapping.

• Lack of resources (e.g., human resources, time, finances) to conduct and complete mapping activities.

• Lack of responses from actors to develop the MHPSS mapping tool.

• Lack of a common MHPSS language and terms resulting in misunderstandings and different descriptions of services and interventions among actors.

Recommended Actions for Mapping in Ukraine:

• Create a common language of MHPSS activities and services to facilitate mapping of service provision (e.g., using WHO 4W’s Toolkit).

• Identify previous mapping initiatives (see examples from Mapping in Ukraine initiatives above) and build on these existing efforts.

• Engage actors at the oblast and community level to provide responses for a more comprehensive mapping.

For example, gather information for mapping through phone calls and during personal meetings or visits.

25 Source: Task Force Meeting #6, April 6, 2017.
26 Source: Task Force Meeting #6, April 6, 2017.
27 Source: Task Force Meeting #6, April 6, 2017.
28 Source: Task Force Meeting #6, April 6, 2017.
29 Source: Task Force Meeting #6, April 6, 2017.
30 Source: Task Force Meeting #6, April 6, 2017.
To help coordinate MHPSS in Ukraine, IMC also leads the MHPSS sub cluster coordination group. In line with the IASC Referral Guidance Note for MHPSS and the IASC 4Ws (Who is doing What, Where and until When) Activity Codes, IMC completed and disseminated a service mapping in Zaporizhzhia and continues to support coordination meetings to further strengthen referral pathways.

International Medical Corps has also performed mapping of services in Kramatorsk, Bakhmut, Druzhkivka, and Zaporizhzhia with a view to strengthening quality referral pathways; there has been conducted a workshop in Severodonetsk to disseminate the mapping methodology. Mapping outcomes are available at http://ngomap.org.ua/, which is a Ukrainian mapping tool. Results of the above mentioned mapping may also be found at MHPSS.net, which is an international psychosocial services mapping tool in line with the Intervention Pyramid from the IASC Guidelines on MHPSS in Emergency Settings.

**Resources for Mapping:**
  Available in English and Ukrainian.

**3. Referrals**

Global Guidance on Referrals: An important part of MHPSS services and activities is being able to refer people who often have multiple and complex needs to other service providers. This includes referral to more specialized mental health services or to other services such as health, psychosocial activities, protection services, nutrition, education, shelter, material or financial assistance, physical rehabilitation, community centre and/or a social service agency.31 In turn, providers from these agencies should also know how to refer to MHPSS services and activities. According to the IASC Guidance on Referrals for MHPSS, “a referral is the process of directing a client to another service provider because s/he requires help that is beyond the expertise or scope of work of the current service provider. The IASC Guidance on Referrals for MHPSS recommends creating an interagency referral network. Developing an interagency referral network requires agreeing on a common referral form or document, describing referral pathways and procedures for each organization, and then training relevant staff on the referral form, pathways and procedures. Continued mapping of services and coordination meetings are essential for the continued functioning of an interagency referral system. For example, coordination meetings and updated mappings provide organizations with an opportunity to provide information on changes in services or new referral procedures. Developing an interagency referral network should be an intersectoral process because access to a range of services (e.g., support for survivors of gender based violence, financial aid, and legal support) can influence mental health and psychosocial wellbeing of conflict-affected populations.

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Referrals in Ukraine:
• State Referral Mechanisms: At the beginning of the conflict the government provided information through the mass media on national and local level on where to receive services. With the conflict protracted, information provision has not become sustainable.32

• UNFPA Referral Cards33: UNFPA has created referral cards with information about available health, psychosocial and GBV services and their contact details for Donetsk, Luhansks, Kharkiv, Dnipropetrovsk and Zaporizhzhia oblasts available at: https://www.humanitarianresponse.info/en/operations/ukraine/sexual-and-gender-based-violence. UNFPA also created an interactive referral mapping with information about medical and psychosocial services available at: https://sites.google.com/unfpa.org/gbv-sc-ukraine/довідники-перенаправлення.

Challenges with Referrals in Ukraine:
• There is a lack of established MHPSS referral mechanisms in Ukraine, including to psychosocial support services provided by civil society actors and between government services and NGO/INGO services.34 35
• There is a lack of awareness about different agencies, services and means of referral on different levels

Recommended Actions for Referrals in Ukraine:
• Ensure regulated coordination between state actors and NGOs in making referrals.36
• Create a referral system clearly describing interagency delineation of responsibilities for MHPSS services, including interagency referral procedures.37
• Conduct referral workshops to facilitate information sharing and referrals between different service providers

Resources for Referrals:
• Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2017: Inter-Agency Referral Form and Guidance Note available at: https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings/content/inter-agency-referral-guidance
Available in English and Ukrainian.

Key Terminology:
Cluster System: “Clusters are groups of humanitarian organizations, both UN and non-UN, in each of the main sectors of humanitarian action, e.g. water, health and logistics. They are designated by the Inter-Agency Standing Committee (IASC) and have clear responsibilities for coordination.”38

UNFPA: United Nations Population Fund
Referral Cards: A document describing available services in a particular area.
Best Practices on Coordination

Countries: Belgium, Spain, Finland, Denmark, Japan, Canada, Turkey, Georgia, Greece
Type of Emergency: earthquakes, floods, school shooting, bombing in underground, festival panic, influx of refugees
Type of Response: Emergency, Preparedness

Activities performed in compliance with IASC Guidelines:
• MHPSS Coordination
• Information sharing: among actors and best practice dissemination
• Referrals
• Mapping

To strengthen the development of an integrated mental health and psychosocial support system in Ukraine by promoting awareness and understanding of the IASC MHPSS Guidelines in Emergency Settings at national, regional, and local levels International Medical Corps (IMC) has facilitated the establishment of the Ukraine Interagency Task Force to operationalize the IASC Guidelines for MHPSS in Emergencies in the Ukrainian context of protracted conflict and to develop adapted IASC-related materials specific to Ukraine.

This document was prepared by IMC per request of a Ukraine Task Force member for good practices of IASC Guidelines application globally. Its goal is to inform the Document “IAC Guidelines on MHPSS in Emergency Settings. Initial Context Analysis in Ukraine on Coordination” thus constitutes an Annex to the mentioned above Document.

The key sources of information for the provided below good practices are the EU Project “Operationalizing Psychological Support in Crisis: Overview of Best Practice in the EU” and the Participant Manual “Ready Calgary. Building Community Resilience” by Calgary Emergency Management Agency (CEMA, Canada).

Different agencies and organizations which facilitated an emergency response in EU countries have shared their observations about the countries` good practices which are in line with the “IASC Guidelines for MHPSS in Emergency Settings”. It should be considered however, that none of these emergencies (except for the refugee response in Greece) were considered humanitarian emergencies which warranted support by international actors. The IASC defines a complex emergency as “a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict, and which requires an international response that goes beyond the mandate or capacity of any single and/or ongoing UN country program” (Oxford Pocket Dictionary, 1992). In some contexts, or examples (e.g., Canada) international assistance and INGO’s were not involved in the response. In many humanitarian emergencies in the context of coordination, it is important to consider how international agencies, INGO’s or other additional actors are included in or leading
specific coordination mechanisms. Therefore, the broader guidance note on coordination would also need to draw from other examples of humanitarian emergencies and include the role of NGOs and INGOs. Some of the shared good practices from Europe are as follows:

• MHPSS COORDINATION

BELGIUM (a train accident emergency). The psychosocial response was carried out as described in Psychosocial Intervention Plan (PSIP) which is a part of the National Emergency Plan. Psychosocial Intervention Plan describes:

- coordination of the psychosocial responders from Immediate phase over the Transition phase to the After-care.
- centers to be set up for an emergency response:
  - Reception Center for people affected
  - Shelters
  - Telephone Inquiry Center
  - Central Information Processing Point

The Immediate phase of response includes two important players/responders:
- local PSS networks (PSN)* and
- Belgian Red Cross PS Intervention Team
  *See more on the Belgium`s PSS network in Guidance Note on Community Mobilization.

SPAIN (2004, bombing in undergrounds of Madrid). The coordination mechanism applied under the emergency was the following:

Security Coordinator of Madrid City Council appointed SAMUR-CP* responsible for the coordination of the family assistance and support Center operations where the main purpose was provision of psychological and logistic support and services to survivors and family members. The role of the Center can be described as a coordinator of the
- local government resources,
- the airline,
- the country government,
- NGOs,
- social services and
- other organizations to meet the needs of the survivors` families.

SAMUR-Civilian Protection Service identified volunteer psychologists from Spanish Red Cross, Official College of Psychologists of Madrid, Mental Health services, Social Service, etc. Psychologists from SAMUR-CP gave guidelines for psychosocial support during crisis to the professionals from other institutions.

*SAMUR is a pre-hospital emergency service in the City of Madrid under the management of the General Directorate of Emergency and Civil Protection of the City Council of Madrid.
**CANADA** (2013 flood in Calgary). Alberta Province’s Emergency Management Agencies are formed as a result of Section 11.2 of the Province of Alberta’s Emergency Management Act, which directs that a *municipality* will establish an *emergency management agency* to act as the agent of the local authority in exercising the local authority’s powers and duties under the Act (see **Chart #1**). There shall be a director of an *Emergency Management Agency*, who shall
- prepare and *co-ordinate* emergency plans and programs for the municipality;
- act as director of emergency operations on behalf of the emergency management agency;
- co-ordinate all emergency services and other resources used in an emergency; and
- perform other duties as prescribed by the local authority.

Alberta Province Emergency Management Agencies’ (EMA) roles and responsibilities flow from the Municipal Emergency Management Plan, the main policy document that identifies when and how a state of local emergency is declared. An activation of the Municipal Emergency Plan shortens the chain of command and has the director of EMA, designated by a City Council as the *fire chief*, directly reporting to the mayor and council. During the 2013 flood emergency in Calgary the Calgary Emergency Management Agency (CEMA) personnel
- staffed the Emergency Operations Center,
- activated Municipal Emergency Plan and
- declared the state of local emergency.

**GEORGIA** (2008, conflict in South Ossetia)

An active *MHPSS Sub-Cluster* including government and non-governmental organizations *facilitated by WHO* helped coordinate MHPSS services among different actors. “Mental Health and Psychosocial Support (MHPSS) sub-cluster group of the World Health Organization in Georgia met on a regular basis to discuss the needs of conflict-affected persons and coordination between the Governmental and Non-Governmental Organizations (NGO) representatives, including the Georgia Red Cross Society, trying to assist them.”

- **COORDINATION OF INFORMATION DISSEMINATION TO AFFECTED POPULATION AND BEST PRACTICE SHARING AMONG ACTORS** **JAPAN** (2011 earthquake)
  - private sector and volunteer technical communities are integrated within formal disaster management and response structures of Japan. For example, Radio Ishinomaki is a well-established local commercial radio station in Ishinomaki City. The city authorities have decided that future *disaster warnings and announcements must be transmitted by radio*. Radio Ishinomaki takes part in local government drills for broadcasting announcements.
**DENMARK** (2006, Music Festival panic emergency): there was a big need in raising awareness of the public at large of what constitutes common reactions to abnormal events after 9 people were killed in a stampede during a music festival. Since then there are volunteers trained to provide psychological first aid during the festival.

**FINLAND** (2008, school shooting): the PSS focused on psychoeducation about the common reactions caused by such crisis as well as calming methods, relaxing and other forms of self-care.

**Japan (2011 earthquake)**
- one of the first countries which adopted translated version of the IASC Guidelines, introduced MHPSS concept and integrated it to the National Emergency Preparedness Program. PFA trainings were developed and organized by the National Institute of Mental Health for defense forces, police, firefighters, nurses, school teachers. The MHPSS training system was integrated into the training plans of several Universities for Psychologists and Psychiatrists

**MAPPING:**

**Greece** (2015-2016, refugee influx)
- IMC conducted a rapid assessment and map of MHPSS actors on Lesvos, Samos, Leros and Kos as well as mapping of MHPSS actors in Athens. The rapid assessment was integrated into a multi-sectoral needs assessment. Based on the information gathered, IMC created a summary of services provided and placed the services on the appropriate levels of the IASC Guidelines Intervention Pyramid which was used for service planning. IMC and “Babel” Community Center had the obligation to share the updated mapping with all the actors participating in the MHPSS Sub-Working Group including the UNHCR health sector. This information is also valuable for the Governmental Health Sector (see Greece 4W Mapping Report in Annex 1).

**Serbia (2015, refugee influx)**
- IMC supported a quick 4Ws mapping of MHPSS services supported by the MHPSS Coordination group and used a geographical map to show gaps.

**Turkey:** (2014, refugee influx)
- “4Ws mapping document of MHPSS actors and resources was applied in Turkey by the MHPSS coordination group which included Turkey Ministry of Health, a local NGO and the WHO representatives. The document was an outcome of the MHPSS technical meeting held in Gaziantep, Turkey in July 2014. The meeting was co-chaired by WHO, UNHCR & International Organization for Migration.” It is available online at [http://mhpss.net/resource/4ws-mhpss-turkey-mapping/](http://mhpss.net/resource/4ws-mhpss-turkey-mapping/)

**REFERRALS:**

**FINLAND (2008, school shooting).**
The crisis management including referral mechanisms were immediately initiated under the lead of the local health center’s chief physician and specialized emergency
psychiatrist. Immediate crisis management was carried out by municipal public health nurses, social workers, local crisis teams, and volunteers of the Finnish Red Cross. *See more on Local Crisis Teams in Guidance Note on Community Mobilization*

**SUMMARY of GOOD PRACTICE in line with the IASC Guidelines on COORDINATION:**

MHPPS coordination in line with IASC Guidelines implies building common understanding among actors with diverse view on MHPPS to ensure timely resolution of shared problems via sustainable coordination structures by means of intersectoral programming. All the mentioned above countries have the coordination process indicators applicable in responding to an emergency which testifies to the countries` strategic focus on emergency preparedness.

The key observation from several EU countries` and Canada`s good practices of MHPPS coordination in emergency setting is that an emergency response is decentralized, namely municipalities ensure sustainability of emergency coordination structures among various actors including the MHPPS ones.

The IASC Guidelines for MHPPS in Emergency Settings connects to the good practices of MHPPS coordination in EU countries, Canada and Japan connect to the “IASC Guidelines for MHPPS in Emergency Settings” and include the following:

<table>
<thead>
<tr>
<th>Summary of Coordination Good Practices</th>
<th>Coordination Functions per IASC MHPSS Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>in EU countries and in Canada emergency coordination structures include MHPPS component and act as agents of local authorities in exercising local authorities’ powers and duties; INGOs are always part of any coordination structures with their roles and responsibilities clearly defined</td>
<td>Determine coordination mechanisms, roles and responsibilities at local, regional, national and international levels</td>
</tr>
<tr>
<td>in EU countries, in Canada and in Japan emergency plans of national, regional and municipal levels envisage MHPPS interventions as an obligatory component of any emergency response</td>
<td>Integrate MHPPS activities into national policies, plans and programmes</td>
</tr>
</tbody>
</table>
in EU countries MHPSS coordination includes various actors representing health, MHPSS, education, protection and social services as well as representatives of affected communities, INGOs, local NGOs and key government ministries. Identify MHPSS focal points for emergencies in each region and from various agencies, working in different sectors who can participate in multi-sectoral coordination groups.

Develop sustainable coordination structures, including a range of government and civil society stakeholders.

In humanitarian emergencies mapping of MHPSS actors and resources is usually done by either an INGO or a UN organization together with local NGOs or state actors following the IASC Guidelines 4W template as it is or modified (see 4W MHPSS Mapping template in Annex 3) in coordination with state actors where appropriate.

Identify qualified organizations and resource persons to conduct a 4W’s MHPSS Mapping.

Many European countries utilize local service guides and directories to facilitate referrals and specify referral points in the event of an emergency. in EU countries and Canada information sharing is supported via close cooperation between private sector and local self-governments.

Enhance information sharing among humanitarian actors about existing services provided.

In EU countries information dissemination to and psychoeducation among affected population relates to relief efforts and positive coping methods.

Coordinate information dissemination (e.g. relief efforts, services, positive coping) to the affected population.

CANADA. Chart 1. Province Emergency Management Agencies

<table>
<thead>
<tr>
<th>PROVINCE Emergency Management ACT</th>
<th>MUNICIPAL Emergency Management AGENCIES X, Y, Z</th>
<th>EMERGENCY PLANS &amp; PROGRAMS with PSS component</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESTABLISH</td>
<td>COORDINATE</td>
<td>ALL EMERGENCY PSS focused SERVICES &amp; RESOURCES</td>
</tr>
</tbody>
</table>
Greece 2016 Basic Mental Health and Psychosocial Support (MHPSS)  
4Ws Mapping Report

December 31st, 2016

Reporting agencies for the 4Ws Mapping until December 2016: IMC--MHPSS Program and Babel

CONTEXT

The process of designing and developing the MHPSS 4Ws Mapping was discussed and agreed upon during the MHPSS Sub-Working Group meetings that initiated in September 2016 and have been Co-Chaired by IMC and Babel. Feedback was also provided by all the actors present in the Sub-WG during its implementation.

