Day 1: Tuesday 30 October 2018

9.35 am conference starts

Welcome & Security briefing (Save the Children)

- Threat level: medium
- Restriction: North border region (Zarqa, Irbid, Mafraq) restriction for personal travel
- Category: Terrorism (escape, seek shelter, fight only as last resort)
- Civil Unrest, Downtown on Friday noon.

Things to Avoid: Stadium

  Downtown at Friday afternoon.

  Harassment: Avoid crowded areas

Relocation site, Amman Kempinski Hotel.

Tom Krift

Save the Children, Welcomes the participants.

- ongoing conflict and violence leads to Toxic stress.
- IDP and migrants waiting for future.
- Refugees living with hope and fear of relocation.
- We need to bud resilience for children who are recovering from wounds
- We need to elevate our programs and scales, we are in the 2nd level, we need to have mental health specialist in schools and clinic to give services

Thank you

Self-introduction of participants, Name and Organization.
Co-Chairs – Fahmy and Sarah

IASC Reference Group on Mental Health and Psychosocial Support

IASC Secretariat

Co-Chairs

WHO & IFRC

Global level:

• Health
• Protection
• Education
• CCCM
• Nutrition
• IASC Disability TT
• IASC Secretariat

Country level:

• MHPSS Technical WGs:
  • (IDP, refugee & migrant settings)

Expanded membership in 2018 (4 new) 52 full members | 9 Observers | 7 Donor organisations


RG Objectives:

• Dissemination of IASC Guidelines
• Country level technical support
• Inter-agency coordination and linking (emergencies)
• Development of new tools for MHPSS
• Advocacy (internal & external)

2018 Global WGs:
• Advocacy
• Community based MHPSS
• Disability
• Disaster Risk Reduction
• Global cluster engagement
• Monitoring & Evaluation
• Peacebuilding
• Staff & volunteer care

2018 Emergencies:

• Afghanistan
• Bangladesh-Myanmar
• DRC-Congo
• Indonesia
• Iraq
• Mali
• Nigeria
• South Sudan
• Syria crisis
• Uganda
• Ukraine
• Yemen

Requests by geographical location:

Total: 250 requests from 62 different agencies (41 RG members) in 36 countries

41 RG member agencies made requests to the Co-Chairs during 2018.

Requests by theme:

Technical support is by far the highest (how I do things, questions about programing)

Followed by Material (where can I get copies, ((web sites)) , Partnership, Referral (how do I work in this country), others, Academia (Academic wants to do researches), Advocacy, Vacancies/HR, Advocacy, Training Support
**MHPSS working groups support:**

Co-chairs Field Support Missions:

Each mission has its own objectives

South Sudan (2) to address what we discussed last year in Geneva.

Ukraine (2) capacity building.

Bangladesh Afghanistan, Uganda, Nigeria, Syria

**Global IASC MHPSS RG coordination calls:**

Rohingya crisis (2) Ebola Virus Disease Outbreak in DRC

Indonesia Earthquake and Tsunami

**Others:**

Teleconferences with MHPSS working groups:

South Sudan Turkey Bangladesh DRC

MHPSS Forum IASC MHPSS NEWSLETTER

**Mainstreaming of IASC MHPSS Guidelines and Tools**

Co-Chairs facilitated specific collaborations, events or projects with the following:

**Donors:**

- Wilton Park Dialogue
- Berlin UNICEF-BMZ Workshop

**Global Initiatives:**

- IMC toolkit
- IOM Guidance
- International Courses
- UN Special Rapporteur Report
Coordination Structures:
- Joint Operational Framework
- HC & PC
- Joint missions
- CP AOR
- Surge cap development

IASC:
- TT on Disability (Collaboration)
- HDN (Joint meeting)
- AAP (Joint training)
- IASC Secretariat

New tools & translations:
- Ready to be published on the web site.
- Translation include cultural component.
- Some languages (Bangla, French, Portuguese, Russian, Spanish, Indonesia Briefing Kit, DRC-Congo Briefing Kit)

Q by UNHCR, Health and protection cluster, how are we involved in it?
A: they have not started yet, but the money is there.

Agenda discussed by Sarah.
Advancing Advocacy for MHPSS, Report on 2018 Advocacy Events
Leslie Snider, MD, MPH

2018 MHPSS Advocacy Events

- Wilton Park (Save, DFID)
- Berlin (UNICEF, BMZ)
- Inter-agency technical group (Dutch MFA)
- The Blueprint Group (Wellcome Trust)
- DFID Round Table (Inter-agency group, MHPSS Collaborative)

Wilton Park: Healing the Invisible Wounds of War (Jan 2018)

- Convened by Save the Children and DFID
- Follow-on to the 2015 UNICEF/Dutch government forum: Growing Up in Conflict
- Inspired by Save Middle East 2017 report Invisible Wounds: the impact of six years of war on the mental health of Syria’s children

Growing up in conflict, the impact on children’s mental health and psychological well being

- Fund innovative approaches to MHPSS programs and research
- Clarify and strengthen links between MHPSS, social cohesion and peacebuilding
- Strengthen multi-layered inter-sectoral approaches to children’s wellbeing
- Focus on resilience and the social ecology for children, adolescents & families
- Attain rigor in action research for community-based MHPSS
- Achieve quality and scale in MHPSS interventions

Wilton Park Dialogue: Goals:

- Discuss and evaluate good practice in MHPSS for children and adolescents during and after conflict, lessons learned globally and innovations from new programming
- Share best practice for making programmes multi-sectoral, coordinated and integrated with humanitarian missions
- Discuss challenges of implementing MHPSS programmes and how to address these, including age and gender sensitivities, stigma, accessing difficult-to-reach areas and strengthening national capacity, with a focus on the Middle East
- Develop a global roadmap setting out priority pathways needed, likely challenges and solutions, and necessary collaborations for scaling up
Wilton Park Dialogue: Key Themes:

- How and when is it possible to go to scale?
- How can MH prevalence figures be reported so that the full spectrum of MHPSS needs and responses can be captured?
- How can we best organize and deliver MHPSS across a layered system of complementary support that meets the needs of different groups?
- How can we build on recent donor momentum for greater investment to match the magnitude of needs?
- Is the current financing system sufficient, sustainable and appropriate to needs?
- How do we avoid duplication as interest and programmes scale up? Could donors encourage a thoughtful multi-sector consortium bid?