OBJECTIVES

The aim of the MHPSS 4Ws mapping was to gather information about the services that are being provided in the sites all around Greece and in the urban settings. Part of the initial idea was to create a tool which could be easily accessed and used by professionals to provide essential information about MHPSS services. This tool could also be very helpful in order to avoid the overlapping and the duplications of services when new initiatives were to be launched.

In order to ensure the effectiveness of the MHPSS 4Ws mapping, it was very important that all actors would perceive it as a work “in progress”. As it was repeatedly discussed during the MHPSS Sub-Working Group, each organization needed to update the information regarding the current situation and activity of its programs. IMC and Babel had the obligation to share the updated mapping with all the actors participating in the MHPSS Sub-Working Group but also with the UNHCR health sector. This information will also be valuable for the Governmental Health Sector.
PROCEDURE

Basic MHPSS mapping categories were developed based on IASC and WHO guidelines and basic categories for services and activities. In order to have all the information gathered for the mapping an e-mail was sent to all the actors asking to fill in the map and also a copy of the mapping was available in every meeting for the newcomers or the updates. The process of collecting all the information was time-consuming since mapping wasn’t perceived as a major priority by many organizations. However, IMC and Babel had agreed on updating the mapping every two weeks after the MHPSS Sub-Working Group had taken place.

RESULTS

As it is evident in the mapping (see Table 1) there are certain sites where there are many different services being implemented by different actors while there are some other sites where no services have been recorded. Main gaps in services and activities include the lack of efficient psychiatric care on site and access to psychiatric clinics/hospitals, which has been a challenge in most of the sites throughout Greece. This is especially the case on the islands there is only one psychiatrist visiting each site once per month. As a consequence urgent needs are not met and reports by MHPSS actors point out the need of increasing the frequency of visits or number of psychiatrists. Due to this gap, availability of psychotropic medication for people with mental disorders is scarce, while monitoring of people on medication and follow-up is not timely or adequate.

There are also several gaps in psychosocial support activities. Due to the current living conditions in many of the sites, some of the psychosocial support activities are not feasible since they are affected by the weather conditions and the lack of indoor common use spaces. There is also a significant impact of the poor living conditions on people’s psychosocial wellbeing, which often causes additional distress and despair. The need to advocate for this has been repeatedly discussed in the MHPSS WG’s meetings and with UNHCR. The need for MHPSS and other actors to advocate for the improvement of the living conditions has led to the development of an advocacy letter that has been drafted and is to be sent to the pertinent ministries of the Greek Government. Additionally, in some of the sites there is a lack of activities that include PoC of both genders, with some actors focusing more on women, or in other cases there is a lack of coverage for all age groups. There are also several sites where information of existing actors is missing. The lack of services in some of the other sites could therefore either reflect the real situation, or is a consequence of not having received the necessary information from the actors. Regardless of the attempts that were made, many of the organizations, and mainly those placed out of the Attica region, have not filled in the map. It might be needed to approach actors working in other areas of Greece, or attend health coordination meetings in the islands, Epirus, or Northern Greece. At this point, the updated MHPSS 4Ws map has been shared with all the actors interested and was also published in the UNHCR’s website in order to be more easily accessed.
<table>
<thead>
<tr>
<th>Site Profiles -- Attica</th>
<th>MHPSS 4Ws Coordinated by IMC and Babel -- Last Updated: 31/12/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site name</td>
<td>Specialized MH (psychiatry)</td>
</tr>
<tr>
<td>Site name</td>
<td>Basic MH Interventions</td>
</tr>
<tr>
<td></td>
<td>PSS Support</td>
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<tr>
<td></td>
<td>PSS Activities</td>
</tr>
<tr>
<td></td>
<td>Informal Education</td>
</tr>
<tr>
<td></td>
<td>Staffing</td>
</tr>
<tr>
<td></td>
<td>Date Site Info Last Updated</td>
</tr>
<tr>
<td>Agios Andreas</td>
<td>IOM (only referrals), BABEL (only referrals)</td>
</tr>
<tr>
<td></td>
<td>BABEL, SN</td>
</tr>
<tr>
<td></td>
<td>IOM, BABEL, SN</td>
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<tr>
<td></td>
<td>IOM, BABEL, SN</td>
</tr>
<tr>
<td></td>
<td>IOM: 1 psychologist + 1 SW.</td>
</tr>
<tr>
<td></td>
<td>BABEL: 2 psychologists + 1 social worker.</td>
</tr>
<tr>
<td></td>
<td>SN: 1 psychologist + 2 SW.</td>
</tr>
<tr>
<td></td>
<td>04-11-2016, 18-11-16</td>
</tr>
<tr>
<td>Elliniko I -- Hockey</td>
<td>MDM (clinic), BABEL (only referrals)</td>
</tr>
<tr>
<td></td>
<td>MDM, BABEL (only referrals), SC</td>
</tr>
<tr>
<td></td>
<td>MDM -- Network for Children’s Rights and Arsis</td>
</tr>
<tr>
<td></td>
<td>MDM; SC -- Network for Children’s Rights</td>
</tr>
<tr>
<td></td>
<td>MDM: 2 psychologist + 1 SW</td>
</tr>
<tr>
<td></td>
<td>SC Network: 6 CFS animator + 2 cultural mediators + 1</td>
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<tr>
<td></td>
<td>CFS supervisor. SC Arsis: 1 SW + 1 lawyer (to be recruited),</td>
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<tr>
<td></td>
<td>1 psychologist (1 day per week).</td>
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<tr>
<td></td>
<td>11/4/2016</td>
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<tr>
<td>Elliniko II -- West</td>
<td>BABEL (only referrals)</td>
</tr>
<tr>
<td>/ Olympic</td>
<td>BABEL</td>
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<tr>
<td>Baseball Stadium</td>
<td>BABEL</td>
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<tr>
<td></td>
<td>BABEL</td>
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<tr>
<td></td>
<td>BABEL: 2 psychologists + 1 SW</td>
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<tr>
<td></td>
<td>1 SW + 1 play therapist.</td>
</tr>
<tr>
<td></td>
<td>11/4/2016</td>
</tr>
<tr>
<td>Elliniko III --</td>
<td>BABEL (only referrals), MDM (ECHO) (only referrals)</td>
</tr>
<tr>
<td>Baseball</td>
<td>BABEL (only referrals), MDM (ECHO), SC -- Faros and Arsis</td>
</tr>
<tr>
<td>Stadium</td>
<td>SC -- Faros and Arsis</td>
</tr>
<tr>
<td></td>
<td>MDM (ECHO, SC)</td>
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<tr>
<td></td>
<td>SC -- Faros</td>
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<tr>
<td></td>
<td>SC -- Faros: 6 CFS animators + 2 cultural mediators + 1</td>
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<tr>
<td></td>
<td>CFS supervisors. SC Arsis: 1 SW + 1 lawyer (to be recruited),</td>
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<tr>
<td></td>
<td>1 psychologist (1 day per week).</td>
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<td>11/18/2016</td>
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<tr>
<td>Eleonas</td>
<td>BABEL (only referrals)</td>
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<td>IRC, BABEL (only referrals)</td>
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<td>IRC, SC</td>
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<td></td>
<td>IRC, SC</td>
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<td></td>
<td>IRC: 3 psychologists.</td>
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<td>11/4/2016</td>
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<td>Elefsina</td>
<td>BABEL (only referrals)</td>
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<td>BABEL</td>
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<td>BABEL, SC</td>
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<td>SC</td>
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<td></td>
<td>SC</td>
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<tr>
<td></td>
<td>BABEL: 3 psychologists.</td>
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<td></td>
<td>SC: 2 cultural mediators + 2 psychosocial animators + 1 SW.</td>
</tr>
<tr>
<td></td>
<td>11/4/2016</td>
</tr>
<tr>
<td>Malakasa</td>
<td>BABEL (only referrals), MSF-F (referrals)</td>
</tr>
<tr>
<td></td>
<td>BABEL (only referrals), MSF-F</td>
</tr>
<tr>
<td></td>
<td>SC -- Faros and Arsis</td>
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<td>MDM (ECHO, SC)</td>
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<tr>
<td></td>
<td>SC -- Faros</td>
</tr>
<tr>
<td></td>
<td>MSF-F: 1 psychologist + 1 interpreter.</td>
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<tr>
<td>Rafina</td>
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<td>BABEL</td>
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<td>IOM, BABEL</td>
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<td>IOM, BABEL</td>
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<td></td>
<td>IOM: 1 psychologist + 1 SW.</td>
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<td></td>
<td>BABEL: 2 psychologists + 1 SW</td>
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<tr>
<td>Skaramagas Port</td>
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<td></td>
<td>IMC, MDM, IRC, BABEL (only referrals)</td>
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<tr>
<td></td>
<td>IMC (planned), Faros (Lighthouse)- Family center for women and</td>
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<tr>
<td></td>
<td>children, MSF, MDM, IRC, HRC</td>
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<td></td>
<td>Faros (Lighthouse)- Day-center for UAM and minors, IRC, HRC</td>
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<td></td>
<td>IRC, HRC</td>
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<td></td>
<td>IMC: 1 psychiatrist + 2 psychologists, Faros (Lighthouse)-</td>
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<td></td>
<td>Family center for women and children: 1 psychologist. MSF: 1</td>
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<td>psychologist. MDM: 1 psychologist.</td>
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<td>12/14/2016</td>
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<tr>
<td>Site Profiles --</td>
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<tr>
<td>Central Greece/Thessaly</td>
<td>Site name</td>
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<td>Thermopyle</td>
<td>Trikala (Atlantic)</td>
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<td>Larisa -- Koutsachero</td>
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<td>Ritsona</td>
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<td>MSF-F</td>
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<td>SC, HRC</td>
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<td>SC, HRC</td>
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<td></td>
<td>MSF-F: 1 psychologist + 1 interpreter.</td>
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<td></td>
<td>SC: 1 SW + 2 psychosocial animators + 2 cultural mediators.</td>
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<tr>
<td>Oinofyta</td>
<td>SC</td>
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<td>SC</td>
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<tr>
<td></td>
<td>SC: 1 SW + 2 psychosocial animators + 2 cultural mediators.</td>
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<thead>
<tr>
<th>Site Profiles -- Central Macedonia</th>
<th>Site name</th>
<th>Specialized MH (psychiatry)</th>
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<tbody>
<tr>
<td>Site Profiles -- Attica</td>
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<tr>
<td>Site Profiles -- Central Greece/Thessaly</td>
<td>Site name</td>
<td>Specialized MH (psychiatry)</td>
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<td>Trikala (Atlantic)</td>
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<td>Larisa -- Kipselochori</td>
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<td>Site Profiles -- Central Macedonia</td>
<td>Site name</td>
<td>Specialized MH (psychiatry)</td>
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<td>Derveni -- Dion--ABETE</td>
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<tr>
<td>Site Profiles -- Eastern Macedonia and Thrace</td>
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<tr>
<td>Site name</td>
<td>Specialized MH (psychiatry)</td>
<td>Basic MH Interventions</td>
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<td>Drama</td>
<td>MDM, IMC</td>
<td>MDM, IMC</td>
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<th>Site Profiles -- Epirus</th>
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<td>Doliana</td>
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<td>Filipiada</td>
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<tr>
<td>Katsika Ioanninon</td>
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<tr>
<td>Katsina Ioanninon -- EMAK</td>
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<tr>
<th>Site Profiles -- Western Greece/Peloponnesse</th>
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<tr>
<td>Site name</td>
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<td>Andravidas</td>
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RECOMMENDATIONS
To continue and facilitate coordination and mapping of actors and gaps, the following is recommended:

- To facilitate information sharing and coordination, MHPSS actors from all sites in Greece should become part of the MHPSS Working Group, or in case that this is not feasible due to the geographical distance (e.g., islands from the mainland), MHPSS Working Groups should be created in the different areas and the information should be shared with the Athens-based MHPSS WG.

- In order to better organize the MH services and PSS activities, information should be shared with MHPSS working groups and relevant camp actors concerning the plans for closure, moving of populations form one site to another, and the plan of the Ministry for the PoC in the islands.
• Involve more the Ministries of Health and Migration in the processes of the MHPSS Working Group and continue close communication with the Health Coordination Group that is now lead by the Ministry of Health.
To continue and expand the MHPSS mapping activities, the following is recommended:
• Continue updating the MHPSS mapping document through the MHPSS coordination group
• Consider organizing a more expended and detailed mapping based on UNHCR/WHO 4Ws MHPSS Mapping Tool Criteria with dedicated staff who can individually work with each organization to fill out the mapping and understand MHPSS terminology
• Organize workshops in different regions on the development of 4Ws Mapping based on the IASC and WHO Guidelines for MHPSS in order to promote the gathering of information and increase knowledge around the importance of this activity.
• Promote the information sharing gathered through the 4Ws, as a tool of advocacy for the human rights and accessibility to MH services for the PoC, through meetings with key stakeholders, public events and community outreach activities.

Contact: If you have any questions regarding this mapping report, please contact Dr. Inka Weiss becker, IMC Senior Global Mental Health and Psychosocial Support Advisor:
iweissbecker@Internationalmedicalcorps.org
## EXAMPLE OF 4WS DATA REPORTED IN JORDAN (2010/2011)

<table>
<thead>
<tr>
<th>Activity Code</th>
<th>Description of 4Ws Activity Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity 1</td>
<td>Information dissemination to the community at large</td>
</tr>
<tr>
<td>Activity 2</td>
<td>Facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general</td>
</tr>
<tr>
<td>Activity 3</td>
<td>Strengthening of community and family support</td>
</tr>
<tr>
<td>Activity 4</td>
<td>Safe spaces</td>
</tr>
<tr>
<td>Activity 5</td>
<td>Psychosocial support in education</td>
</tr>
<tr>
<td>Activity 6</td>
<td>Supporting the inclusion of social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation</td>
</tr>
<tr>
<td>Activity 7*</td>
<td>(case-focused) psychosocial work</td>
</tr>
<tr>
<td>Activity 8*</td>
<td>Psychological intervention (e.g., counselling, psychotherapy)</td>
</tr>
<tr>
<td>Activity 9*</td>
<td>Clinical management of mental disorders by non-specialized health care providers (e.g. PHC, post-surgery wards)</td>
</tr>
<tr>
<td>Activity 10*</td>
<td>Clinical management of mental disorders by specialized mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/ general health facilities/ mental health facilities)</td>
</tr>
<tr>
<td>Activity 11*</td>
<td>General activities to support MHPSS</td>
</tr>
</tbody>
</table>

*Of note: some activities under Activity 7 or 8 may also be coded under Activity 9 and 10 when these occur in health care settings. Categories 7-10 are thus not mutually exclusive.*
<table>
<thead>
<tr>
<th>MHPSS activity code (4Ws)</th>
<th>IASC Guidelines action sheet number</th>
<th>Level of IASC Guidelines pyramid</th>
</tr>
</thead>
</table>
| 1. Disseminating information to the community at large                                    | Information on the current situation, relief efforts or available services: 8.1                              | 3 If tailored to specific groups  
2 If tailored to the population in general and on positive coping methods  
1 If tailored to the population in general and on the emergency, relief efforts, and legal rights |
| 2. Facilitating conditions for community mobilisation, community organisation, community ownership or community control over emergency relief in general | 5.1                                                                                                           | 1                                                                                           |
| 3. Strengthening community and family support                                              | Communal healing ceremonies: 5.3                                                                                 | 3 if focused support is given to promote the social integration of individuals or marginalized groups  
2 if activity focuses on strengthening community and family supports                                   |
| 4. Safe spaces                                                                            | As part of protection: 3.2 (key action 5)  
As part of community organization: 5.1 (key action 5)  
As part of strengthening community or family support 5.2 (key action 4)  
As part of education 7.1 (key action 1)                                             | 2 (and sometimes 3)                                                                            |
| 5. Psychosocial support in education                                                       | As part of education 7.1                                                                                       | 1, 2, or 3                                                                                   |
| 6. Supporting including social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation | In protection: 3.1, 3.2  
In health services (social aspects) 6.1 (key action 1)  
In nutrition: 9.1  
In shelter and site planning 10.1  
In WATSAN 11.1                                                               | 1 (usually)                                                                                               |
| 7. (Person-focused) psychosocial work                                                      | Psychological first aid (PFA): 4.4 (key action 6), 5.2 (key action 5), 6.1 (key action 5)  
Other: Touched upon in 5.2 (key action 5)                | Variable                                                                                     |
| 8. Psychological intervention                                                              | Individual or group psychological debriefing: not covered  
Basic counselling for individuals: not covered  
Basic counselling for groups or families: not covered  
Interventions for alcohol/substance use problems: 6.5  
Psychotherapy: not covered                                                                 | 4, if it involves formal psychotherapy  
3. Other                                                                                      |
| 9. Clinical management of mental disorders by nonspecialized health care providers (eg PHC, post-surgery wards) | 6.2                                                                                                           | 4                                                                                           |
| 10. Clinical management of mental disorders by specialized mental health care providers (eg psychiatrists, psychiatric nurses and psychologists working at PHC/general health facilities/mental health facilities) | If specialist attached to PHC: 6.2  
Mental health facilities: 6.3                                                                  | 4                                                                                            |
| 11. General activities to support MHPSS                                                    | Situation analyses/assessment: 2.1  
Training / orienting: 4.3  
Technical or clinical supervision: 4.3  
Psychosocial support for staff / volunteers: 4.4  
Research: not covered                                                                 | Not applicable (except for training and supervision, which can be mapped on the pyramid depending on content of the training and supervision) |
# MHPSS Activity Codes and Subcodes

**READ THIS FIRST!**

- MHPSS stands for mental health and psychosocial support.
- The list includes the most common activities that are conducted under the heading of MHPSS in large humanitarian crises.
- The list is not exhaustive. You should use the category ‘other’ (describe in column C of the data entry sheet) to document activities not included in the list.
- The list is descriptive rather than prescriptive. No judgment is passed whether included activities are appropriate or not. A number of the mentioned activities are or can be controversial. For guidance on recommended practices, see IASC (2007).
- **INSTRUCTION: FILL IN THE RELEVANT MHPSS ACTIVITY CODE (SEE COLUMN A BELOW) AND SUBCODE (SEE COLUMN B BELOW) IN COLUMNS A AND B OF THE DATA ENTRY SHEET. IF ONE WORKS BROADLY IN AN AREA, THEN CHOOSE THE SUBCODE ‘OTHER’**

<table>
<thead>
<tr>
<th>Column A: MHPSS activity code (4Ws)</th>
<th>Column B: Examples of interventions with subcodes. Record all that apply.</th>
</tr>
</thead>
</table>
| 1. Disseminating information to the community at large | 1.1 Information on the current situation, relief efforts or available services in general  
1.2 Raising awareness on mental health and psychosocial support (e.g., messages on positive coping or on available mental health services and psychosocial support)  
1.3 Other (describe in column C of the data entry sheet) |
| 2. Facilitating conditions for community mobilisation, community organisation, community ownership or community control over emergency relief in general | 2.1 Support for emergency relief that is initiated by the community  
2.2 Support for communal spaces/meetings to discuss, problem-solve and plan action by community members to respond to the emergency  
2.3 Other (describe in column C of the data entry sheet) |
| 3. Strengthening community and family support | 3.1 Support for social support activities that are initiated by the community  
3.2 Strengthening parenting/family supports  
3.3 Facilitation of community supports to vulnerable people  
3.4 Structured social activities (e.g., group activities)  
3.5 Structured recreational or creative activities (do not include activities at child-friendly spaces that are covered in 4.1)  
3.6 Early childhood development (ECD) activities  
3.7 Facilitation of conditions for indigenous traditional, spiritual or religious supports, including communal healing practices  
3.8 Other (describe in column C of the data entry sheet) |
| 4. Safe spaces | 4.1 Child-friendly spaces  
4.2 Other (describe in column C of the data entry sheet) |
| 5. Psychosocial support in education | 5.1 Psychosocial support to teachers / other personnel at schools/learning places  
5.2 Psychosocial support to classes/groups of children at schools/learning places  
5.3 Other (describe in column C of the data entry sheet) |
| 6. Supporting including social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation | 6.1 Orientation of or advocacy with aid workers/agencies on including social/psychosocial considerations in programming (specify sector in column C of the data entry sheet)  
6.2 Other (describe in column C of the data entry sheet) |
| 7. (Person-focused) psychosocial work | 7.1 Psychological first aid (PFA)  
7.2 Linking vulnerable individuals/families to resources (e.g., health services, livelihoods assistance, community resources etc.) and following up to see if support is provided.  
7.3 Other (describe in column C of the data entry sheet) |
| 8. Psychological intervention | 8.1 Basic counselling for individuals (specify type in column C of the data entry sheet)  
8.2 Basic counselling for groups or families (specify type in column C of the data entry sheet)  
8.3 Interventions for alcohol/substance use problems (specify type in column C of the data entry sheet)  
8.4 Psychotherapy (specify type in column C of the data entry sheet)  
8.5 Individual or group psychological debriefing  
8.6 Other (describe in column C of the data entry sheet) |
| 9. Clinical management of mental disorders by nonspecialized health care providers (eg PHC, post-surgery wards) | 9.1 Non-pharmacological management of mental disorder by nonspecialized health care providers (where possible specify type of support using categories 7 and 8)  
9.2 Pharmacological management of mental disorder by nonspecialized health care providers  
9.3 Action by community workers to identify and refer people with mental disorders and to follow-up on them to make sure adherence to clinical treatment  
9.4 Other (describe in column C of the data entry sheet) |
| 10. Clinical management of mental disorders by specialized mental health care providers (eg psychiatrists, psychiatric nurses and psychologists working at PHC/general health facilities/mental health facilities) | 10.1 Non-pharmacological management of mental disorder by specialized mental health care providers (where possible specify type of support using categories 7 and 8)  
10.2 Pharmacological management of mental disorder by specialized health care  
10.3 Inpatient mental health care  
10.4 Other (describe in column C of the data entry sheet) |
| 11. General activities to support MHPSS | 11.1 Situation analyses/assessment  
11.2 Monitoring/evaluation  
11.3 Training / orienting (specify topic in column C of the data entry sheet)  
11.4 Technical or clinical supervision  
11.5 Psychosocial support for aid workers (describe type in column C of the data entry sheet)  
11.6 Research  
11.7 Other (describe in column C of the data entry sheet) |
Guidance Note on Health Services

Summary: the Guidance Note relates to the Health domain, which crosses all layers of the interventions pyramid. In particular, this Guidance Note focuses on recommendations relating to integration of Mental Health and Psychosocial Support (MHPSS) into primary care, and the role of primary & general health care providers in identifying & treating mental health problems & referring to specialized services.

Introduction: 
As part of the project “Improving Mental Health and Psychosocial Support (MHPSS) for Conflict Affected Populations in Eastern Ukraine through Increased Capacity for Psychosocial Support Activities and Services Aligned with IASC Guidelines among National Actors, Organizations and Agencies,” a Task Force, consisting of state actors, academic institutions, international organizations and local organizations was created in order to contextualize global IASC Guidelines to Ukraine. The IASC Guidelines on MHPSS in Emergency Settings also provides guidance psychological and social considerations in the overall provision of general health care in emergencies. Together, the Task Force reflected on this guidance and its application in Ukraine. The points mentioned in this document are drafted by Task Force members, based on discussions during workshops and meetings with Task Force Members from 2016 to April 2017 about the IASC Guidelines section on health to explore its existing and potential application in Ukraine.

Background:
The humanitarian crisis in Ukraine has affected the lives of more than 5 million of internally displaced and conflict-affected people. Those affected have been dealing with conditions which place enormous strain on their mental health, including forced displacement, disruption of social networks, disconnection from families, unemployment, and trauma associated with military actions. These factors place them at an increased risk of developing mental health difficulties which, if not identified and addressed as quickly as possible, could develop into more serious disorders requiring more intensive interventions and increasing the chances of longer term disability. The current conflict has also placed those with pre-existing mental disorders in an increasingly vulnerable situation as mental health facilities and services are stretched beyond capacity, disrupted or destroyed and specialist staff are displaced.

Ukraine benefits from the existence of a relatively large number of highly trained general health and mental health care specialists, as well as high numbers of individuals trained in a variety of psychological interventions. Specialist state-run mental health services are provided via a well-established network of outpatient dispensaries, day programs

39 IASC Guidelines on MHPSS in Emergency Settings, Action Sheets 6.1 and 6.2
and inpatient facilities, and recent reforms have been attempting to introduce mental health services into primary care through the role of family doctors. There are also large numbers of private providers of psychological services, and strong networks of volunteer psychologists and therapists established since the start of the conflict to support those affected. These factors create the potential for good access to mental health services for conflict-affected individuals and communities across all parts of the health system.

There are, however, a number of barriers to achieving the recommendations set out in the IASC Guidelines with regards to health services in Ukraine, particularly in relation to the provision of mental health care by non-specialist providers. Mental health training for general and family doctors is limited, and many doctors feel unable to identify or treat mental health problems with confidence. Legislation prevents doctors without specialist psychiatric training to prescribe many psychiatric medications, and restrictions also exist around the making of formal diagnoses which in turn impacts on the recording of epidemiological data in primary health care facilities. High levels of stigma amongst both the general public and health care providers results in low levels of help-seeking and a reluctance on the part of health care providers to discuss issues of mental health or suggest the need for treatment with their patients, often until they are experiencing severe problems. Legislation regarding patient confidentiality places limitations on information-sharing across parts of the health and social services systems and makes it difficult for general health care providers to follow-up referrals in order to ensure that patients have indeed accessed specialist services. Finally, a general lack of coordination and communication between state health services, social services and NGOs results in limited understanding amongst service providers about what other services are available in their local area, how they might be able to work together and what the appropriate referral pathways are for clients between various parts of the service system.

**Recommended Actions:** short term and long-term interventions at variety levels:

**Workforce Capacity:**
- short-term actions include trainings for primary HC providers in basics of mental health care including PFA, stress management, problem solving through individual projects or by NGOs;
- long-term actions mean embedding mental health care in trainings for HC workers through universities or state health facilities as part of systemic reforms
- attach psychologists to primary health care teams and/or
- establish specialist MH outreach teams at psychiatric dispensaries within the state system

**Referral Mechanisms:**
- all agencies are to be aware of state facilities & NGOs providing specialist MH services in their local areas by means of A) direct contact with agencies or service providers or B) local coordination groups and mapping activities
- if there are barriers due to formal referral protocols or legislation then review the protocols at regional or state levels
  Health Information System

- PATIENT CONFIDENTIALITY: to consider a state level centralized health information system to provide information on levels of need and service utilization considering safeguarding related issues.

- Localized data collection system development through regional MHPSS coordination groups (short-term)

- Any data collection system developed to consider a) formal barriers and B) lack of confidence and training in psychiatric diagnosis amongst non-specialist HC providers.

**Key Messages:**

- There are barriers to implementing IASC guidance on provision of mental health care
  - SHORT-TERM SOLUTIONS suggest primary and general health care providers receiving capacity building support with consideration of the limits of their roles and responsibilities under the current legislation
  - Attach psychologists to primary health care teams and/or
  - Establish specialist MH outreach teams at psychiatric dispensaries within the state system
  - Local coordination mechanisms allowing increased communication between state services and NGOs
  - LONG-TERM SOLUTIONS envisage a systemic reform by embedding mental health care in the primary health care system and expending mental health care service provision to professional groups beyond psychiatry

**Key Terminology:**

**Example/Case Study:**

In 2015 the WHO developed and delivered a mental health training program to general doctors and nurses working in mobile emergency primary health teams in Eastern Ukraine. The goal was to ensure that the mental health needs of conflict-affected communities was being addressed by primary health care providers and that patients requiring specialized treatment were being identified and referred to appropriate services. From the outset it was clear that many barriers existed for these teams in provision of mental health services. Legislation limiting their ability to diagnose and prescribe impacted their confidence and perception of their role in managing mental disorders. It was seen as outside their responsibility, and an issue which was not relevant for most of their patients. When they did suspect that a patient required specialist services, they were reluctant to refer to state psychiatric facilities for fear of the treatment their patients might receive and the impact of being registered as a psychiatric patient on their future employment and access to social services.
Through the course of the training these barriers were addressed to some extent. Participants were provided with information on how to identify mental health issues and shown basic intervention skills including PFA and stress management. They were also provided with accurate information about the treatment given in the state mental health system and how to make referrals. It was clear, however, that sustained changes in practice were unlikely to occur without systemic reform which formalized the integration of mental health services into primary health care and expanded the role of primary health care providers. This knowledge was influential in the WHO’s subsequent decision to set up specialist mobile mental health teams operating under the state system, with the aim to both deliver services and to strengthen the links between community agencies, family doctors and state psychiatric facilities.

Resources:

The mhGAP Humanitarian Intervention Guide contains first-line management recommendations for mental, neurological and substance use conditions for non-specialist health-care providers in humanitarian emergencies. It is available in Russian and Ukrainian translations.

Psychological first aid: Guide for field workers provides direction in delivering psychological first aid, a framework, which involves providing humane, supportive and practical help to individuals who have experienced a crisis or traumatic event. It is available in Russian and Ukrainian translations.
“Community mobilization’ refers to efforts made from both inside and outside the community to involve its members (groups of people, families, relatives, peers, neighbors or others who have a common interest) in all the discussions, decisions and actions that affect them and their future. As people become more involved, they are likely to become more hopeful, more able to cope and more active in rebuilding their own lives and communities.

At every step, relief efforts should support participation, build on what local people are already doing to help themselves and avoid doing for local people what they can do for themselves.”

- IASC Guidelines for MHPSS in Emergency Settings, page 61

Introduction

Community mobilization promotes the mental health and psychosocial wellbeing of conflict and crisis-affected populations. When persons affected by emergencies are included in actions and decision-making processes that influence them, they can regain a sense of control and play an active role in rebuilding their lives and communities. Community members often take actions to provide emergency relief, care for themselves and support others. Where possible, formal response efforts should map, coordinate with and build upon these existing natural supports and local initiatives.

The IASC Guidelines for MHPSS in Emergency Settings describes the process of community mobilization to ensure services:

• build upon existing resources,
• are suitable for the context,
• include persons who are vulnerable, and
• involve community members in design, implementation and evaluation of MHPSS initiatives.

A lack of participation can be stressful for community members. Community mobilization increases ownership of programs and interventions, further strengthening their sustainability. The IASC Guidelines Community Mobilization Action Sheets explain the following:

• Action Sheet 5.1 – how to ensure community members continue to be key actors in emergency response.
• Action Sheet 5.2 – how to “activate and strengthen local supports and to encourage a spirit of community self-help.”

40 The basis for this guidance note is the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergencies (IASC, 2007). Please see the IASC MHPSS Guidelines for more detailed guidance on community mobilization. Other reference sources are cited.
41 UNICEF Draft
42 IASC, 2007, p. 101
• Action Sheet 5.3 – how to promote “general communal religious and cultural (including spiritual) supports for groups of people who may not necessarily seek care.”
• Action Sheet 5.4 – how to “meet children’s core needs and help to reduce emergency-induced distress in safe, protected and structured settings, while providing relief and support to care-givers.”

The community mobilization steps described below guide efforts related to each of the four action sheets. Following the process of community mobilization is critical to promote self help among affected populations. Some of the steps of community mobilization are cross cutting with other sections of the IASC Guidelines such as coordination, monitoring and evaluation and human resources.

Background

Ukraine possesses a history of community mobilization efforts such as volunteers providing support to affected populations through humanitarian aid centers. The current conflict in Ukraine influences community mobilization. To respond to the conflict in 2014, a large volunteer movement emerged and supported internally displaced persons in Ukraine. Some volunteers provided Psychosocial Support (PSS) individually while other volunteers provided services through community centers supported by NGOs. The rise of volunteers changed the pre-existing structure of PSS and communities composition.

Initially right after the start of the conflict, many community members experienced an increased sense of patriotism, citizenship and hope for the future. Community members often united around the common goal to improve their lives. Three years into the ongoing conflict, many community members feel a sense of disappointment, apathy and disbelief due to the lack of improvements in their lives. Community members also feel a sense of volunteer fatigue and burn out. These feelings may discourage community members from playing an active role in rebuilding their lives and communities.

As Ukraine is in the process of decentralization, the Government reshapes the historically formed administrative-territorial boundaries of current communities by means of delegating more authorities to local governments in order to ensure decentralized service providing to communities. Before 2014 Ukraine had a centralized approach in responding to emergencies, and the State Emergency Agency of Ukraine mobilized communities at all levels via the centralized system of civil defense. In 2014 and after, a strong volunteer movement appeared in response to the military conflict. Volunteers and NGOs quickly acquired necessary skills learning from INGOs to perform respective functions when responding to a military conflict and coping with its aftermaths. Despite the conflict challenges, the active civil society able of ownership and control of emergency response emerged in Ukraine.