Given that children’s exposure to conflict can vary significantly & the scale of needs – more nuanced and innovative approaches are needed, as well as strong evidence to identify what works...including how and when it is possible to go to scale.

There is a need to distinguish between those living with anxiety/stress and those who have serious MH needs or developmental disorders requiring more specialized care. “PSS” is too often a catch-all term, but careful differentiation is needed about what is being delivered, why and to whom.

Layered system – particularly in protracted and complex conflicts, all layers should be implemented at the same time to address the full spectrum of MHPSS needs

Greater momentum...

Funding challenges: emergency funding requires to immediately start delivering services – not allowing time for capacity building or integration across sectors

Joint needs assessment don’t strongly feature MHPSS across sectors – not always ownership of it (viewed as protection or health issue). So, integrating MHPSS across a wider range of clusters doesn’t happen (funding competition)

Emergency funding is very short-term – but consequences of a conflict are medium to long term with implications for service design & delivery. Graduated approach, across all layers, with some services sustainable long after the immediate emergency ends.

“The average period of displacement of refugees is 10-25 years, and most PSS programming lasts for only 10-week cycles”

“Current funding opportunities are not set up to support genuine collaboration.”

“There are many new funding applications and many new organizations working on MHPSS, but duplication and quality are real issues.”

We’re moving towards a tipping point of having MHPSS properly into our emergency responses.”
These are some of the key quotes from the meeting...

War Child called for a commitment to ring-fencing 1% of aid for MHPSS work in crisis responses.

And there is a need for more collaboration and less competition.

Despite a growing # of agency deliver MHPSS interventions, not all work is done across the spectrum, nor across the full age range (infants, children, adolescents, young people)

With similar tools/approaches used by different agencies, need to

1) assess how we know what works,
2) what can be replicated and taken to scale,
3) how to reduce duplication and address the wide range of different MHPSS needs, not just a subset.

Wilton Park Dialogue: Innovations:

• Evaluating stress attunement programmed for adolescents with stress bio-markers from hair samples (Mercy Corps, No Lost Generation Campaign funding)
• #Me/We Syria: changemakers and storytelling with flexible approach and psychometric scale to assess behavioral changes

Sesame Seeds:

• International Rescue Committee and Sesame Workshop
• Transforming children’s learning and social emotional skills and mitigating the effects of toxic stress through Sesame Seeds...
  • Mass Media: reaching 9.4 million children
  • Home: home visits and digital content supporting 800,000 caregivers
  • Centers: community sites transformed into nurturing early learning centers
• Generating evidence through formative and operational research, and RCT to assess impact on physical development, literacy and numeracy, and socio-emotional skills

This is the largest early childhood intervention in the history of humanitarian response for displaced Syrian children and young people – and is helping to restore hope and opportunity to millions of children, caregivers and communities.

It utilizes:

- Mass media through a locally produced tv and digital platform reaching 9.4 million children in Iraq, Jordan, Lebanon and Syria
- Supports 800,000 caregivers through home visits and digital content to support children’s early learning and mental wellbeing

- Transforms community sites into nurturing early care centers

The implementers are generating evidence on the impact for children and caregivers, to further inform the program, and to shape how services are delivered in the wider humanitarian system.

The intervention is the Winner of the MacArthur Foundation 100&Change competition – it is evidence-based, cost-effective, scalable, replicable and Life Changing!

Wilton Park: Global Roadmap:

1. Multi-sectoral programming and coordination

   • Leadership – MHPSS has potential to support all sectors in a sustainable way, but a key challenge is who takes responsibility/lead.

     • Change in the current hum architecture around cluster co-coordination (reducing competition for funding pools) will help meaningfully integrate MHPSS programming and reduce gaps/duplication

     • Coordination – need to strengthen the coordination chapter in the IASC MHPSS guidelines to make clear the group will support all clusters with technical input

     • All level 3 emergencies should have an MHPSS Technical Advisory Group under the inter-cluster group (rather than a specific sector) – TAGs at field and country levels

     • Establish globally deployable technical experts as MHPSS surge capacity

     • Expand technical expertise particularly for child/adolescent MHPSS

     • Train cluster coordinators on MHPSS for children with simple tools like a checklist to see how MHPSS fits within their sector

     • Definitions – improve definitions of child/adolescent MHPSS through a child subgroup within IASC MHPSS RG

     • Develop age and gender-appropriate packages, standards, tools and training across full spectrum of child/adolescent MHPSS needs

     • Provide interagency know how to MHPSS Coordination Groups and TAGs in the field

     • Build capacity and develop child-focused MHPSS indicators for each hum sector

     • Targeting marginalized groups – lack of knowledge currently on how to include children with disabilities and severe mental health problems in MHPSS programming & of available resources

     • Train organizations and individuals on inclusive resources/techniques
• Ensure donors are proactive in requiring vulnerable groups to be identified and served within funding applications (children affected by SGBV, CAFAAG)

• Develop surge roster of MHPSS technical professionals, experienced MH practitioners with both professional qualifications and field experience

• “No longer is it adequate for organizations to make multiple similar funding applications to concentrate on delivering PSS activities that fail to address the needs of children and adolescent who require mental health and psychosocial support.”