43 IASC, 2007, p. 106
44 IASC, 2007, p. 111
Action sheet 5.1 Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors

Before planning any activities to mobilise the community it is essential to learn about the context, e.g. cultural norms, the socio-political context, and potential risks of community mobilization (e.g., power dynamics that may marginalize different subgroups).

There are several key actions that can facilitate conditions for community mobilization, community ownership and control of emergency response. These actions include:

a. Identify and meet community stakeholders
b. Participatory assessment of community needs and resources
c. Facilitate participatory planning of solutions and interventions

a. Identify and meet community stakeholders
Communities are naturally resilient and possess strategies to cope. Communities include members who provide formal or informal support in situations of crisis. External actors (i.e. INGOs, national NGOs) responding to emergencies have the responsibility to speak with and receive input from diverse members of affected communities, such as key informants, for example local leaders, representatives from specific subgroups and vulnerable populations.

In Ukraine, examples of local leaders, inter alia, include specialists from the education and social sectors who collaborated to provide psychological support and trainings. Volunteers, civil society and NGO’s responded quickly in the emergency situation in 2014 and played an important role. For example, during Maidan the Red Cross Ukraine responded, and other civil society organizations provided support through psychologists and many people were willing to help both professionally and materially/financially. For internally displaced persons, individual village members, village councils and communities provided support when new families came to a village. Depending on the type of emergency, community members respond differently. If it is a civil emergency such as a flood, it is historically accepted for community members to wait for the State Emergency Service (DSNS) to respond and to follow instructions of its professionals. In the conflict situation that started in 2014, community members began to respond proactively.

Furthermore, it is important to explore where community members seek support and learn about the existing human resources within the community. Community members who may already be providing support to affected people may include spiritual leaders, social workers, volunteers, local council members, government leaders, health care providers, mental health care providers, recreational leaders or traditional healers.

50 Source: Task Force Meeting #6, April 6th 2017.
Also, keep an age, gender and diversity perspective in assessing community resources. Be sure to ask about who may be vulnerable due to disability (developmental or physical), ethnicity, religion, beliefs or other reasons.

b. **Participatory assessment of community needs and resources**

Conduct participatory assessments in order to include the perspectives of a variety of community members. For example, gather the perspectives of women, men, older persons, youth and children, people with disabilities, and people with various income levels, ethnic backgrounds and political views. In emergency settings, organizing safe spaces for these discussions to occur among community members is critical to the process of community mobilization.

> “Facilitating community social support and self-help requires sensitivity and critical thinking. Communities often include diverse and competing sub-groups with different agendas and levels of power. It is essential to avoid strengthening particular sub-groups while marginalizing others, and to promote the inclusion of people who are usually invisible of left out of group activities.” – IASC MHPSS Guidelines, p. 100.

Help people to reflect on how the community was before the emergency, how the community has changed since the emergency, their goals for the future and steps required to achieve those goals. Topics for participatory assessments may include:
- priority problems and suggested solutions
- pre-existing forms of family and community support (e.g., festivals, groups, sports activities)
- the influence of the emergency on coping and social support systems
- type of community-led relief efforts, including helpful initiatives from local organizations
- existing coping mechanisms and social, cultural, religious or spiritual supports
- available resources (e.g., human, financial)
- potentially harmful local/natural support practices (e.g., initiatives that violate human rights or cause additional distress).

If possible, share the findings of participatory assessments with an emergency response coordination group in order to ensure everyone has the relevant information for joint planning of interventions, decrease assessment fatigue and ensure everyone has relevant information.  

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52 Source: Unicef Draft, p.12
53 Source: IASC Guidelines, p. 101
In Ukraine, recently emerged local organizations constituting from former volunteers who responded to the Maidan needs and then the military conflict in the East of Ukraine. They act now as NGO PSS service providers in a few towns in the East of Ukraine. The NGOs use focus group discussions to explore priority problems and existing resources. They have facilitated focus group discussions with ATO veterans and their family members to determine their needs for social and psychological services and to determine the areas for new peer to peer groups. During the focus group discussions, participants highlighted the need for discussion of social problems (benefits) both in the ATO veterans community itself and with local governments, the need to organize family leisure and organize space for peer communication for war veterans and their family members.

c. **Facilitate participatory planning of solutions and interventions**

After coordinating with existing actors and completing a participatory assessment, the next step is participatory planning. To facilitate participatory planning, share findings from the assessment with community members and leaders, and jointly develop next steps. Next steps can include programs or services. Be careful that new initiatives build upon – rather than destroying or undermining – natural supports and community led initiatives. If possible, initiatives should restore previous natural support mechanisms in the community. Examples may include further supporting community members to provide relief efforts, promote self-care and social support, and foster appropriate communal cultural, spiritual, and religious healing practices.

In Ukraine, round tables are a frequently used tool to facilitate participatory planning of different activities. For example, a few local NGO PSS service providers request input from ATO veterans, their family members and community members to facilitate participatory planning of the NGOs `PSS program activities. When facilitating round tables, members of the local communities define the topics for the roundtables. During self help groups organized by the NGO PSS service-providers facilitators also ask the participants to share what topics they want to discuss in the groups.

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**Action sheet 5.2 Facilitate community self-help and social support**

Actions to facilitate community self-help groups and social support can include for example:

a. **Supporting community members with the implementation**

b. **Training and capacity building**

a. **Support community members with the implementation**

Support community members to implement their planned interventions through technical assistance (training and supervision), supporting staff wellbeing, and providing materials or financial support.

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54 Source: IMC Partner
55 Source: IMC Partner
56 Please note, training staff and providing staff support are outlined in further detail in Action Sheets 4.1, 4.2, 4.3, and 4.4
One of the NGO PSS service providers operating in Zaporizhzhia facilitated a community-based activity for families titled “Family circle” which was implemented in one of the Zaporizhzhia districts for 275 participants with support of the hosting town council. A local sponsor donated transportation and presents for children. Female community members conducted craft workshops for children. The NGO service provider together with a local magazine hosted a coloring contest for children on the topic of “My friendly family.”

b. Training and capacity building

Training and capacity building may include Psychological First Aid, how to facilitate self-help groups, training and supervision for child friendly spaces facilitators, how to ensure inclusion of persons with disabilities, and when and how to refer people in need of higher level support. The political context, safety concerns and available community resources may influence the role community members can play. Community members should be encouraged to participate as much as possible. As an example in Ukraine, organizations trained volunteers on self-care in Ukraine.57

One of the NGO PSS service providers in Kramatorsk developed a course on civil activism, which embodies the principle of involvement of communities in building and developing the country along with the state power authorities by means of mobilization of citizens (particularly ATO veterans). When the course started, the NGO PSS service provider observed distrust for the government among their beneficiaries. At the time, some veterans saw the only way to resolve the problem as “throwing a grenade at the Verkhovna Rada” (the parliament). The civil activism course developed by the NGO PSS service provider helps war veterans with lecturing and training on how to apply the human rights along with analyzing and responding to community needs. From February 3 to February 8, 2017, war veterans who were the participants of the civil activism course together with the representatives of the Department of Social Security and of the State Emergency Agency of Ukraine helped residents of the City of Avdiyvka rebuild their damaged houses. This effort strengthened the role of war veterans in the community. Now the veterans see peaceful ways to make changes. Although there is still a lot of distrust regarding the local government, the veteran community is becoming more included and ready to participate in developing their community.

One of the NGO PSS service providers while operating in Bakhmut and Druzhkivka facilitates workshops for affected community members to make crafts. Participants of the craft workshops provided positive feedback. The participants provide input on the type of crafts to do during the workshops. Participants note that it is difficult to focus on reading books or other daily routines due to the influence of the conflict. Making crafts provides them with something else to focus on aside from their daily concerns, they enjoy the process of making crafts and feel satisfaction with their work. Participants note that this process inspires them to continue to live and to strive to make their life better.

The value of the workshops was also about the opportunity to share about positive coping strategies, to acquire some practical skills which can help to bring incomes to IDP families

**Action sheet 5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices**

An NGO PSS service provider in Kramatorsk organized an event to remember the people affected by a genocide in Ukraine from 1932 to 1933 called Holodomor. To honor those who lost their lives, children and their parents made paper doves and set them to fly into the sky. The NGO also initiated and developed the event titled ‘Donetsk Region Meets its Defenders.’ The event seeks to unite Ukrainian ATO veterans, military psychologists, activists, representatives of the authorities and community members to commemorate annually the heroes of the modern history of the Donetsk Region. The new tradition will unite those who fought for Ukraine and hope to develop the region.

One of the NGO PSS service providers operating in Zaporizhzhia region started an awareness raising campaign titled ‘In the middle of a sentence’ to honor the Day of Remembrance of Victims of Political Repressions. In the campaign, ATO veterans read poems by Ukrainian poets who were political prisoners recorded on video clips. The video clips provide information about the poet’s biography, the goal of the project, the project’s founders and information about the ATO veteran reading the poem. The video clips will be shared on social networks to raise awareness about the Day of Remembrance.

**Action sheet 5.4 Facilitate support for young children (0-8 years) and their caregivers**

An NGO PSS service provider in Kramatorsk developed and implemented activities for Parenting Group which allowed parents to meet, share experiences and support each other. Topics of discussions included active listening, stress management, positive parenting, anger management, the importance of play and self-care.

One of the NGO PSS service providers while operating in Bakhmut and Druzhkivka developed and implemented a “Parent and Child” class providing an opportunity for parents and children to learn and do activities together.

**Challenges for Community Mobilization in Ukraine:**

**Challenges related to Action Sheet 5.1.**

- The change of administrative borders of the historically formed communities in Ukraine due to the decentralization reform agenda. Clarifications needed about a regulated process of coordination between civil society, the state and local self-governments to identify those who can respond in an emergency and how they should it.

- To involve community actors in emergency preparedness, use the resource of volunteers and NGO’s in a sustainable way after the initial emergency response.
Challenges related to Action Sheet 5.2.

- Community members’ fatigue related to the conflict. 58
- Different ethnicities, languages and political views in communities depending on the geographical area of Ukraine.
- To gather feedback from NGO’s when identifying existing community members who can respond to emergencies. 59
- Psychologists from NGOs or volunteers who undertake response efforts under circumstances of shelling and emergencies may not be prepared to respond to these types of emergencies. 60
- To identify the necessary financial resources for community mobilization. 61

Recommendations for Community Mobilization in Ukraine:

Recommendations related to Action Sheet 5.1.

- Establish a coordination mechanism for volunteer based activities ensuring that volunteers provide support as part of a particular organization rather than as individuals (e.g., guided by a code of conduct, with necessary preparation, training and clear roles and responsibilities). 62
- Establish a regulated mechanism for coordination between state bodies and NGOs that outline their roles in emergencies. 63
- Include active community members and volunteers in local councils and promote community mobilization initiatives within the newly amalgamated communities. 64
- Consider experience of the already amalgamated territorial communities in terms of their responsibilities in emergency response and their respective practices
- Promote participation of volunteer organisations and individual community members in fire guards under the supervision of the State Agency on Emergency Issues (DSNS) of Ukraine
- Prepare normative base for community mobilization considering the following:
  - Different levels of community mobilization (central, regiona, municipal)
  - Experience of DSNS in support provision to IDPs and with NGOs transforming it into appropriate legislative initiatives
  - Experience of DSNS as of 2008 when it developed regulatory documents as a central coordinating body on psychological help provision.

59 Source: Task Force Meeting #6, April 6th 2017.
63 Source: Task Force Meeting #6, April 6th 2017.
Recommendations related to Action Sheet 5.2.

- Include the definition and steps of community mobilization into regulatory documents at the agency and interagency levels, while developing action plans, determining roles and conducting trainings for all actors of emergency response (State, NGO, and INGO) as well as incorporating them into school curriculums.\(^{65}\)
- Learn the real needs of the affected population from affected people directly. Deliver joint trainings on participatory assessment of community needs and resources between state and civil society actors.\(^{66}\)
- Deliver seminars on Psychological First Aid and emergency response.\(^{67}\)
- Develop guidelines or leaflets describing appropriate actions in emergency settings.\(^{68}\)

**Case Study: NGO “Dopomoga Dnipro”\(^{69}\)**

Starting in 2015, the NGO “Dopomoga Dnipro” encourages internally displaced persons to start businesses and organizations. In Ukraine, an unintended impact of humanitarian aid is that it does not encourage people to work. It is important to consider how persons who are internally displaced can actively participate. In an area where internally displaced persons were ignored, the NGO “Dopomoga Dnipro” met with people from the host community to identify needs and resources for IDPs.

The NGO learned villages did not know that IDPs could receive grants. Next, the NGO “Dopomoga Dnipro” facilitated participatory planning of solutions and interventions by developing joint action plans to move people beyond just discussing their problems. To support community actors to implement and sustain MHPSS initiatives, the NGO “Dogomoga Dnipro” provided community members with information about potential projects and activities. As a result, the NGO “Dopomoga Dnipro” provided 22 grants for self employment including people with disabilities in one region, providing a good example of how communities can organize themselves.

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\(^{66}\) Source: Task Force Meeting #6, April 6th 2017.
\(^{69}\) IMC Ukraine, National Conference, June 14th 2017.
**Tools and Resources:**

*To identify and meet with community stakeholders,*

- Coordination Guidance Note Ukraine

*To conduct participatory assessment of community needs and resources,*


*To support community members to implement and sustain MHPSS initiatives,*

- Inter-Agency Referral Guidance Note for MHPSS. Available in English at: https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings/content/inter-agency-referral-guidance
• International Rescue Committee Parenting Skills training available in English at: https://mhpss.net/resource/irc-parenting-skills-training_sessions/.


• Thinking Healthy: A manual for psychological management of perinatal depression available in English at: http://www.who.int/mental_health/maternal-child/thinking_healthy/en/


• International Federation of Red Cross and Red Crescent Society (IFRC Resource) Caring For Volunteers: A Psychosocial Support Toolkit available in Russian and English at: http://pscentre.org/topics/caring-for-volunteers/.

To monitor and evaluate community MHPSS initiatives,


• IFRC M&E Framework for Psychosocial Programs: http://pscentre.org/resources/monitoring-evaluation-framework-word-files/
Best Practices on Community Mobilization

Introduction
On request of Task Force members, different agencies and organizations in EU and other high- and middle- income countries have shared their observations about the countries’ good practices in emergency response which are in line with the “IASC Guidelines for MHPSS in Emergency Settings”. It should be considered however, that none of these emergencies (except for the refugee response in Greece) were considered humanitarian emergencies which warranted support by international actors. Some of the shared good practices from Europe are as follows:

Countries: Belgium, Canada, Denmark, England, Finland, Georgia, Hungary, Japan, Kosovo, Norway, and Spain
Type of Emergency: a train accident, school shooting, earthquake, flood, terrorist attack, armed conflict
Type of Response: Emergency and Preparedness
Activities:
• Supporting or implementing community mobilization
• Improving or creating conditions for community mobilization
• Participatory assessment of community needs and resources
• Evaluating effects of community mobilization

SUPPORTING or IMPLEMENTING COMMUNITY MOBILIZATION

BELGIUM (a train accident emergency)
- Belgium’s municipalities have a Psychosocial Support Network that performed well in the emergency. Local PSS networks’ members are mainly personnel from local social services. The teams receive a 2-day training in
  - basic tasks in Reception Centers and Telephone Inquiry Center (see GN on Coordination)
  - how to register affected people
  - psychological first aid

FINLAND (2008, school shooting), lessons learned:
- training in psychological first aid must be mandatory for all volunteers. Local and nationwide exercises are an important learning arena for good preparedness.
- to place an increased focus on municipal crisis teams* and reinforce their position, and also to extend the nationwide coverage of the crisis team network.
*See more on Municipal Crisis Teams below
SPAIN (2004, bombing in undergrounds of Madrid)
- to provide space for communal mourning i.e. rooms to grieve privately were provided.

**IMPROVING or CREATING CONDITIONS FOR COMMUNITY MOBILIZATION**

NORWAY (2011, shooting in school):
- municipalities should sign agreements of intent with the NGOs in order to make the role of organized volunteers clearer
- training in psychological first aid and support must be mandatory for all volunteers.

JAPAN (2011, earthquake):
- Local community led media in particular radio contributes more effectively to the information needs of communities in disaster zones than national broadcasting media. *Emergency broadcast license schemes are of critical importance*. Emergency responders, including formal ones need to work closely with them before, during and after disasters.

CANADA (2013, flood in Calgary):
- Effective community mobilization was strong, and facilitated by the emergency management professionals whose skills take considerable time and resources to develop.
- Volunteer efforts structured and include community associations, religious groups, and professional organizations that raise volunteers at the grassroots level. Volunteer framework for oversight can also identify skill sets in advance and the development of a skills database that can be drawn from during an emergency.
- Volunteer management plan/framework created and facilitate developing a skill inventory, and articulating suitable roles for volunteers prior to an emergency
- Private sector included through business education and the formalizing of business continuity plans (BCPs) and emergency response plans (ERPs). Planning meetings and relationship building prior to a disaster are equally important in this regard.
- Community centers used as a point of entry or coordination for volunteers.