• MHPSS coordination groups → MHPSS technical advisory groups to ensure consistent standards & quality of all MHPSS cross-sectoral work

• An MHPSS Technical Advisory Group for all level 3 emergencies

• An MHPSS child and adolescent sub-group under the IASC MHPSS RG

• Donor dialogues would help to influence the needs for standards and guidelines

• Develop a roster of MHPSS technical experts for surge capacity

2. Engaging young people

• “For adolescents and young people, what matters is their future trajectories. They’re not so concerned about the past and the current.”
  • Better understand developmental differences between younger and older children and adolescents, and how context impacts their developmental milestones

• “Approximately only 20% of young people in populations we work in actually engage in our programmes. What about the other 80%?”
  • Young people often feel “excluded” and recruitment through community leaders may not reach the most vulnerable or disengaged young people
  • Increase use of technology in delivering MHPSS awareness and addressing needs of young people (language of resilience and trauma may alienate young people)
  • Take our work to them through consistent outreach and mobile work going into their spaces (ensure programming hours are accessible to working young people)

• “They are not beneficiaries but participants in their own lives.”
  • See young people as experts in their own worlds – design activities through their lens to foster belonging, connectedness and empowerment in their own lives
  • Caution about the donor discourse of preventing “extremism” – majority of young people are peaceful and trying to find positive paths in life
  • Hum structures not adequately set up to deal with young people – need ‘young people experts’ as strong peer mentors
• Teach young people about their own neurobiology – how their bodies and brains respond to threat
• Focus on belonging and connectedness, particularly where social networks have crumbled
• Focus on tight social bonds, power, a role and a voice and promising social change
• Designers and implementers of MHPSS activities must better understand specific age-relevant needs of young people and their diversity
• Must be a concerted effort to ID the most excluded young people, better understand root causes of their exclusion and effects on their mental health to design appropriate & relevant interventions
• Invest in a cadre of youth experts and see young people as experts in their own lives in hum contexts
• Proactively articulate how young people can be a positive driving force in their communities with appropriate support
• Engage young people in relevant, innovative ways

3. Supporting caregivers

• Caregivers’ wellbeing
• Focus not only on caregiver knowledge, but also well-being through holistic lens of their situation, relationships between caregiver couples, family dynamics and negative coping mechanisms
• Be sensitive to caregiver distress, not just how they should ‘do the right thing’
• Cascading of MHPSS-related information
• Make key MHPSS concepts accessible (not literacy dependent) on how stress and anxiety affect caregivers’ bodies and minds
• Promote local champions and give access to materials (social media, radio)
• Ensure shared language/concepts between children, caregivers, staff to demystify and talk about reactions and bring everyone closer together
• Maximize multi-sectoral entry points for support to meet caregiver MHPSS needs
• Integrated case management – link CP case management with MHPSS interventions (e.g., nutrition programming for caregivers/children)
• Keep a self-reliance and livelihood perspective to break cycles of dependency and the impact on wellbeing and mental health
• Diversify the concept of caregivers to include grandparents, older siblings (child-headed households) and other family members that play key roles
• Engage caregiving professionals such as teachers and health professionals
• Focus on caregiver wellbeing and MHPSS needs, not only on their parenting knowledge
• Mirror language, techniques and knowledge shared among children, caregivers, families and frontline workers to destigmatize MHPSS
• Ensure multi-sectoral, multi-layered approaches through various entry points to support all caregiver needs
• Diversify the concept of caregivers to include family members, grandparents, siblings, aunts and uncles

4. Strengthening national capacity

• “We need the human resource capacity to deliver this work.”
• Despite recent growth and prioritization of MHPSS, not enough growth in well-trained, supervised, experienced MHPSS practitioners
• Recognize the global shortage of MH professionals and meaningfully build a strong (para-) professional cadre specialized in child/adolescent MHPSS, beyond short-term capacity strengthening (and short-term funding)
• No agency has an explicit focus on children with more specialized needs – lack of advocacy and systematic programme content development and testing → develop inter-agency pool of deployable surge of senior MHPSS professionals
• “Are we trying to walk a path we don’t have the right shoes for?”
• Visualize national capacity in a fluid way: each layer (or organization or professional) should understand their role and how it supports the overall flow of interventions in the pyramid
• Increasingly violent and protracted conflicts mean greater needs for children suffering severe distress – specialist services as well as services at layers 1, 2 and 3 delivered by confident, skilled and supervised staff
• As people are mentored and coached, they can develop professionally and deliver additional services as well as mentor others
• Human resources – need well-trained, experienced, supervised MHPSS practitioners – there is a global shortage and we need to plan for developing a cadre with child/adolescent expertise – paritucularly for specialized needs (surge)
• Need better flow and integration across layers of the pyramid – with different actors knowing their role across the layers
• Need more killed, supervised staff for layers 1,2,3, as well as specialist services
• And opportunities for professional development
• “We need to develop a stepped approach – but what does that actually look like on the ground?”
• Siloed efforts, staff trained only on their organization’s manuals, reinforced by donor aims and requirements and short-term funding cycles results in only short-term training
• Wide donor engagement needed for long-term upskilling in MHPSS
• Strengthen lateral relationships with academic and government partners, as well as ‘wrap-around’ service models
• “We need to see beyond the agency imperative, and look at the individual need level.”
• Develop collaborative, multi-partner, lateral relationships for continuing professional development with integration into mainstream systems (accreditation)
• Look toward tech companies’ “boot camps” to see if 12-week intensive training programmes could provide an alternative to 4-year degree courses or as a helpful addition.

• Strengthen supervision and build well-trained supervisors

• focused on strengthening lateral relationships among agencies, governments and academic partners to UPScale and provide wrap-around service models.

• We need to go beyond short-term training to accredited programs

• Boot camp models were an interesting discussion

• And supervision with well-trained supervisors – need to build this cadre

• Comprehensively identify crucial gaps

• Develop skills/knowledge and the codesign of age and gender sensitive activities together with communities (not manualized)

• Develop pool of senior child/adolescent MHPSS experts on deployable surge capacity for emergency response and longer-term capacity strengthening

• Use innovation from tech companies and look for further creative models (‘barefoot psychologists’) to support work in remote locations

• Develop inter-agency MHPSS staff training package on child/adolescent needs

• Advocate for funding of long-term MHPSS capacity building

• Expand to a broader focus in capacity building, including clinical and counseling skills, leadership, management, proposal writing, supervision and coaching

Wilton Park Next Steps:

• Save the Children proposes to:

  • Work with MHPSS.net and IASC MHPSS RG to widen dialogue through series of webinars inviting a wide range of experts and specialists with the aim to continue to develop the roadmap

  • Through inception period of new Global Collaborative for Child and Family MHPSS, work closely with RG members to fill the gaps in child-focused care

  • Work with donor groups on funding streams to better support the work needed, reduce duplication and promote inter-agency collaboration

  • Initiate temporary child/adolescent working group in the RG

  • Ensure attention to children with more specialized needs so they no longer fall through the cracks
• Learn from our experts on young people, SGV and disability to bring them into the discussion – and young people themselves

• Wilton Park proposes to:
  • Include MHPSS learning with future Youth Dialogues and explore further dialogue with Save the Children on responses to young adolescents associated with armed groups, and the needs of adolescent girls in humanitarian settings

• DFID proposes to:
  • Host a roundtable discussion as a follow-on to Wilton Park Dialogue to share outputs with wider civil society and gain traction on taking forward the recommendations
Task recommendation and questions
Where is women in this?
I can’t see gender at all

Mental health and technology
Link with education and psychosocial wellbeing is a key topic

Timing and visa issue

Advocacy Update

• Un secretory general decide on the importance of mental health.
• Canadian minister of health, Australia, UK, Dutch government, are interested on mental health
• Many lessons from London summit
• Development of experience to face challenges in life.
• No health without mental health
• Reforming mental health
• How people are coming out of there mental health problems and difficulties
Rebuilding Lives
Addressing Needs, Scaling-up and Increasing Long-term Structural MHPSS Interventions in Protracted and Post-Conflict Settings

MHPSS Expert-level Meeting, Berlin, 4th – 5th July 2018

Zeinab Hijazi (UNICEF) & Stephanie Faucon (GiZ)

About this meeting

The 2-day expert level meeting “Rebuilding Lives: Addressing Needs, Scaling-up and Increasing Long-term Structural MHPSS Interventions in Protracted and Post-Conflict Settings”, convened by BMZ and UNICEF in Berlin, represented:

“A call for collective action to advocate for and invest in mental health and psychosocial support for people displaced by conflict, especially vulnerable groups who are at most risk for developing mental health issues, including (1) children and youth, (2) persons with disabilities, (3) survivors of gender-based violence, and (4) people on the move.

Working Group Session

The WG session was the primary segment of the meeting and aimed to address gaps in knowledge and action and develop specific recommendations for the different stakeholders that are essential to making shifts in the current MHPSS dialogue, including:

- Donors
- Policy makers (e.g. government, and UN agencies)
- implementing agencies
- researchers. And other stakeholders identified by the WGs during the meeting

Working Groups by Thematic Area

<table>
<thead>
<tr>
<th>WG1. Children &amp; Adolescents/Youth</th>
<th>Three tiers of the social-ecological framework: children, family/caregivers, and community (including elderly)</th>
<th>Chairs: CP Alliance/UNICEF (Hani M.) &amp; Save the Children (Leslie S.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WG2. Persons with physical &amp; developmental disabilities</td>
<td>Support &amp; Inclusion</td>
<td>Children and adults</td>
</tr>
<tr>
<td>WG3. Survivors of Sexual &amp; Gender Based Violence</td>
<td>Prevention &amp; Response</td>
<td>Children, women and men</td>
</tr>
<tr>
<td>WG4. Refugees &amp; IDPs</td>
<td>People on the move</td>
<td>Transitions from short term emergency to longer term development as part of protracted conflict and emergencies</td>
</tr>
</tbody>
</table>
Where we are at now?
A Working Document for Stakeholder Consultation
Review and Feedback by Key Humanitarian Actors

UNICEF and BMZ will be facilitating a series of consultations as part of a comprehensive review of the working document:

**Phase 1:** An expert meeting in Berline, that developed recommendations and actions across different stakeholders within 4 thematic areas linked to MHPSS in humanitarian settings (This work aimed to build off of the findings from Wilton Park and the Hague) – Berlin July 2018

**We are here**

**Phase 2:** A period of online consultation facilitated through MHPSS.net through a dedicated consultation page.

Invites through social media channels and email will call for participation in feedback and discussion

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**Key Recommendations within Thematic Area 2**

Actions and recommendations were created based on the priority themes and outputs established in the Working Group. The four priority recommendations were:

1. Prioritize people with disabilities to lead the mainstreaming of disability inclusion at both the international and advisory levels, and during field implementation.