HUNGARY (Community Preparedness for Flooding)
- As part of a workshop on flood preparedness and psychosocial support members of a tightly knit town discussed the many sources of support that were necessary and forthcoming in their response and recovery work. Regarding the success of the municipal response, the group commented that: “...there is a regular personal relationship between the affected population and the officers from the municipality. [It] is a little town (7700 ppl.) and many officers have multiple positions, local government officials were able to establish relationships [with
citizens] long before the events. This trust was an important element of the success of their work.”

JAPAN (2011, earthquake and tsunami)
- Disasters provide a unique opportunity to transform the way decision-makers plan and approach risk management. Post-disaster reforms in Japan provide an example of best practice and lesson learned.
- In the immediate aftermath of the earthquake and tsunami that hit Sendai in 2011, evacuation centres did not respond to women’s needs as they were mostly run by men; effectively, women had no place to change or breastfeed, had no separate bathrooms and lacked sanitary products. Moreover, in 2011 Sendai comprised only 10% of women working on the city’s DRR. Japan is now changing this dynamic: women are represented at all prefectural disaster management councils and women will be included in the global project to train 40,000 officials and community members to play leading roles in DRR and reconstruction.

PARTICIPATORY ASSESSMENT OF COMMUNITY NEEDS

- The research project ‘Children, young people and flooding: recovery and resilience’ with children who were directly affected by flooding in England following the winter storms of 2013/4 in both an urban and a rural setting. Participants developed Children’s and Young People’s Flood Manifestos, giving recommendations for more effective local and national flood prevention, mitigation and adaptation. These Manifestos together with the project film also demonstrate a key problem – that flood policy in the UK (prevention, preparation, response, recovery) is currently too fragmented to be able to respond to the children’s concerns, since those concerns often fall between the responsibilities of different government departments.”

Georgia (2008, Conflict in South Ossetia):
- An assessment group visited the collective centers of people who fled from their homes and made a preliminary assessment of needs. The Georgia Red Cross Society actively coordinated with the Georgian Government, Ministry of Refugees and Accommodation of Georgia, Ministry of Labour, Health, Social affairs of Georgia and had been actively participating in vulnerability assessment process in close cooperation with the abovementioned governmental structures to define the exact description and the quantity of required items for displaced people.

EVALUATING EFFECTS OF COMMUNITY MOBILIZATION

DENMARK (2001, Stampede at Roskilde Music Festival)
78 Volunteers connected with the Danish Red Cross (DRC) and provided Psychological First Aid (PFA).

Evaluation: After the response, the volunteers completed a survey.

CANADA, Calgary (2013, flooding)
- In the weeks and months after the 2013 Southern Alberta floods, The City of Calgary, Calgary Chamber of Volunteer Organizations (CCVO), and others reached out to non-profit organizations and key City departments to capture some of the lessons learned and to assess how the community could better prepare for a future emergency. The aim is to create a more informed, prepared and coordinated approach to emergencies.

Community Support Team (CST)
A community support team consists of a coordinator, CST leader and members. Such team is an example of an organizational response model proposed by emergency management professionals to community associations in their organizing team members and volunteers.

SUMMARY of GOOD PRACTICE in line with the IASC Guidelines on COMMUNITY MOBILIZATION:
According to the IASC MHPSS Guidelines the process of response to an emergency should be owned and controlled as much as possible by the affected population. As people become more involved they are likely to be more able to cope and actively rebuild their own lives and communities. All of the afore presented good practices of community mobilization in EU countries refer to efforts made from both inside and outside the communities to involve its members in all the discussions, decisions and actions that affect them and their future. The self-help approach is the characteristic feature for all the measures undertaken as community mobilization good practices either at the emergency or preparedness phase of an emergency response regardless of the country and emergency origin.

The key observation from the EU countries` and Canada`s good practices of community mobilization is that it is strongly facilitated from the emergency management professionals especially of the municipal level. Continual efforts of emergency service personnel are supported by communities.

The IASC Guidelines based capitalization of the good practices of MHPSS coordination in EU countries, Canada and Japan includes the following:
### Summary of Community Mobilization Good Practices

<table>
<thead>
<tr>
<th>Good Practice</th>
<th>Community Mobilization per IASC MHPSS Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>- In Canada, the Calgary community mobilization program engages in participatory mapping and context analysis of local communities</td>
<td>Facilitate conditions for community mobilization, ownership and control of emergency response in all sectors</td>
</tr>
<tr>
<td>- EU countries, Canada and Japan augment media ties into emergency operations to support self-help and community involvement in the emergency response</td>
<td></td>
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<tr>
<td>- in EU countries, Canada and Japan municipalities augment private sector preparedness</td>
<td></td>
</tr>
<tr>
<td>- EU countries and Canada regulate volunteering by signing agreements of intent with NGO as well as structuring community support via different organizational models</td>
<td></td>
</tr>
<tr>
<td>- in EU countries, Canada and Japan emergency professionals ensure emergency response via different networks like crisis teams network, PSS (social services) network, volunteer network</td>
<td></td>
</tr>
<tr>
<td>- in EU countries, Canada and Japan grassroots organizations – community associations, religious groups and professional organizations – constitute volunteer framework for organizing activities and providing social support;</td>
<td>Facilitate community self-help and social support</td>
</tr>
<tr>
<td>- in EU countries, Canada and Japan community centers facilitate community social support activities</td>
<td></td>
</tr>
<tr>
<td>- In EU countries, Canada representatives of vulnerable population – women, children and their care givers – actively participate in different assessments and in decision making committees which improves the response to their concerns in an emergency</td>
<td>Facilitate support for young children (0-8 years) and their care givers</td>
</tr>
<tr>
<td>- EU countries, Canada and Japan support volunteering by mandatory training in psychological first aid and by developing a volunteer skills inventory/database</td>
<td>Train/supervise existing community workers on providing appropriate emergency MHPSS support</td>
</tr>
</tbody>
</table>

See Annex 1 as Canada`s good practice of community mobilization on the example of Calgary Emergency Management Agency (see GN on Coordination, Chart 1 & Chart 2). The Calgary community mobilization Program READY Calgary presents emergency response professionals` practice related to
- participatory mapping and context analysis of local communities
- development of a community response plan, strengthening local capacity to implement such plans
- development of mechanisms for mobilization of internal MHPSS resources and integration of external resources
- development of community – owned and – managed social support activities.

The key structural points of the Program shared in this document encompass:

- Program philosophy, Goals, Structure
- Program Content
- Roles and Responsibilities for Stakeholders
- Community Emergency Action Planning
- Community Response Organizational Models
- Community Support Structures
- Resources (forms of services, contacts and psychosocial care contacts/referrals)

For more information on other parts of the READY Calgary Program as well as on more details for each of the mentioned above key structural points check with the International Medical Corps team.
Community Mobilization Program by Calgary Emergency Management Agency (CEMA)

This program was developed to empower community members with important information related to emergency preparedness, response and recovery for individuals, families and communities for a more resilient Calgary. While the response phase is covered in the program, it is not the central focus of this program because disaster and applicable emergency response efforts are ultimately led and coordinated by professionally trained emergency services personnel. As such, citizens must listen for and respond to official instructions shared by these individuals during times of emergency or disaster.

<table>
<thead>
<tr>
<th>READYCalgary Program Philosophy</th>
<th>READYCalgary Program Goals</th>
<th>READYCalgary Program Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To actively engage and empower individuals to create a whole community.</td>
<td>Section 1. Covers the fundamentals of emergency management particularly significant for individuals and families.</td>
<td></td>
</tr>
<tr>
<td>2. To educate and inform Calgarians on the importance of emergency preparedness.</td>
<td>Section 2. Further develops on the material in Section 1 to reflect the needs and requirements of an entire community.</td>
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</tr>
<tr>
<td>3. To develop forms of resilience to the negative impacts of future disaster or emergencies</td>
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</tr>
</tbody>
</table>
The READYCalgary Program course Content by Sections:

Section 1. Individual/Family (as CEMA Program members)
- Emergency plans
- 72-hours emergency kits
- What’s in my backyard
- Evacuation/Shelter-in-place
- Volunteering/donating
- Resources/Education/Training

Section 2. Community (Community Support Team)
- Map your community
- Communication plan
- Business continuity
- Community Support Teams
- Networking/Partnerships
- Plan exercises/Training

READYCalgary Program – ROLES and RESPONSIBILITIES for STAKEHOLDERS

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calgary Emergency Management Agency (CEMA)</td>
<td>Program Administrator</td>
<td>➤ Establish framework and curriculum. ➤ Provide access to program materials and resources. ➤ Maintain Community Facilitator database. ➤ Evaluate and audit programs</td>
</tr>
<tr>
<td>Agency Members, Invited Partners and Other Emergency Management Organizations/ Resources</td>
<td>Subject Matter Experts</td>
<td>➤ Provide resources, support and information s required.</td>
</tr>
<tr>
<td>Community Associations Special Interest Groups Non-Profit Organizations</td>
<td>Community Facilitators</td>
<td>➤ Coordinate and organize participants. ➤ Deliver program to community members and citizens. ➤ Maintain participant database and submit numbers (only) to CEMA. ➤ Provide course feedback to CEMA.</td>
</tr>
<tr>
<td>Citizen</td>
<td>End User</td>
<td></td>
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</tr>
</tbody>
</table>
| ➤ Participate in the curriculum.  
➤ Understand, monitor, and assess the risks to minimize losses in an emergency or disaster.  
➤ Personally prepared for up to 72-hours.  
➤ Assist themselves and others in prevention, mitigation, preparedness, response and recovery activities for the next emergency or disaster.  
➤ Understand that building resilience is a long-term and continuous active process. |  |

➢ **Community Emergency Action Planning** (EAP) is a 5-step process:

Step One: Analyze your neighborhood or community.  
Step Two: Analyze the hazards and risks.  
Step Three: Develop strategies to limit the impacts.  
Step Four: Write an emergency action plan (EAP).  
Step Five: Exercise your plan (and adjust as needed).”

➢ **Community Response Organizational Models**

A core message shared by CEMA is that preparedness is a collective responsibility. During an emergency or disaster, the priorities for Community Support Teams (CST) must align with those of The City of Calgary in order to support the official response effort.

➢ **Community Support Structures**

Providing structure to your support teams will ensure that tasks are carried out efficiently and that proper safety, accountability and coordination of all CST members are provided. Best practice for developing a community support structure follows these considerations and guidelines:
- The structure is flexible to include the number of members available to participate at any given time.
- Based on Core Community Support Functions.
- May be based on existing community organizational structure, geography or designated community attributes.
- Has a manageable span of control. This relates to the number of individuals or resources that one Community Support Team (CST) Coordinator can effectively manage (see Span of Control below).
- Will consider accountability.

All Individuals must abide by instructions provided by emergency services personnel. Community Support Team (CST).

**Resources:** Emergency Contacts; Services; Psychosocial Care

Monitoring and Evaluation
“Information and communication systems can be designed to help community members play a part in recovery processes and thus be active survivors rather than passive victims.”
- IASC MHPSS Guidelines, Action Sheet 8.1, page 157

“A helpful step in coping is having access to appropriate information related to the emergency, relief efforts and legal rights...and about positive coping methods.”
- IASC MHPSS Guidelines, Action Sheet 8.2 page 163

Introduction:

In emergencies, the provision of simple information can empower, protect and promote the wellbeing of affected persons. Accurate information about the crisis situation and loved ones, available services and how to access them (including MHPSS), coping with stress and helping others cope can decrease distress levels. The IASC Guidelines for MHPSS in Emergency Settings provides guidance on how to develop materials tailored to an emergency context and highlights important information to distribute.  

Many challenges exist in emergencies to find and disseminate credible, accurate information. The usual channels for communication may be disrupted, and some groups may abuse the existing channels for specific agendas (e.g., to spread rumors or hate messages, to fabricate stories about the emergency situation or to cover up neglect of duties in delivering aid and protection to civilians). A lack of trustworthy information about the emergency and services can cause great anxiety and confusion for affected people. Responsible mechanisms to gather, update and disseminate appropriate information at the right time is crucial. Information dissemination on rights and entitlements, positive coping and emergency services can help survivors to play an active part in their own recovery and ensure participation, accountability and transparency in relief efforts. Ensuring people have access to culturally appropriate information on positive coping can help them more effectively help themselves and others in their family and community.

IASC Guidelines Information Dissemination Action Sheets:

- 8.1 Provide information to the affected population on the emergency relief efforts and their legal rights
- 8.2 Provide access to information about positive coping methods

70 The basis for this guidance note is the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings (IASC, 2007).
71 Please see the IASC MHPSS Guidelines for more detailed guidance on information dissemination in emergencies. Other reference sources are cited.
Global Guidance and Ukrainian Applications on Information Dissemination

Based on input from the MHPSS subcluster members from March to May 2017, this guidance note describes existing practices, challenges and recommendations to strengthen information dissemination to conflict-affected populations in Ukraine.

Key actions for developing and disseminating information following crisis events include:
1. Assess existing information resources and gaps,
2. Strengthen community participation in developing, validating and disseminating information,
3. Develop accessible, culturally relevant information and adapt information for different subgroups,
4. Coordinate key stakeholders to develop and distribute consistent information on positive coping.

The key actions are adapted from the IASC MHPSS Guidelines information dissemination action sheets. Each key action is described below, along with specific challenges in Ukraine and ways organizations have applied the principle.

1. **Assess existing information resources and gaps**

A first step is to learn what information and messages are currently being disseminated and affected people’s access to information. Questions to consider include:

<table>
<thead>
<tr>
<th>Questions to consider</th>
<th>Challenges in Ukraine(^{72})</th>
</tr>
</thead>
<tbody>
<tr>
<td>What messages are being distributed, both useful and harmful(^ {73})?</td>
<td>People in Ukraine are often exposed to various view points and inaccurate information. Persons living in the grey area and NGCA may have limited or no access to Ukrainian mass media technologies.</td>
</tr>
</tbody>
</table>

\(^{72}\) Source: MHPSS Subcluster
\(^{73}\) Examples of harmful messages are those that are inaccurate/outdated, stigmatizing, trauma-focused rather than resilience-focused, or those that repeat horrific images or stories, or that contain hate speech.
<table>
<thead>
<tr>
<th>Who has access to information and who does not? Who controls media channels, including control of media for a specific agenda?</th>
<th>Specific subgroups have limited access to the information, e.g., people in the military, people with impaired mobility and limited social supports (e.g., isolated older persons). For some people, it may be challenging to identify sources for information about missing persons or tortured prisoners. It is unclear which source of information should be trusted when there are multiple competing perspectives of those who disseminate information in a community (e.g., political or religious). International and national organizations experience challenges accessing NGCA to facilitate psychosocial support activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the gaps in information about people’s rights, available services and positive coping?</td>
<td>Some groups may experience difficulties accessing information to address social stressors. For example, information about how to start a business. As services are constantly changing, service providers often have inaccurate or outdated information about how to access services and referral pathways. Lack of one single source with updated accurate information on available MHPSS services. In remote areas where MHPSS services are not available, information about positive coping strategies and evidence-based self care is often lacking.</td>
</tr>
</tbody>
</table>

**Applications in Ukraine:**

- **Assessing information access:** In a conflict intense area of Ukraine, an organization completed a survey of internally displaced persons exploring what information they could access about their needs for better information access. Based on the survey results, the organization developed recommendations to improve their information dissemination to internally displaced persons.
2. **Strengthen community participation in developing, validating and disseminating information**

Involving community members – especially those subgroups for whom information is being targeted – is essential to the process of information development and dissemination. Maximize community participation in order to find out to what extent people know about existing information, and what types of messages they want to disseminate. Involving community members to also ensure that information can be easily understood (uncomplicated) and written in an empathic, supportive way. Through focus groups and interviews, be sure to include the participation of diverse community members, including children and adolescents, men and women, and people with disabilities or particular experiences (e.g., persons in the military or veterans). It is also useful to speak with influential local people to determine how and where to best deliver messages, and what public impact messages may have.

**Applications in Ukraine:**

- **Incorporating community feedback on self-care strategies:** An organization developed information on self care through a team workshop based on community feedback.

- A local organization received educational materials used in Pakistan. The materials discussed the word community. In Ukraine, the word community has a different meaning than in Pakistan so the organization adapted the materials to reflect the meaning of community in Ukraine.

- Instead of disseminating information only through distributing leaflets, an organization distributed the leaflets through health workers and supported the dissemination with medical staff such as felchers who could provide additional information to compliment what was described in the leaflets.