2. Create accessible, targeted and tailored MHPSS interventions that are inclusive in emergencies (e.g. gender-based violence and disabilities).

3. Create awareness and mainstream actions for individuals with physical, psychosocial and intellectual disabilities in the MHPSS sector.

4. Better understand the unique needs of individuals with physical, psychosocial and intellectual disabilities, and of their caregivers in order to create MHPSS programming that addresses these needs.
around draft version of the recommendations and actions from the initial meeting in Berlin- Ongoing through end of November 2018.

➔ Final Technical Revision

Online CONSULTATION & Feedback.

Review and consolidate recommendations and actions across the 4 thematic areas developed at the meeting in Berlin.

EXPECTED OUTCOME

Consolidated Technical & Field level Feedback to revise the working draft with recommendations and actions across target groups.

Dedicated page via MHPSS.net:

https://app.mhpss.net/rebuilding-lives-consultative-process/

Where you can:

- Access details of the meeting in Berlin
- Download the working document in word format for direct input
- Access online feedback form developed to collect feedback more widely
Panel Discussion and recommendation for 2019

1. CCCM good relation, serious training all over the world,
We are preparing core training 14 sessions of 2 hours, training one on mental and psychosocial support.
2 additional supplementary models. For PFA – usual pfa training tools. Prevention and follow up

2. Nutrition MHPSS
   Strong link with mental health, JPVV, PSS
   Try to contribute to make sure all developmental aspect is under consideration
   3-day annual conference about IUCF- very important
   Discussion if feeding and health practice in conflict, we must concentrate on that point, need to link development and better coordination.
   Treatment of malnutrition but not much on prevention.
   MHPSS like to increase prevention and PSS.
   CASH is push to all sectors.
   Not so much cash based evidence, cash for wash, MHPSS, cash for wash, nutrition....etc.
   AYCF indicators being revised (world vision and save the children)
   Operation guide for infant feeding, emergency moment release
   Management of acute malnutrition guidelines.

3. Education:
   Opportunity to be back in the party
   We need to know if you have interesting indicators
   school and education, where to access children.

   Challenges: either too much health focused or not in the agenda, we need a balance.

5. JBV in Government and non-government control areas.
   4 operations
   • Damascus

Cross borders
   • Iraq
   • Jordan
   • Turkey

At Jordan the operation Is ceased, just the follow up till it’s completely closed
Turkey cross border, training and review the manual and provide assessment. It is not at the level we expect.

Meeting in Dec. to discuss various issue, we are working in different AOR.s

Moving forward we need to integrate and collaborate and cross-fertilize – intra cluster coordination.

A chapter focused on PSS and understand of duties and roles

Work closely with WHO

What is the follow up and what’s needed to be done, what else can we do?

We need a real support and how to deal with man and boys that have JBV and have been tortured, need to work on that and have more studies

6. Protective cluster and child protection

Split - child protection (unicef)
- child protection alliance.

7. MHPSS

Task force templets

Working group

Assessment measurements and evidence, M&E frame work, define some measurement instruments.

We need to assess in a more lighter and quicker way, so we have recommendation for effective programs

Extensive consultation, who need to be targeted

Family strengthening and Psycho social well being

Development of E learning modules

Case management task force, supervision training packages in Arabic, English and French

Global protection cluster.

Q, is it possible to do training on pss Guidelines?

A. Its there and its compulsory for the actress to read, was done 2 years ago

Distant support, tele conference and coordination group, requires collective efforts.

A study available on effect of cash on children and women.
It is important to hear what the challenges from the local level are, does their quid lines make sense, are they helping you on CASH for JBV. From researches on cash and cash programs, it didn’t bring gender equality.

There is a need to review and research, you have to look at management in integrated issue on JBV or cash....etc.

PFA is a skill sets to do certain type of activity.

Assess how effective is information sharing mechanism, new courses and follow up meetings. (coast and expenses)

We did try to calculate the coast, but we could not follow the coast, estimate was very low, it depend on the type of engagement

**Q. Why does your agency take a co-chair role?**

IMC, MHPSS

It is the largest mental health provider, we have a lot of expertise and global representation, A history of leadership in the coordination role.

NIRC and mental health is growing area and for a better coordination

ICF: Decided to lead in Afghanistan and Bangladesh as we have excellent back ground and expertise and complaining of lack of coordination. Also, it’s important for us to try to balance the ration of work to harmonize the approach.

IOM: a way to get back to the group, we have to establish the work group, and capacity building for all agencies

WHO: because it is offered to us, usually its from the health sector as chairman or co-chair

**Q. How does your agency obtain findings?**

IMC: For most countries, it is the MHPSS coordinator. We don’t have specific funds for coordination, but in Iraq, we secure foreign founds to a full MHPSS working group.

NRC: Don’t have a dedicated person

UNHCR: Does not work on project funding, we should have it in our work plan

WHO: They have to scarifies 25-50% of staff time
Donors welcome activities such as mapping but the difficulty in coordination
IOM: Their own resources are assigned
They allocate donors and they priorities the distressed countries.

**Q. Functions of CO-Chair?**

Technical leadership, governance,
What power comes with being a co-chair? And how do you get the government on board?

UNHCR: I see technical working group is as powerless working groups, we are with open working atmosphere. The government involvement is from the beginning to the end, it depends on the stage of emergency.

WHO: The government might be too engaged so it can’t be neutral. Coordination. We chose to support existing mechanism, we made a task force with UNHCR.

IOM: Each agency coordinates their relationship with its own cluster. With government involvement, the problem who have the last decision.

MOH are not aware of the challenges, we share the information to update them.

WHO: Best TOR are done by the group to reflect, we have to be creative.

**Q. How to make sustainable involvement of the people?**

A. Coordinating about sharing experience and found synergy, it’s about sharing information and synergy together to make a real change.

Coordination is top down approach- recognize local expertise and assess what people need

The government is the natural actors to take the lead, we need powerful key people to take this decision. We need to engage local NGOs. this is added value. They need resources not just handle them the tasks, so we need to follow with them.

In Asia more national NGOs involvement, in Africa only TPODC. In the middle east, NGOs but not nationalized

Red Crescent doing a lot of work for years.

**Q. how do you solve working groups when they are not needed?**

A. Keep some kind of structure In case the crises comes back again, and keep some kind of coordination and focal points. Never total closure.
Q. Inter countries cooperation for those working in the same region?

A. For security reason, sometimes it is impossible to happen, even when it is lifesaving, we were advised that will do more harm than benefit. Sometimes organization and ministries working together have a negative outcome like what happened with Ebola outbreak.

Q. Do you have to be a technical to join a group

A. No, you don’t, sometimes it is better to call it a working group than technical group in order not to high tank the group and have it difficult to work and manage.

The name technical or not depend if the cluster system are using this term.
International Committee of the Red Cross

_Health Care in Danger Initiative_

Erin Downey, MPH, ScD

Health Adviser, Health Unit

Red Cross and Red Crescent Movement

The individual roles

No Hospitals, No hope, every day problem occur for the health worker

**Q, what are the mechanism when hospitals are bombed...etc, what is the action?**

A. We cannot get engaged,

We need more date, we promote collection of quality data and strengthen the local trying to strengthen the domestics, we encourage countries to collect their own data.

_The “Movement” is unified and guided by seven (7) fundamental principles: Humanity, Impartiality, Neutrality, Independence, Voluntary Service, Unity, Universality._

who is who in the International Movement of the Red Cross and the Red Crescent: one of the largest humanitarian networks in the world, present and active in almost every country. Unified and guided by seven (7) Fundamental Principles (http://www.ifrc.org/en/who-we-are/vision-and-mission/the-seven-fundamental-principles/)

- **The ICRC:** in time of armed conflict or armed violence. Movement's founding body. In addition to carrying out operational activities to protect and assist victims of war, it is the promoter and guardian of international humanitarian law. It is also the guardian of the Fundamental Principles.

- **National Red Cross and Red Crescent Societies:** any time. They embody the work and the principles of the Movement in more than 180 countries. Act as auxiliaries to the public authorities of their own countries in the humanitarian field and provide a range of services including disaster relief and health and social programmes. In wartime, National Societies assist the affected civilian population and where appropriate, support the army medical services.

- **The International Federation of Red Cross and Red Crescent Societies:** natural and technological disasters. Founded in 1919, the Federation directs and coordinates international assistance of the Movement to victims of natural and technological disasters, to refugees and in health emergencies. It acts as the official representative of its member societies in the international field. It promotes cooperation between National Societies, and strengthens their capacity to prepare effectively for disasters and to carry out health and social programmes.

Explain that all components, together with the States parties to the GC, meet every four years in the International Conference discussing humanitarian issues (incl. IHL) and adopting related resolutions.

Explain emblems:
• origin of the red cross: Swiss flag reversed, as recognition towards Switzerland which convened the conference where GC I was adopted. No religious meaning of the cross in the Swiss flag.

• origin of the red crescent: adopted by Ottoman armed forces as a result of misunderstanding or prejudice towards the cross. Stress that crescent does not equate Moslem (e.g. Indonesia or Lebanon red cross societies)

• origin of the red crystal to give opportunity to include other emblem(s) within (e.g. David's shield)

Recall rule: one State – one emblem

Recall ICRC use: red cross with double black circles with French text within, wherever

**Health Care in Danger (HCiD) Initiative Defined**

An International Red Cross and Red Crescent Movement initiative, aimed at:

- addressing violence against patients, health-care workers, facilities and medical transport, and
- ensuring safe access to and delivery of health care in armed conflict and other emergencies

**HCiD efforts are not limited to the conflict or armed violence context**

Violent incidents affecting health care

57% attacks by armed non State actors (32%) or State armed actors (25%), and 14% by individuals

Most of incidents on which data were collected occurred against, inside, or within the perimeter of health-care facilities

**ICRC INCIDENT GATHERING**

2011: This study is based on an analysis of reports collected over a two and-a-half year period describing 655 violent incidents affecting health care in 16 countries where the ICRC is operational. In all, 1,834 people giving or receiving care and others were killed or injured, of whom 20.1% (368/1834) were already wounded or sick and 8.7% (159/1874) were health-care personnel. Hospitals and other health-care premises were damaged in 17.7% (116/655) of events, and ambulances were damaged in 4.9% (32/655) of events.

2012: Over the course of 2012, the ICRC – through a variety of sources – collected information on 921 violent incidents affecting health-care during armed conflict and other emergencies in 22 countries. These incidents involved the use or threat of violence against health-care personnel, the wounded and the sick, health-care facilities and medical vehicles. This interim report analyses the main patterns of such violence that were identified:

1. Local health-care providers appear to be the group most affected, accounting for 91% of all cases (National Societies were affected in 16% of the cases); international health-care providers accounted for 7% of the cases.
2. State security forces and armed non-State actors were responsible for a large proportion of the incidents. The proportion of acts or threats of violence attributed to armed non-State actors or to State security forces varies significantly.

3. Health-care staff (doctors, nurses and paramedics) accounted for about 60% of the people directly affected.

4. Two trends have emerged since a previous ICRC study: “follow-up attacks” affecting first-aiders and disruption of vaccination campaigns by violent means.