- An organization prepared and adapted leaflets for Ukraine about self and family care for people with recent injuries. Despite proofreading, the final printed materials still included grammar and spelling errors. Despite the need, the organization could not disseminate the materials. The errors would decrease the credibility of the content.

3. **Develop accessible, culturally relevant information and adapt information for different subgroups**

To ensure information is accessible, culturally relevant and useful for different subgroups, it is important to think about both the content of messages and what forms of media and dissemination strategies would be most effective. The following checklist can help to determine the relevance and quality of the information being provided:
Is the information...

- Relevant to the culture and context?
- Easy to understand? (e.g., information for adults should be understandable by a 12 year old, information for children should be age-appropriate using words or pictures)
- Accessible via various media and channels?
- Adapted for (and accessible by) different subgroups?
  - Age, gender and disability inclusive
  - Tailored for specific experiences (e.g., for IDPs)
- Written in a way that emphasizes strengths and resilience and does not label the target population (e.g. as ‘traumatized’)?
- Not harmful (avoiding horrific images or inaccurate information)?

Consider who is reached by existing messages and who may be left out and then adapt messages to reach various subgroups by different media channels.

**Applications in Ukraine:**

- **Easy to understand messages:** An organization provides information verbally for older persons about their pensions and how they can access health care. Several service providers in Ukraine report to frequently disseminate information about common stress reactions, information about available services, and where to access additional support if they experience difficulty functioning.

- **Information tailored to different subgroups:** Different organizations provide information for youth about how to access recreational activities; information for persons serving in the military about their rights and information about self-care to volunteers.

- **Information tailored for specific experiences:** An organization tailored information according to the changing needs of persons affected by the conflict over time. In 2014, the organization provided information about which roads were safe for evacuation and how to avoid danger. Currently, the same organization provides information on how to secure jobs, housing and scholarships for students. In the future, they will focus on providing information to help people recover.

- **Accessible via various media channels:** An organization provides information about how to access their hotline through social media (facebook). Another organization created its page in another social media as based on the information obtained from the focus group discussion it was found to be more popular for their target audience. Several service providers in Ukraine disseminate information through tv, radio, hotlines, leaflets (e.g., PFA booklets), calendars, theatre and posters displayed in public spaces, schools, or summer camps.
- **Supporting resilience**: An organization gives information to parents about how to help children of different ages. The organization disseminated the information among parents and professionals.

- **Not harmful**: An organization provides information on steps to improve wellbeing, a coloring book to reduce stress and pamphlets with accurate information about suicide prevention.

Culturally appropriate information on positive coping can “increase the capacity of individuals, families and communities to understand the common ways in which most people tend to react to extreme stressors and to attend effectively to their own psychosocial needs and to those of others.” (IASC MHPSS Guidelines, page 163). It is important in developing messages on positive coping to focus on people’s resilience and avoid labeling whole affected populations (e.g. as ‘traumatized’) while also recognizing that some people will experience mental health problems and will need information about available services. Examples of appropriate terms in Ukraine are suggested in the box below. See also the Do’s and Don’ts recommended at the end of this guidance note.

<table>
<thead>
<tr>
<th>Examples of RECOMMENDED TERMS (Can be used in place of terms to the right)</th>
<th>Examples of TERMS THAT ARE GENERALLY NOT RECOMMENDED to be used outside clinical settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distress</td>
<td>Trauma</td>
</tr>
<tr>
<td>Anguish</td>
<td></td>
</tr>
<tr>
<td>Tormented</td>
<td></td>
</tr>
<tr>
<td>Psychological and social problems/effects/difficulties</td>
<td></td>
</tr>
<tr>
<td>Adverse events</td>
<td>Traumatic Events</td>
</tr>
<tr>
<td>Adversity</td>
<td></td>
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<tr>
<td>Terrifying</td>
<td></td>
</tr>
<tr>
<td>Life threatening</td>
<td></td>
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<tr>
<td>Horrific events</td>
<td></td>
</tr>
<tr>
<td>Severely distressed people</td>
<td></td>
</tr>
<tr>
<td>Signs of distress</td>
<td>Traumatized People</td>
</tr>
<tr>
<td>Reactions to difficult situations</td>
<td>Symptoms</td>
</tr>
<tr>
<td>People with extreme/severe reactions to the emergency</td>
<td></td>
</tr>
<tr>
<td>Structured activities</td>
<td>Non-clinical activities</td>
</tr>
</tbody>
</table>

4. Coordinate key stakeholders to develop and distribute consistent information on positive coping

Information dissemination is more efficient and effective when stakeholders work together to develop and disseminate appropriate, consistent key messages. Stakeholders may include staff of local and international NGOs, UN agencies, local government, service providers and local leaders in communities. Once key messages are agreed, an inter-agency platform can be created to give all stakeholders access to the shared essential messages. Dissemination of messages can also be coordinated to make best use of the resources of all stakeholders in order to reach various subgroups in the community.

Applications in Ukraine:

➢ An organization worked together with local community health providers to develop materials raising awareness of mental health issues. An organization created leaflets to raise awareness about mental health. The leaflets included topics such as ‘What is mental health?’ ‘What is depression?’ ‘What is anxiety?’ and ‘Coping with Death.’ To develop materials, the organization collected information from primary health care staff and psychologists from mobile units about the common problems service users experience, their existing beliefs about mental health, and frequently asked questions. The organization disseminated the materials through health facility waiting rooms and awareness sessions conducted by mobile units.

Summary of Recommended Actions for Information Dissemination in Ukraine:

- Provide people with information about common stress reactions. For example, “it is common to feel sad after being displaced to a new area.”
- Provide information that encourages people to use positive coping and self-help strategies and avoid negative coping strategies (e.g. drinking alcohol), especially in remote areas.
- Provide people with information about when and where to seek additional support. For example, “if you are not feeling better, this is where you can seek help.”
- Provide information about self care targeted to service providers.
- Consider social media as one of the sources of the information dissemination.
- Disseminate information through different sources.
- Provide accurate, up-to-date and verified information.
- Consider factors that may influence people’s perception of the messages they receive (e.g., who provides the information).
- Coordinate the development, exchange and dissemination of key common messages among various actors (e.g., state, local NGOs, INGOs).
- Create a database of existing materials for Ukraine for specific areas and regions.
- Develop a single source of information for available MHPSS services.
- Train staff on how to conduct psychoeducation sessions to based on information dissemination principles.

**Resources:**


**DO’s**

<table>
<thead>
<tr>
<th><strong>DO’s</strong></th>
<th><strong>Don’ts</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Use simple, direct language that makes</td>
<td>Don’t use complicated or technical</td>
</tr>
<tr>
<td>sense to the affected people (e.g., use</td>
<td>language (e.g., no psychological/psychiatric terms)</td>
</tr>
<tr>
<td>local terms) and that can be understood</td>
<td></td>
</tr>
<tr>
<td>by a 12 year old. Include clear and</td>
<td></td>
</tr>
<tr>
<td>simple explanation of terms.</td>
<td></td>
</tr>
<tr>
<td>Focus on community priorities and keep</td>
<td>Don’t include too many messages at once, as this can confuse or overwhelm</td>
</tr>
<tr>
<td>messages short, focused and concrete.</td>
<td>people.</td>
</tr>
</tbody>
</table>

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Whilst some concepts are consistent across emergency settings, always adapt materials to culture and context.
- Discuss how best to adapt with colleagues, other organizations and affected people.
- Consider issues of appropriate personal distance, touch and gender in stress management strategies.

Consider the nature of the conflict and use international materials from similar conflicts.

<table>
<thead>
<tr>
<th>Don’t simply translate information from another country and use it in Ukraine without adaptation or consideration of the context.</th>
</tr>
</thead>
</table>

Target information to different subgroups (e.g., older persons, parents). Be inclusive with regards to age, gender and disability.
- Consider that people of different ages have different needs, values and may need a different approach in the language.
- Consider the geographic location of your target audience (e.g., urban or rural) in adapting information.

| Don’t produce materials that are of limited relevance to your target population. |
| Don’t use a font or format that is difficult for your audience to read or inappropriate for the target group. |

Gather input from experts and community leaders who are trusted by the community in developing and disseminating information.
- Consider who delivers the messages and how they are delivered. Use trusted community persons and known information portals/media already known and accessed by the community.

| Don’t send outsider into a community to deliver messages without connecting to key community members. |
| Don’t simply distribute information from outside organizations or sources unfamiliar to the community without considering the “messages and messengers”. |

Emphasize that most people will recover and will do better over time if they have access to support, and most will not be “traumatized” (e.g., will not develop PTSD). Remember that people have a lot of resilience.

<p>| Don’t refer to an entire population as “traumatized” in order to avoid stigmatizing them or causing confusion. |</p>
<table>
<thead>
<tr>
<th>Select wording carefully (e.g., “stress”, “hardship”) so that people feel comfortable to pick up materials, take them home and share them without feeling stigmatized.</th>
<th>Don’t label materials with terms that can be seen as stigmatizing or disrespectful (e.g., “Help for traumatized populations”).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect people’s dignity and acknowledge their strengths and abilities for self-help.</td>
<td>Don’t view people only as passive victims.</td>
</tr>
<tr>
<td>Provide information on where people can learn more, and keep information on services and referral pathways updated.</td>
<td>Don’t forget to continually update referral resources and their contact information.</td>
</tr>
</tbody>
</table>

The following do’s and don’ts (adapted from the IASC MHPSS Guidelines) are useful to keep in mind for information dissemination that is culturally relevant and accessible:
PART 3. IASC Guidelines. Ukraine Case Studies
Case Studies

INTRODUCTION
During the project period IMC partners in Ukraine prepared case studies to illustrate how they embedded the IASC Guidelines on MHPSS into their organizations. These examples help to further bring the Guidelines ‘to life’, demonstrating best practice – but also giving examples of challenges – from which all MHPSS players within Ukraine (and abroad) could learn and benefit.

Ethical considerations
While preparing examples, great care was taken to protect the anonymity, the confidentiality and the right to privacy of the people involved. Examples that could compromise the safety of the organization and/or people involved (clients as well as staff and volunteers) were avoided. For individual cases an informed consent was obtained.

OPERATIONALISING THE GUIDELINES IN UKRAINE

IMC has supported five local partners to apply the IASC Guidelines for MHPSS in Emergency Settings to their service delivery. The partners’ have been selected based on their experience in and desire to continue delivering psychosocial support, promoting human rights, raising awareness campaigns to meet the needs of those affected by the conflict in Ukraine.

While each organisation has a different focus and worked with different groups of affected people, they each worked to enhance coordination with other agencies.

The partner organisations all make an effort meeting the six core principles outlined in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings:

1. Human rights and equity
2. Participation of affected populations in all aspects of humanitarian response
3. Do no harm
4. Building on available resources and capacities
5. Integrated support systems
6. Multi-layered supports
CASE 1: HROMADSKE RADIO

Hromadske Radio is an independent radio station based in Kyiv. It is created by independent journalists. The radio station is an objective informant and a non-partisan discussion platform. The tasks of Hromadske Radio are to present live points of views about the events in the country and in the world. The editorial policy of of Horamadske Radio is transparent. It is guided by the principles of neutrality, independency and balanced news presentation.

The Project «Fulcrums» («Tochky opory»), started in May 2016 and finalised in July 2017. It produced 114 live call-in talk shows with live phone calls from listeners.

It all started after a focus group with veterans on December 6, 2016. One of the veterans - Andriy Ilchenko from NGO ‘Pobratymy’ (Brethren) - called the radio and offered to produce a series of live talk shows with veterans who would come to the studio and share their experience with listeners.

«Our society is afraid of veterans because it doesn’t know what to do with them» - he said.

The veterans believe that in Ukrainian there is no adequate image of them, but that there are many stereotypes and myths about veterans. The idea was to create a media platform where veterans could talk for themselves and interact with other veterans and civil population. Andriy Ilchenko (NGO ‘Pobratymy’) also wanted to support other veterans in the process of psychosocial adaptation upon their return from the war. He was ready to be a co-host of those talk shows so they could be based on the peer-to-peer principle which could help veterans feel themselves more comfortable in the studio and talk more frankly with the audience. Besides, he gave some critical feedback saying that our hosts, having no relevant experience, asked wrong questions.

Hromadske Radio decided to make a veteran sub-project within the Project «Fulcrums» and invited Andriy Ilchenko (NGO ‘Pobratymy’) to be an expert-guest of the live talk show which he called «Veteran Hour» (VH). The VH was broadcast twice or thrice a month on Saturdays. Every time Andriy invited veterans (men and women) to tell their stories and talk on the relevant topics. Veterans shared their coping mechanisms.

The mail goals of the Veteran Hour were:

1. Support veterans (men and women) and their family members, give them opportunity to advocate for themselves, express our gratitude and respect;
2. Help civil population better understand veterans and their role in our society, form an adequate image of a veteran;
3. Create a platform for interaction between veterans and civil population.

Involved in the live call-in talk shows were: Affected populations such as: IDPs, veterans and their families, people who live on the uncontrolled territory, on the frontline and near it; and Service providers such as: helping professionals, psychologists, psychotherapists, social
Success, challenges, and Lessons Learned

The veterans’ platform within the Project was a success. It was sometimes a challenge that the involved veterans were not professional hosts, creating some technical difficulties (for example, asking questions simultaneously with hosts), but this could be addressed. After every talk show staff and veterans discussed the work and tried to find the ways to improve it, they took feedback from guests and target audience, and organized listening groups. In retrospect, it might have been useful to conduct some individual workshops with presenting veterans prior to the broadcasting.

It is a great experience to use a participatory approach, peer-to-peer support, and case method in live radio talk-shows when people can advocate for themselves, share their stories and coping strategies - and that’s what evokes trust in the audience most of all. It was a good idea to create a Veteran Media Platform where hosts-veterans will talk on hot topics that are live, actual and interesting for all Ukrainians, veterans and civilians.

Related IASC Guidelines on MHPSS Core principles, Domains and Action Sheets

Core principles:

All core principles were taken into consideration in this example, but especially

1. Human rights and equity – Were discussed during the talk shows. For example, during the show “Do Veterans Have To Fight In Public Service Same As They Had To On Front Line?” people were informed about their rights

2. Participation - Hromadske Radio conducted focus groups and organized a feedback from our target audience in order to identify, mobilize and strengthen the potential, skills and capacities of veterans, their families, community and civil society, we supported the veterans’ initiative, suffice it to mention that the veterans elaborated the project and the ways of its implementation themselves;

3. Do no harm - before running the VH Hromadske Radio had consultations with the veterans and prepared for possible risks, they had the veteran in the studio who asked right questions, the veterans shared their coping strategies the hosts were very attentive and sensible to the guests and callers;

4. Building on available resources and capacities - Hromadske Radio produced the VH based on the resources they had; the talk show had a peer-to-peer format where the expert guest (and actually the co-host) Andriy Ilchenko from NGO ‘Pobratymy’ invited veterans and offered the topics, which was a unique experience for the whole team of Hromadske radio.
Domains and Action Sheets

Domain: Community mobilisation and support
- Action sheet 5.1 Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors
- Action sheet 5.2 Facilitate community self-help and social support

Domain: Information dissemination
- Action sheet 8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights
- Action sheet 8.2 Provide access to information about positive coping methods
CASE 2: NASNAHA

Charitable Fund “Nasnaha” is an organisation created to support well-being of those who has been affected by the conflict in Ukraine – women and men, boys and girls. The main activities of the organisation are aimed at resolving complex psychosocial issues related to children, aged people and gender. The organisation staff acts following the principles of humanity and the rights based approach, namely, the right for life with dignity, right for humanitarian aid, right for protection and security.

CF «Nasnaha» has worked on embedding the IASC Guidelines on MHPSS in emergency settings in the organization’s services and capabilities since May 2016.

Nasnaha has worked with the IASC Guidelines matrix of interventions, during coordination meetings, needs assessments and monitoring and evaluation (M&E), trainings and supervision, working meetings, etc. They developed a plan of roundtables with the participation of interested governmental and non-governmental parties for coordination.

Needs assessments and M&E on issues related to mental health and psychosocial support were carried out through focus group discussions with beneficiaries, and roundtables with governmental and non-governmental organizations. The local population affected by the conflict, and in particular women, men, children, older people, people with severe physical, neurological or mental disorders or disorders that existed before the conflict were identified as being at risk. Service gaps were identified on the level of specialized services, the fourth-level services on which the organization does not work.

Following a special request from the parents of children with autism, Nasnaha raised awareness on this issue during roundtables. Focus groups discussions with beneficiaries were conducted by the organization, and possible ways to address the request for support, raised by parents were assessed. Peer-to-peer support groups were considered and beneficiaries and volunteers established their own public organization in April 2017: a center for children with special needs. Nasnaha provides training and supervision to the volunteers.

Success, challenges, and Lessons Learned

The overall result was satisfactory for the beneficiaries. Nasnaha acted as a mediator between the public sector and government agencies, and facilitated coordination between the community and public sector. Nasnaha managed to mobilize community members, and support capacity development of local people (training of specialists, staff support and volunteers). In this way they made use of available human resources and supported their involvement in learning.

Initial challenges that the organization encountered included disappointment of people in the existing system of support. This could be overcome through round tables discussions, focus groups, participation of the affected population, support of volunteers, involving them in the system of inter-actions and supervisors. The lack of understanding of some community members could be overcome by involving volunteers in the training system,
and in certain activities and interventions.

Lessons learned included that the IASC Guidelines on MHPSS can be helpful to prepare a strategic plan together with humanitarian actors and communities, and to support the protection and improvement of mental health and psychosocial well-being of the population.

A significant portion of the provision of mental health and psychosocial support can be realized by the affected communities themselves, and without external organizations. It is important to strengthen local capacity, provide self-help support. The development of a multi-level system helps meeting the needs of different groups.

Recommended actions for improvement:

- Pay attention to education and capacity development
- Liaise with local community leaders
- Observance of human rights

**Related IASC Guidelines on MHPSS Core principles, Domains and Action Sheets**

*Core principles:*
All core principles were taken into consideration in this example, but especially

1. Human Rights and Equity: the rights and special needs of a vulnerable group were addressed

2. Participation: the affected population identified the needs for peer-to-peer support for parents of children with special needs

4. Building on available resources and capacities: There were no services available for children with special needs, but parents and volunteers built on what was available and used – with the support from Nasnaha - their own experiences to support their peers.

*Functions, Domains and Action Sheets*

**Function: Coordination**

- Action Sheet 1.1: Establish coordination of intersectoral mental health and psychosocial support
- Function: Assessment, monitoring and evaluation

- Action Sheet 2.1: Conduct assessments of mental health and psychosocial issues
- Action Sheet 2.2: Initiate participatory systems for monitoring and evaluation
- Domain: Community mobilisation and support

- Action sheet 5.1: Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors
- Action sheet 5.4: Facilitate support for young children (0–8 years) and their care-givers
CASE 3: NATIONAL UNIVERSITY OF KYIV-MOHYLA ACADEMY (NaUKMA)

National University of ‘Kyiv-Mohyla Academy’ (NaUKMA) is a well-known higher educational institution of the national scale based in Kyiv. The Centre for Mental Health and Psychosocial Support is a structural subdivision of NaUKMA aimed at increasing the level of mental health and psychological culture of the Ukrainian population through provision of psychological assistance by means of raising awareness, training specialists, and conducting research activities. The main actor in the project implemented by IMC from NaUKMA became Mental Health Center (in cooperation with University Faculties of psychology and pedagogy, and Volodymyr Poltavets School of Social Work).

After development and piloting of educational programs in a form of trainings for different target groups (social workers of NGOs, state Centers of Social Services for Family, Children and Youth, psychologists, volunteers, teachers of higher educational institutions), two manuals have been prepared:

1) **Academic training**: a guide for lecturers on psychosocial support for affected populations in emergencies based on resilience approach (300 copies);

2) **Non-academic training**: a manual for trainers on psychosocial support to people affected by emergencies, (500 copies).

The developed trainings, curriculum, and manuals are based on a resilience approach and reflect Ukrainian context of application of the IASC Guidelines on MHPSS, providing Ukrainian case studies, while linking the Ukrainian expertise and experience and international best practices.

The curriculum consists of 9 modules:

1) **The impact of emergencies on a person, family, community** (human rights advocacy, coordination; information dissemination etc.)

2) **Models of work for social workers/volunteers in emergencies** (coordination; food safety and nutrition; temporary accommodation and planning; sanitary and hygiene; information dissemination; community mobilization and support etc.)

3) **The concept of resilience within the context of impact on a person, family, community in emergencies** (human resources; education etc.)

4) **Principles of mental health and psychosocial support in emergencies** (human resources; education; information dissemination etc.)

5) **Needs, challenges and resources of professionals** (human resources; education; information dissemination)

6) **Engaging the clients and establishing the contact** (information dissemination; assessment, monitoring and evaluation etc.)

7) **Psychosocial recovery interventions at the level of an individual, family and local community** (assessment, monitoring and evaluation; community mobilization and support; information dissemination; health case services; education; human rights advocacy etc.)
8) Clients’ referral (coordination; assessment, monitoring and evaluation; community mobilization and support; information dissemination; human rights protection; health care services etc.)

9) Organization of social workers’ team work (human resources; education; information dissemination)

Success, challenges, and Lessons Learned

So far (September 2017) 119 people, volunteers, social workers, lecturers, psychologists, participated in trainings across Ukraine (including affected regions). Each of them claimed these trainings to be useful for their professional development and further professional activities.

One of the main challenges was finding the most appropriate translation of the term ‘resilience’ into Ukrainian. It was finally agreed between the project experts and engaged into the trainings academics and professionals that it will be written in Ukrainian as it is in English, with the definition to be provided by the WHO.

Another challenge was adapting the training content for various target groups, as each group has a different background and professional interests. To address it, the preliminary study of the training needs was arranged.

Contextualizing the Ukrainian experience of piloted trainings for an academic format, while referencing to the IASC Guidelines was also difficult. To address it, the most recent studies by international scholars and the most recently updated manuals produced by international organizations (WHO, IMC etc.) on psychosocial support in emergencies were used by experts. The access to various resources was ensured by the support of IMC.

Main lessons learned include that in order to achieve success in IASC Guidelines on MHPSS implementation in a certain country, there is a need to contextualize it within the local country context (professional, community, political) by different means: via including local cases; understanding local social work development issues, existing theory and practice to build upon them new knowledge and practices; via respect and trust the local professionals’ experience and vision while localizing the Guidelines into their professional environment.

Before starting implementing the IASC Guidelines, there is a need to understand the logistic of the document, its theoretical background (resilience concept, eco-social model, strengths perspective). It is necessary to train the personnel in a good and clear way on the structure and details of the IASC Guidelines on MHPSS. It is essential to use examples from Ukrainian practice, and to ensure timely and regular advisory sessions for the staff engaged.

Recommended actions for future improvement include to consider one’s own experience and contextualize the Guidelines within one’s own professional background; to consider local context and experience of addressing emergencies issues (and not only the one from
outside); and to ensure more flexibility and freedom in applying the IASC Guidelines on MHPSS in practice, less control and more trust to those people implementing the Guidelines.

Related IASC Guidelines on MHPSS Core principles, Domains and Action Sheets
The trainings and training material prepared by NUAKMA addressed all core principles, functions and domains from the Guidelines, and contextualised them. In particular, the following principles and action sheets are addressed in this example:

Core principles:
All core principles were taken into consideration in this example, but especially

4. Building on available resources and capacities: local staff, was trained, using local experience and local examples

Functions, Domains and Action Sheets
Function: Coordination

- Action Sheet 1.1: Establish coordination of intersectoral mental health and psychosocial support
- Action Sheet 2.1: Conduct assessments of mental health and psychosocial issues; assessment of training needs
- Action Sheet 4.3: Organise orientation and training of aid workers in mental health and psychosocial support.
CASE 4: RESURS

NGO “Resource” is focusing on creating a network of support and self-help groups for ATO veterans and their family members in Zaporizhzhia region. Facilitators for groups are recruited from veterans’ wives and other family members. Facilitators lead groups in collaboration with psychologists. This organisation also supports Family Club events aimed at socialization of ATO veterans as well as strengthening relationships within families and communities.

Many veterans experience disturbance of sleep, increase of aggression, change of values, state of depression, and excessive alcohol consumption as a destructive way out of the stressful state. Furthermore, demobilized ATO participants face challenges of employment primarily because of disabilities and employers’ stigmatization of veterans. At the same time, women, children, and family members of veterans, experience tension. All these factors provoke an increase of conflicts inside families of veterans, domestic violence, conflicts of veterans with the community, thus creating high emotional tension among the population of the region.

Self-help groups were organized and conducted by trained veterans-facilitators under supervision of specialists-psychologists of Zaporizhzhia NGO ‘Resurs’, international organizations like IMC, and local governmental organizations. The self-help groups for veterans’ families promote understanding the veteran’s state after demobilization, as well as giving veterans a possibility to be involved in the process and understanding that they are not alone; to be able to communicate with those who have similar experience. The peer-to-peer support approach in these promotes trust to humans, community, and society.

The aim of the groups is to help veterans overcome challenges of inter-personal and intra-family life and interaction in social settings; they also help with sleep disturbances, increased aggression, difficulties in adaptation to peaceful life, and integration of war experience into the structure of personal experience.

To implement the project effectively, clear job descriptions and a code of conduct was developed, in line with the IASC Guidelines on MHPSS. Trainings on Guidelines were conducted for all the project staff.

Success, challenges, and Lessons Learned
The self-help groups were considered to be successful. Working on basis of “peer-to-peer” principle removed barriers. They promote community involvement in supporting ATO veterans to adaptation to civil life.

The main challenge in the process of creating self-help groups was finding motivated veterans and involving them in conducting groups. The problem was tackled by multilevel dissemination of information about project possibilities starting from private
communication with volunteers close to veterans and ending with wide informing community through different PR tools. A lesson learned was that the dissemination of information and the promotion about self-help groups among local communities should be done systematically.

In spite of veterans’ negative attitude to psycho-social support there is a need for it and similar projects working on basis of “peer-to-peer” principle give a possibility address this need. We recommend using the model of organizing work of self-help groups (developed during the project) for the affected population as widely as possible in resembling social contexts

**Related IASC Guidelines on MHPSS Core principles, Domains and Action Sheets**

**Core principles:**
All core principles were taken into consideration in this example, but especially

2. Participation of affected ATO veterans, their families and communities

4. Building on available resources and capacities

**Functions, Domains and Action Sheets**
Function: Assessment, monitoring and evaluation

- Action Sheet 2.1: Conduct assessments of mental health and psychosocial issues; assessment of training needs
  Domain: Community mobilisation and support

- Action sheet 5.1: Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors

- Action Sheet 5.2 Facilitate community self-help and social support
CASE 5: STUDENA

Non-profit organization «STUDENA» implements cultural and educational and human rights projects. It acts to reduce aggression and increase tolerance in the society. The organization promotes the idea of equity of rights and opportunities for people regardless their race, sex, religion. The key areas of STUDENA’s activities are social adaptation of combatants, gender equality, culture and education and human rights advocacy.

The organisation works in post-occupation territories, in and around the City of Kramatorsk.

At the Me, the Community Public Activism School operating at the Poruch Center, human rights has been a repetitive subject at lectures. In March 2017, a group of people that attended the school decided to come up for the rights of veterans with a disability in Kramatorsk. They established an organization to address the needs these veterans. They advocated, amongst others, for the construction of ramps and making the city more comfortable and accessible for people with special needs.

STUDENA created a safe place where affected people can receive information and answers to questions they may have. The needs of the people from the area were assessed, without forcing the Centre’s vision upon them. This enabled trustful relations between beneficiaries and the Center.

Awareness of rights, existing laws and regulatory acts, but also social support helped people taking responsibility for their own lives. It mobilized people to provide support to members of their community and led to the establishment of a self-help structure.

Success, challenges, and Lessons Learned

Discussions about human rights subject not only helped people to learn about the existence of these rights, but also enables an understanding to a rights-based approach within the community.

One of the challenges was that some students of the Me, the Community course were ready to take responsibilities, while others were hesitant. It was possible to overcome this through informational and educational campaigns and activities. Beneficiaries constantly felt supported at Poruch.

An improvement of coordination between governmental and nongovernmental structures, would be helpful to further enhance the support.

Related IASC Guidelines on MHPSS Core principles, Domains and Action Sheets

Core principles:
1. Human Rights and Equity: The discussions and activities around human rights helped mobilizing community members
2. Participation: students as well as other people in the area participated

4. Building on available resources and capacities

**Functions, Domains and Action Sheets**

Domain: Community mobilisation and support

- Action sheet 5.1. Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors.
- Action Sheet 5.2. Facilitate community self-help and social support. At the centre conditions for community mobilization were created and people created self-help groups Function Protection and Human Rights
- Action Sheet 3.2. Identify, monitor, prevent and respond to protection threats and failures through social protection
- Action Sheet 3.3. Identify, monitor, prevent and respond to protection threats and failures through legal protection
PART4. National Conference Summary
National Conference

A National Conference was organized on June 14 and 15, 2017 in Kyiv to bring together actors working on mental health and psychosocial support to people affected by the conflict in Eastern Ukraine.

PARTICIPANTS

- Local NGOs which provide psychosocial support to conflict-affected populations
- Members of the Interagency Task Force on operationalization of the IASC Guidelines of Mental Health and Psychosocial Support in Emergency Settings in Ukraine
- Representatives from the Inter Agency Standing Committee (IASC) Reference Group on Mental Health and Psychosocial Support (MHPSS)
- Donor community: United States Agency for International Development (USAID); Swiss Agency for Development and Cooperation (SDC), the World Bank; Israeli Embassy in Ukraine
- The International Committee of the Red Cross (ICRC)
- International NGOs such as Médicins du Monde (MDM), Danish Refugee Council (DRC), Caritas Ukraine, Médicins sans Frontières (MSF), People in Need (PIN) and Malteser International.

OBJECTIVES

1. To share Ukrainian practice, outcomes, achievements, and challenges relating to the operationalization of the IASC Guidelines on MHPSS
2. To inform about the IASC Guidelines on MHPSS and advocate for its application in practice
3. To collect suggestions and agree on further steps on operationalization of the IASC Guidelines on MHPSS in Emergency Settings in Ukraine.

RESULTS

1. To share Ukrainian practice, outcomes, achievements, and challenges relating to the operationalization of the IASC Guidelines on MHPSS

IMC invited Members of the Interagency Task Force on operationalization of the IASC Guidelines of Mental Health and Psychosocial Support in Emergency Settings in Ukraine, NGOs, government agencies which provide psychosocial support to conflict-affected
populations. The conference provided a good opportunity to share experiences on Mental Health and Psychosocial Support (MHPSS) in Ukraine. Participants shared their achievements, and challenges related to the operationalization of the IASC Guidelines on MHPSS.

At the same time, it provided an opportunity to inform various actors (international organizations, state organizations, local organizations, academic institutions and donors) about the IASC Guidelines and advocate for its application in practice. The National Conference highlighted the following areas of the IASC Guidelines for MHPSS: health, coordination, community mobilization and information dissemination. International speakers highlighted the global guidance on the topic and speakers from Ukraine described the application of the domain in Ukraine.

As a result of discussing the experience of work in line with the IASC Guidelines recommendations, it became obvious that its institutionalization would need great efforts and a lot of time from both the public and civil society sectors. The participants of the event agreed that institutionalization of the document made its usage a requirement at the system and organizational level. Such a requirement envisions change of policies, procedures and practices. Global Coordinator of Reference Group for MHPSS represented the IASC MHPSS Guidelines Institutionalization Checklist to the participants of the Conference. A sample of the Checklist is provided in Annex 2 to this section.

2. To inform about the IASC Guidelines and advocate for its application in practice
During his presentation, a representative of the State Emergency Agency of Ukraine showed examples of how the Agency used the core principles of the IASC Guidelines since 2015. During his presentation on coordination in Zaporizhzhia, a representative of the State Emergency Agency of Ukraine in Zaporizhzhia Region - described how the use of the intervention pyramid can improve the Agency work on referrals.

IMC’s five partners described the use of the IASC Guidelines on MHPSS in their programmes and facilitated discussions with the participants about the application of the Guidelines within Ukraine. The Global IASC MHPSS Reference Group Coordinator highlighted the diversity of actors involved in discussion about the IASC Guidelines in Ukraine stating “it is a unique component to have donors, universities, local NGOs and INGOs all being involved.” To promote further use of the IASC Guidelines, IMC distributed stickers that said ‘I use the IASC Guidelines in my work’ at the National Conference.

3. To collect suggestions and agree on further steps on operationalization of the IASC Guidelines on MHPSS in Emergency Settings in Ukraine.

3.1 Task Force
Procedures required for endorsement of the IASC Guidelines on MHPSS makes official endorsement challenging, as this requires a longer term process. However, during the Task Force Meeting on April 6th 2017, the Task Force agreed on the package of IASC Guidelines
and Associated Products for dissemination in Ukraine which demonstrates their readiness to use and officially approve the IASC Guidelines for MHPSS at state level. At the National Conference, state agencies publically described their possible application of the IASC Guidelines for MHPSS during their presentations.

### 3.2 State Actors

#### State Emergency Service of Ukraine (DSNS National (Kyiv))

The State agency member of the Interagency Task Force on operationalization of the IASC Guidelines expressed an openness to engage with local and international organizations and apply the IASC Guidelines for MHPSS. This demonstrates significant progress and may be related to the work with the Task Force to strengthen collaboration with various actors.