2012-2013: From January 2012 to December 2013, ICRC documented 1,809 incidents of assaults or threats against patients, health-care personnel, ambulances or medical facilities. Although it is probably only the tip of the iceberg of all the violence affecting health care worldwide, the ICRC report allows seeing some alarming trends and underlines the emergency to protect the medical mission.

2012-2014: This report is based on 2,398 incidents of violence against health care. The data on those incidents was collected from various sources in 11 countries between January 2012 and December 2014 and analysed by the ICRC. The objective was to study and identify the main types of acts and threats of violence against health care in armed conflicts and other emergencies and their effects on people, health-care facilities and medical transports. This report highlights the urgent need to step up and implement measures, particularly those that address the following issues:

1. Protection of health-care facilities: most of the incidents documented occurred against, inside or within the perimeter of health-care facilities.

2. Respect for medical ethics: health-care personnel were subjected to threats and coerced to act against medical ethics and/or to provide free treatment.

3. Safe access to health care – violence against medical transports involved direct or indirect attacks and obstruction, also during demonstrations.

ICRC Health Care in Danger Targets of violence, examples

Hospitals, healthcare sites, e.g., physical rehab, detention
Bombing, shelling, looting, discriminatory access

Personnel (+ health security) Harassment, threats, intimidation, robbery, arrests, forced preferential treatment

Health & Medical Systems. Ministries of Health, universities, medical supplies, slowed/stymied administrative processes

Medical Transport. First responder violence, checkpoint delays блоки, theft, misuse, abduction

Wounded and sick. Killing, injuring, harassing, intimidating denying patients to health/medical needs
Health Care in Danger (HCiD) 2017 – 2019 Strategic Directions

Operationalizing practical measures in the field:

1. Strengthening global to local humanitarian diplomacy
2. Equipping health care providers to be better prepared to prevent, mitigate and/or cope with the impact of violence
3. Promoting the respect and protection of health care by weapon bearers
4. Engaging with the general public to change behaviors and increase awareness of the respect for healthcare
5. Developing and strengthening national legal frameworks
6. Conducting evidence-based research to address this important issue

Humanitarian diplomacy

The Community of Concern in support of promoting the protection of health care

15 organizations, including 10 with global networks:
Health professionals, academia, States’ representatives, weapon bearers, civil society, international organizations and more, seeking to address the issue at local, regional and international levels by supporting HCiD via their expertise

Health Care Providers

Prepared to prevent, mitigate and/or cope with the impact of violence of health care

Preparation

Coordinate with health facility authorities
Include appropriate representatives
Consider availability and timing
Notify security prior access to the area

Assessment

Leadership: hospital management, administration and ICRC to initiate
Discuss the first modules 1 (hazards) and 2 (management)
Tour premise to conduct module 3 (infrastructure)
Allow for at least one day to conduct survey
Express appreciation for the authorities and note expectations Follow-up Plan for the time to analyze and discuss findings with relevant stakeholders, both internal and external

Provide feedback on particular indicators that needs to be highlighted

Security assessment tool:
- 3 Modules: hazards (3 areas), management (6 areas), infrastructure (6 areas)
  - Multiple choice questions
  - Manual that accompanies the tool
  - Excel interface for calculations

Weapon bearers

Promoting the respect and protection of health care

The Legal Framework: This e-learning module covers the importance of the law, the sources of legal frameworks, the beneficiaries, the rights and responsibilities, and the Red Cross, Red Crescent and Red Crystal emblems. (Time to complete: 30 minutes, plus objectives and

National legal frameworks

Developing/strengthening for protection of healthcare from violence

ICRC Humanitarium link to video: Provides positive examples of joint action for protection of healthcare from three countries using Peru, Nigeria, and Pakistan as case examples. (20 min) (https://vimeo.com/294097342)

Evidence-based research

Encouraging and conducting

Countries of Focus:
- Libya
- Palestine
- Ukraine
- Sudan
- Syria
- Venezuela
- Yemen
- John Hopkins: Create a tool to measure/score a city health system’s “life saving capacity” in the immediate aftermath of a mass casualty, 500 000 (USD), 02/2018 discussions
Help the Helpers Programs

Carla Uriarte

MHPSS Specialist

ICRC Geneva

We wanted to share with you a response we have developed for all those helpers in the frontline. As in many agencies staff care is separated from the operational responses, but we believe a lot of I will share now could be applied to anyone working in the field, specially local or national staff.

DOUBLE BURDEN

Exposed to stressful and distressing situations of violence - they experience the same difficulties as the communities they are serving & They may not feel equipped to deal with the emotional and psychological reactions of the people they aim to help.

TOOLS

AIM

ENABLE HELPERS TO HELP THEMSELVES
Managing the stress & psychological impact arising from their role and exposure
Equip helpers with

BASIC PSYCHOLOGICAL SUPPORT SKILLS

TO HELP OTHERS
Skills are culturally appropriate and adapted to the local situation to improve helpers’ effectiveness in their role

ENABLE HELPERS TO HELP THEMSELVES
Stress, stress management
Prevention vicarious trauma
Emotional regulation techniques
Fear management
Critical incidents
Support skills (active listening, verbal and non verbal communication, etc.)
Normalization of reactions to violence and other shocking events
Crisis interventions
Supporting others to keep calm
Detecting acute and severe needs and referring

Communication in difficult situations

**Methodology**

- Peer support groups
  - Select facilitators among the helpers and develop a capacity building process so they can carry out cycles of sessions
  - Directly building capacity of the helpers (i.e., teachers)
- Management Sensitization
- Structural support

**Monitoring**

“Better support the people they help”
Development and Implementation of a Minimum Services Package (MSP) for Mental Health and Psychosocial Support (MHPSS) in Humanitarian Settings

**PRESENTERS:**
- Mark Van Ommeren (WHO)
- Fahmy Hanna (WHO)
- Alison Schafer (WHO)
- Zeinab Hijazi (UNICEF)

**Background**

September 7, 2018: The Dutch government hosted a meeting of international experts on MHPSS in conflict and emergency settings.