#### Ministry of Health (MoH)

When discussing the National Mental Health Concept Program, representative of the Ministry of Health of Ukraine explained that MoH considered the principles of the IASC Guidelines for MHPSS when developing the National Mental Health Concept. Specifically, MOH considered the components of multi-layered support, coordination, M&E, community mobilization and information dissemination. During her opening on the second day, Deputy Minister of the Ministry of Health of Ukraine stated that MOH is exploring how to implement the IASC Guidelines for MHPSS.

#### Ministry of Temporarily Occupied Territories (MTOT)

As a newly formed ministry, the representative of the MTOT explained the new state program on peace building in Eastern Ukraine as an instrument of community mobilization at the local level. MTOT explained how the peacebuilding program refers to all the domains of the IASC Guidelines for MHPSS with a specific focus on community mobilization through peacebuilding, livelihood support and improving access to social services.

#### Others

Also other government representatives expressed their interest in the Guidelines. Procedures required for an official endorsement of the IASC Guidelines are challenging, and requires a longer term process.

### 3.2 IMC’s Partner Organizations

Participants of the Training of Trainers programme on the IASC Guidelines for MHPSS demonstrated their acceptance and use of the IASC Guidelines for MHPSS. They will facilitate orientation seminars.

IMC will also share examples of the use of the IASC Guidelines by local organizations and examples of embedding (institutionalizing) the IASC Guidelines into organizations. IMC prepared a call for case studies on embedding the IASC Guidelines into organizations amongst its’s partners. IMC partners will prepare a case study as part of their final report. These case studies provide practical examples of how organizations can use the IASC Guidelines in their organization in the Ukrainian context.
In total 62 participants completed the satisfaction form.

### National Conference Evaluation

<table>
<thead>
<tr>
<th>How likely is it that you will...</th>
<th>Number of participants who replied yes</th>
<th>Percentage of participants who replied yes</th>
</tr>
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<tbody>
<tr>
<td>Use the knowledge from the conference?</td>
<td>60/62</td>
<td>96.7%</td>
</tr>
<tr>
<td>Implement your next organizations program using knowledge from the conference?</td>
<td>59/62</td>
<td>95.2%</td>
</tr>
<tr>
<td>Use the IASC Guidelines?</td>
<td>59/62</td>
<td>95.2%</td>
</tr>
<tr>
<td>Use our practice outcomes achievements and challenges to improve your program implementation?</td>
<td>58/62</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

When asked for overall feedback, people replied with the following:

- ‘the information was at a very high level,’
- ‘we look forward to receiving the materials,‘
- ‘very important and useful knowledge,’
- ‘would be interested in attending future events,’
- ‘it is great that there are people who work with beneficiaries at the conference’ and
- ‘thank you organizers for the opportunity to take part in the experience shared about our country and the world in general.’

To improve the conference, participants suggested the following:

- ‘wanting to hear the presentations from all partners,’
- ‘more workshops and time to exchange information,’
- ‘more practical examples in the speeches,’
- ‘so much information and it is hard to take everything at once.’

When asked how relevant the conference was to your responsibilities, the average response was 4.7/5.0 (94%). When asked about overall level of satisfaction with the conference, people stated 4.7/5 (94%). When asked ‘if the explanation of the IASC Guidelines was suitable,’ 58/62 (93.5%) responded yes.

National Conference
Kyiv, June 14-15 of 2017
Bratyslava Hotel

The National Conference is aimed at creating a forum platform for MHPSS system stakeholders: state, INGOs, and national NGOs to coordinate and build next steps for joint actions in line with IASC Guidelines on MHPSS in Emergency Settings in Ukraine.

Objectives of the National Conference:

1. To share Ukrainian practice, outcomes, achievements, and challenges relating to the operationalization of the IASC Guidelines.
2. To inform about the IASC Guidelines and advocate for its application in practice.
3. To collect suggestions and agree on further steps on operationalization of the IASC Guidelines on MHPSS in Emergency Settings in Ukraine.

Invited participants:

- NGOs and government agencies which provide psychosocial support to conflict-affected populations
- The Interagency Task Force on operationalization of the IASC Guidelines of Mental Health and Psychosocial Support in Emergency Settings in Ukraine
- Global IASC MHPSS Reference Group
- UN Agencies: UNHCR; WHO; UNICEF; UNFPA
- USAID; SDC; WB
- MDM; DRC; Caritas Ukraine; ICRC; MSF; PIN; Malteser International and others
DAY 1: June 14, 2017
IASC Guidelines on MHPSS in Emergency Settings Global and Ukrainian Context
Moderator: Nadiya Tryshchuk

9:00 – 10:00  Registration

10:00 – 10:25  Opening Welcome

10:00– 10:10  Sergii Khomchenko
International Medical Corps in Ukraine

10:10 – 10:20  Tatiana Rastrigina
USAID Ukraine Health Office

10:20 – 10:25  Sarah Harrison
IASC Reference Group on MHPSS

10:25 – 11:30  IASC Guidelines on MHPSS – Global and Local Context
Domains: Health Care; Coordination; Community Mobilization; Education; Information Dissemination

10:25 – 10:40  IASC Guidelines: General overview  Sarah Harrison
IASC MHPSS RG Coordinator

10:40 – 10:00  WHO: Global Mental Health Agenda  Kenneth Carswell
WHO

11:00 – 11:10  National Mental Health Concept Program  Andriy Karachevskyi
Ministry of Health of Ukraine

11:10 – 11:20  Q&A Session

11:20 – 11:45  COFFEE BREAK
11:45 – 12:00  MHPSS Coordination in line with the IASC Guidelines and good practices world-wide
Sarah Harrison
IASC MHPSS RG

12:00 – 12:10  MHPSS Coordination in emergency settings in Ukraine
Anatolii Sychevskyi
State Emergency Agency of Ukraine (DSNS)

12:10-12:20  Psychosocial support in Emergency settings. Zaporizhzhia experience
Volodymyr Oliynyk
DSNS, Zaporizhzhia

12:20 – 12:30  Coordination: Civil sector experience mapping case Donetsk and Luhansk regions
Nadiya Chorna
NGO Forum

12:30 – 12:40  Community mobilization model. International experience
Sarah Harrison
IASC MHPSS RG

12:40 – 12:50  State program on peace building in Eastern Ukraine as an instrument of community mobilization at the local level
Andriy Sinkevych
Ministry of Temporarily Occupied Territories

12:50 – 13:00  Community mobilization: community mobilization case of Dnipro
Iryna Bulysheva
NGO “Dopomoga Dnipro”

13:00 – 13:15  Q&A Session LUNCH

13:30 – 14:30

14:30 – 14:40  Education domain of the IASC Guidelines Key results on child protection in the context of conflict in Ukraine
Olga Klymovska
UNICEF

14:40 – 14:50  The system of psychosocial support of children in education system of Ukraine
National Academy of Pedagogical Sciences

14:50 – 15:00  Q&A Session

15:00 – 15:10  Information dissemination – IASC Guidelines Approach
Inka Weissbecker
IMC
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker/Representative</th>
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<tbody>
<tr>
<td>15:00 – 15:10</td>
<td>Building awareness on mental health. MH programming in Eastern Ukraine case example.</td>
<td>Monica Mukerjee Médecins du Monde-France (MDM-F)/</td>
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<tr>
<td>15:10 – 15:20</td>
<td>Q&amp;A Session</td>
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<td>15:40 – 16:10</td>
<td>Coffee break</td>
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<td>16:10 – 17:30</td>
<td>Workshops MHPSS Guidelines practical applications examples:</td>
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<td>Sections:</td>
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<td></td>
<td>1. Human Resources</td>
<td>CF ‘Nasnaha’</td>
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<td>2. Community Mobilization</td>
<td>NGO ‘Resource’</td>
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<td>3. Information Dissemination</td>
<td>NGO ‘Hromadske Radio’</td>
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<td>4. Human rights</td>
<td>Radio</td>
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<td>5. Psychosocial support in emergency settings – resilience approach</td>
<td>NGO ‘Studena’</td>
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<td>NaUKMA</td>
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<td>17:30 – 18:00</td>
<td>Plenary: Wrap-up of the 1st day. Presentation of results of information and awareness raising activities on positive coping implemented by partner organizations</td>
<td>Lidia Kasianchuk International Medical Corps</td>
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<td>18:00 – 20:00</td>
<td>Evening Reception</td>
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**DAY 2: June 15, 2016**

**Operationalization and Institutionalization of IASC Guidelines.**

**Evidence-based approaches in MHPSS.**

**Moderator: Kira Lomakina**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>9:00 – 10:00</td>
<td>Registration</td>
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<td>10:00 – 10:10</td>
<td>Opening of the 2(^{nd}) day</td>
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<td>Oksana Syvak</td>
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<td>Ministry of Health of Ukraine</td>
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<td>10:10 – 11:15</td>
<td>Operationalization and Institutionalization: How to operationalize the IASC Guidelines based on practical examples of other countries</td>
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<td>Sarah Harrison</td>
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<td>11:15 – 11:45</td>
<td>COFFEE BREAK</td>
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<td>11:45 – 12:45</td>
<td>Research and evidence-based approaches</td>
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<td></td>
<td>Kenneth Carswell</td>
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<td>WHO</td>
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<tr>
<td>12:45 – 13:00</td>
<td>Q&amp;A Session</td>
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<td>13:00 – 14:00</td>
<td>LUNCH</td>
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<tr>
<td>14:00 – 16:00</td>
<td>Panel discussion (cont): Research and evidence-based approaches</td>
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<td></td>
<td>Kenneth Carswell</td>
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<td>WHO</td>
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<td>14:10 – 14:30</td>
<td>Self-Help Plus Q&amp;A Session</td>
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<td>Katie Mullins</td>
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<td>IMC-Mariupol</td>
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<td>14:30 – 15:00</td>
<td>CETA Q&amp;A Session</td>
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<td>Oksana Varvarych</td>
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<td>NaUKMA/JHU</td>
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<td>15:00 – 15:30</td>
<td>Problem Management + Q&amp;A Session</td>
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<td>Monica Mukerjee</td>
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<td>Médecins du Monde-France (MDM-F)/</td>
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<td>15:30 – 16:30</td>
<td>Conference Findings and Closure</td>
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<td>Anna Goloktionova</td>
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<td>International Medical Corps</td>
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Checklist for Institutionalization of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support (MHPSS)

What is institutionalization?

In this instance, institutionalization is the systematic integration and application of the MHPSS Guidelines and Associated Products at the organizational level within policies, procedures and practice. Institutionalization directly supports implementation of the MHPSS Guidelines by making them a systematic and organizational requirement. It also supports the implementers themselves as once they are institutionalized, using the MHPSS Guidelines is not an added responsibility but becomes part of their individual and organizational work.

Institutionalization also can reduce some common problems around the proliferation of frameworks, whereby humanitarian workers are required to juggle both their existing organizational tools and additional ones, such as the MHPSS Guidelines. If the various tools are institutionalized, the organization will then consider how the different frameworks build on and complement one another. Staff will therefore be better equipped to use the MHPSS Guidelines to complement their organizational tools during programme design, implementation, monitoring and evaluation.

What is the checklist?

IMC adapted a checklist for MHPSS actors to assist in the institutionalization of the MHPSS Guidelines and Associated Products. This checklist is based on a checklist developed by the IASC Global Reference Group for MHPSS. This matrix presents a non-exhaustive list of actions which organizations can utilize when applying the standards internally and in inter-agency coordination. The matrix: [1] Offers suggestions for steps and procedure within an organization [2] Offers strategies that are simple and immediate as well as some long-term goals and [3] Assesses the level of institutionalization to date within the organization concerned.

The matrix will initially serve to provide baseline information on the situation in an organization, it can be completed again to measure development and progress in applying and supporting IASC guidelines and Associated Products. It may also provide a starting point for the development of organization’s institutionalization plans.

Likely challenges

Some key challenges to institutionalization include: decentralization (or organizations functioning as members of one alliance), staff turn-over and including partners within institutionalization plans.

Opportunities such as strategic planning, developing organizational Guidelines and staff orientations are all chances to institutionalize the MHPSS Guidelines and Associated Products. In addition sessions dedicated to institutionalization in every annual meeting are helpful to discuss institutionalization (progress, challenges, lessons learned etc.).
## CHECKLIST FOR INSTITUTIONALIZATION OF THE IASC MHPSS GUIDELINES

**Name of Organization:**

**Baseline/Follow up** (please circle)

<table>
<thead>
<tr>
<th>Policies and Procedures</th>
<th>Who (e.g., state actors, NGOs, INGOs or Academic Institutions)</th>
<th>Implemented</th>
<th>Partially implemented</th>
<th>Has not been implemented</th>
<th>Is Planned</th>
<th>N/A</th>
<th>Notes (e.g. what are gaps and challenges, observations, plans to follow up and when)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The MHPSS Guidelines are presented to and endorsed by the institution's Board</td>
<td>INGO, National, State</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
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</tr>
<tr>
<td>2. The MHPSS Guidelines are incorporated into emergency sectoral strategies: protection, health, education, wash etc.</td>
<td>All</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
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<tr>
<td>3. Senior staff regularly express support publically for the application of the MHPSS Guidelines and Associated Products with the use of existing platforms to inform the public. Examples of public forums include awareness raising events such as World Mental Health Day, coordination meetings, annual meetings, on media (e.g., tv, radio or social media).</td>
<td>All</td>
<td>O</td>
<td>O</td>
<td>O</td>
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**Date:**
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</thead>
<tbody>
<tr>
<td>4. Manuals, curriculums, governing documents of the organization or regulatory documents, normative acts integrate the principles of the MHPSS Guidelines</td>
<td>All</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5. Procedures of contextual analysis, project proposals, evaluation tools and reporting formats incorporate the MHPSS Guidelines</td>
<td>All</td>
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<td><strong>Human Resources</strong></td>
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<td>6. Job descriptions and ToRs for jobs related to MHPSS work in emergencies include references to the MHPSS Guidelines and Associated Products.</td>
<td>All</td>
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<td>7. During interviews, candidates for jobs focused on MHPSS in emergencies are asked questions on the MHPSS Guidelines</td>
<td>All</td>
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<td>8. A Focal Point is assigned to drive organization-wide commitment to and application of the MHPSS Guidelines and Associated Products.</td>
<td>All</td>
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<td><strong>9.</strong> Copies of the MHPSS Guidelines in relevant languages are available for all staff in country and regional offices as well as partners</td>
<td><strong>All</strong></td>
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<tr>
<td><strong>10.</strong> Training for emergency staff include reference to the MHPSS Guidelines and Associated Products and that the agency has endorsed them</td>
<td><strong>All</strong></td>
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<tr>
<td><strong>11.</strong> All departments/subdivisions are briefed on relevant parts of the MHPSS Guidelines and Associated Products.</td>
<td><strong>All</strong></td>
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<tr>
<td><strong>Projects and Programmes</strong></td>
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<td><strong>12.</strong> Assessments of target populations needs and resources are conducted utilizing the MHPSS Guidelines and Associated Products, increasing consistency and quality</td>
<td><strong>All</strong></td>
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<td>13. Programmes are designed and monitored against the MHPSS Guidelines and Associated Products (e.g., IASC Common M&amp;E Framework) and selected indicators</td>
<td>All</td>
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<td>14. Affected population and communities are oriented to and engaged in discussions on the MHPSS Guidelines.</td>
<td>All</td>
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<td>15. MHPSS Guidelines are used in project design documents including proposals to donors</td>
<td>All</td>
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<tr>
<td>16. State bodies and the local authorities are encouraged to use the MHPSS Guidelines to inform national response policy and practice</td>
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<tr>
<td>17. MHPSS specialists meet with field teams to consider specific needs and opportunities for using the MHPSS Guidelines and Associated Products</td>
<td>All</td>
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<td><strong>Inter-Agency Coordination</strong></td>
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<td>18. Local good practice examples of the application of the MHPSS Guidelines and Associated Products application are shared amongst agencies</td>
<td>All</td>
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<tr>
<td>19. The MHPSS Guidelines are introduced and referenced in coordination and/or Cluster meetings</td>
<td>All</td>
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<td>20. Joint sectoral programming decisions are made based on the MHPSS Guidelines and Associated Products</td>
<td>All</td>
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<td>21. Documents that govern cooperation between agencies refer to the use of the MHPSS Guidelines and Associated Products as a framework where applicable</td>
<td>All</td>
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</table>
As described above this tool will help MHPSS staff, that already familiar with the MHPSS Guidelines and Associated Products, to better disseminate them within their own agency or office.

Specific activities that I will undertake in 2017 are:

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4. ______________________________________________________________
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