Objective: To identify actions the Dutch Government could develop and lead globally in three areas:

1. field level programme delivery;
2. global and national advocacy; and
3. international financing for MHPSS in emergencies.

Outputs of the Meeting: Identification of key problems in each of the three areas and explored potential solutions.

**One of the key problems identified:**

While standards and guidelines exist, there is an absence of a package to assist humanitarian actors working across these sectors to operationalise these various standards and guidance.

A need to innovatively bring together a clear set of practical actions (or activities) for:

1. emergency preparedness,
2. the prevention of MHPSS problems, and
3. initial response to MHPSS needs;

... and to do so with approaches that optimise the potential for sustainable MHPSS and care across the health, child protection, and other sectors.

**What is the MSP?**

A Minimum Services Package (MSP) will operationalise:

- The **globally accepted IASC Guidelines on MHPSS in Emergency Settings**, as well as;
- Other established **guidance that includes MHPSS action**, including:
Sphere Standards

CP Minimum Standards

... to offer predictable, costed and clear direction for optimal MHPSS programs.

A Minimum Services Package IS:

- A **costed and essential package of SMART actions** by humanitarian actors in emergency settings;
- **Minimum actions** implemented as a starting point for MHPSS and services;
- **Based in evidence** for effectively promoting MHPSS in emergencies and accurately pricing cost-effective activities;
- Developed to **operationalise existing standards**, such as Sphere and recommended actions of the IASC Guidelines for MHPSS in Emergency Settings;
- Stringently **demonstrated with detailed protocols for implementation** and an evaluation of that process;
- Built collaboratively with multiple stakeholders, experts and groups, and informed by learnings from others (including UNFPAs reproductive health team)

A Minimum Services Package is NOT:

- A **set of kits, supplies or isolated activities** without preparedness training or coordination;
- A **complete MHPSS program implemented alone**, without transition to broader services over time;
- A ‘blindly’ implemented set of activities that are not **based in evidence or without cost projections**;
- **Highly specialized or secondary activities** implemented only after recovery has begun;

What topics will the MSP focus on?

**MHPSS crosses over many sectors**

As outlined in the IASC MHPSS Guidelines: **MHPSS needs to be a consideration in all aspects of emergency response.**

However, MHPSS interventions are most commonly needed, integrated and programmed in the following sectors: **health, community mobilization, nutrition, protection (including child protection) and education.**

**Establishing a MSP for all sectors is necessary in the long term**

→ The **first chapters of the MSP** will focus on two key humanitarian response sectors: Health and [child] protection, with other topics to follow.
Consultations & Design

Ongoing consultation throughout phases of development & demonstration of the MSP

The design phase will:

- Ensure all non-sectoral aspects of the guidelines including coordination, prevention, community mobilization, dissemination of information, human resources, human rights, are incorporated to the recommended and costed actions.
- Safeguard the cross-over nature of MHPSS

→ Making sure the MSP structure, design, interventions and approaches do not separate the concept of mental health (such as by only being managed via health and focused predominantly on adults) and psychosocial support (such as by only being akin to child protection and not linked to health, education, or adult needs).

Considerations for Development

The idea of a minimum services package is not new in humanitarian work. Some of UNFPA’s key learnings, shared with WHO and relevant to this proposed work, include:

- Ensuring multi-agency and organisation inclusion in development, review, testing and finalisation of materials; and including local partners and member states in field level planning and implementation.
- Including all phases of an emergency in the key actions of the MSP, including emergency preparedness, preventative and curative/responsive actions;
- Including multi-faceted approaches to training, such as traditional, class-based, online, video, and other interactive resources;
- Planning at the outset for systematic dissemination of materials at national, regional and global levels, including in collaboration with clusters, working groups, donors, and member states.

Development Strategy

WHO and UNICEF will jointly develop and demonstrate implementation of the MSP for MHPSS by employing a strategy that:

- engages and involves the relevant health and protection groups and clusters and their member organisations;
- builds consensus throughout the MSP development phases;
- disseminates learnings from implementation sites; and
- encourages the final MHPSS MSP to be endorsed (and therefore used) by the majority of humanitarian response organisations in ongoing and future emergencies.

Demonstration Sites
Five countries affected by humanitarian crises will be selected in different regions.

- 5 countries per chapter
  (sites may overlap with joint demonstration of developed chapters)

Who is Involved? (Ideal Scenario - what we will work towards)

Various actors are involved to ensure that the MSP chapters are reviewed, demonstrated, shared and widely disseminated:

  Project Steering Committee

  Provide oversight and assurance of inter-sectoral representation of MSP development and implementation.

  WHO, UNICEF, UNHCR, IASC MHPSS Reference Group, Health Cluster, Protection Cluster, CP Alliance, CP AOR & Other partners (e.g., UNFPA, NGOs, iNGOs, experts in cross-cutting issues)

  [Involved throughout project timeline]

- Engagement of Key Humanitarian Actors & Consultation Groups

  IASC MHPSS RG
  Health Cluster
  Protection Cluster
  CP Alliance & CP AOR

  + Key Humanitarian Actors involved in Demonstrating use of the MSP in the field