MHPSS.net facilitator
Marcio Gagliato

Here are the list of highlights, then there will be ground questions and discussions

STOP AND CHANGE;

Panel session:
Who was in the room - live poll

- Time for questions from audience, - questions in advance of the event, that RG members could engage in.
- Panel too long, people sitting at tables, get them to buss in groups first to engage them not starting on a panel
- Management of survey and timing of survey
- Method to get into a dialog - panel and internet
- More of an introduction to people who just come yesterday, what happened on Tuesday, presentation on the IASC MHPSS WG.
- Time management, less can be more
- Have an external facilitator to manage comments.
- Meet and great activities, nametags

BMZ-UNICEF

- Language too technical for audience
- Difficult to present about conference, when people were not there.
- What was the objective Purpose of the session
- How to involve people who were not there
- Send the working document early to the people in the room
- Split panel and Berlin presentation, too long
- Time management

Marketplace

- Process for building on MHOSS forum agenda?
- Not enough time for marketplace
- Other options than leaflets, environmental friendly.
- Lost opportunity – IASC MHPSS WG to have a table with material
• Present projects rather than products
• Have a world map or topics with this character on photos where people can place information
• Rolling screen- show of IASC RG Products

Working Groups

• Time took for tweets, took out time for discussion.
• Topic selection – be specific and discuss more deeply, e.g. case study.
• Better facilitation, and signs for groups.
• Difficult facilitation – posters, why poster if not used

- Deliverable

- tweets

• Red thread throughout forum.
• Participant driven center.
• Most engaging
• Inviting people to participate.
• Evaluation form to participants- Jordan MHPSS WG.

Review

• Number participating in RG meetings opening up to nonmembers, involving wider MHPASS community
• Heath clusters also has a forum
• Engaging with non IASC members
• Democracy

Strength Panel

• Overview of PM= before panel
• How to manage in a consortium, working together theme
• Humanity concern.
• Liked site visit- opportunity to engage, timing and no client there, good time selection, team prepared.
• How the forum worked will depend on which county it is hosted in, focused on the form of the forum.

Participation

• How to get feedback through throughout the day on the forum.
• Continue having the forum in future years, not in a UN building in Geneva,
• Forum link to RG-HOW?
- Why in the middle of the RG annual meeting?
- Take out the intimidation factor less formal
- Vision is dialog
- Forum could be done in Europe - refugees
- Donor engagement
- First day of RG could be open to all, have 2 day meeting
- Live stream some of the RG meeting.

Recap of yesterday and last year.

Alison: dificult with the reference group as it was closed, we need to listen and people need to know what are we doing.

WHO: practice of having a forum is not new, WHO always engage with others

ISC engaging with non ISC members.

MHPSS.NET: we represent the group, we need to open a space and make sure the space is still open.

Ananda Galappatti: Feedback on what went well and what was useful and what we can improve.

About the first panel,

Who: shall we do that again?

SC: the voice of the person with live experience was very powerful and this is something new

The dialog with the donors is good, not only presentations, the idea brought it forward

We need to know who was in the room, and what do they represent

ICRC: the time for questions by audience was not enough

No donors in the room, are there donors in the room, we needed to introduce ourselves

Translating was difficult and changing and was great. Innovation is what we need to energize the group, we need to know the people and why they are here....etc.

Pannel was great but was too long
We said it was a dialog but it was not.

Online voting made people want to go to their phones, and we don't want that, the survey should have been done in a different way.

We need to introduce to the people what we have done yesterday and why they are here.

Try to open the dialog earlier after the work group, where people are more comfortable with each other.

True management needs to be more strict, thanks to the organizers, a lot of work but we need a facilitator to take care of some of the comments.

About 2nd panel
UNICEF and GIZ, what was useful and what have been needed differently:

The language was very technical

Too much information, if the function is to highlight, we could not highlight.

We need to engage the people, there was no dialog.

High level but the topic is very interesting, we need to inform Jordan on what happens globally.

People looked very tired, how do you start, what is the subject and what do you want to achieve (too complicated language)

UNICEF: I agree, it was short noted, we should have sent the document earlier to people before presenting it. A lesson learned and should have been separate from Berlin meeting.

GIZ: we need more time, In GIZ we did it in 2.5 hours, so not enough time.

SC: we need to begin with meeting, greetings, name tags and introduction and presentation

Comment about the market place:

Very interesting, good opportunity but too short, some tools are more interesting than some presentations, excellent opportunity to know people and each other.

We need to start with market place, breakfast and then move forward.

Too much papers for the environment sake.

Lack of time, the scope could include short summary of present projects, it was a bit messy with coffee break
We need to have a special format for the attendance to fill with name, organization, and topic, so we can identify and meet with each other,

**Q, what might have been done to help people to access?**

A. A rolling screen, pictures of quindolines.

**Working group section:**

What worked and what did not:

Very interesting, we need to go deep and further, not stop on yesterday only, time was enough but we need to structure it differently.

Kelly: toward the end, we become so focused on the tweet, that make us less focused on going deep.

The most engaging activity, we need to do case study together rather than general topics,

- Case study
- Need signs for the groups
- Forced on the tweet

Difficult to prioritize discussion, and then the poster and tweet, when we deliver the poster, I don’t find any benefit on it to others.

We need to prepare it better, we need to rethink to smoothen the process, tweets are bad,

Smaller groups are needed for more engagements,

Note taker and repeater to help keep us on track

There should be more connection and clarification of who we are and where Jordan is, so the people go home with something,

We should send out evaluation form for participants to hear from them.

Let the people have topics and we do selection from that, PARTICIPANT DRIVEN PROGRAM
Q, about the final session, what worked and what went wrong?

Was great, good information, audience need to have more information about the resources that we are talking about.

Q, what was possible for the people to be more engaged?

A, this was the first open forum, we could have engaged people from the beginning and to discuss it with the audience about their suggestion for future meetings.

Good idea to engage local and global actors, so lets do it again.

SITE VISIT

The site visit was good, timing was great, and the idea of no clients at the time of visit was very useful

People where waiting for us,

I like the idea of a forum, we need to have different structures and models for different meetings. Site visit was in the middle, this is very good, so people don’t miss it, the purpose should be clear and it was engagement, we need to introduce ourselves, we need to have signs to shoe who we are.

We need introduction,

We made the final session, the purpose was dialog, but we did not ask them what they took home with them or we did not ask for their final session.

Thoughts on the future

Priorities in the next 5 years, and to manage time so we do what we are here for. We need to make it open for the first 2 days, only 3rd is confidential.

Some parts of the reference group meetings could be life streamed and public.

We didn’t hear a read out from Ahmad!
IASC Reference Group on Mental Health and Psychosocial Support

IASC MHPSS Guidelines Review (2014)

- *Awareness* of the IASC MHPSS Guidelines remains high at HQ level, but this awareness does not necessarily translate to knowledge on the *content* of Guidelines at country level.

- The presence of strong leadership of country-level MHPSS WGs is required to translate awareness of the Guidelines into MHPSS programming.

- The availability and quality of MHPSS human resources at country level remains a challenge.

- *Institutionalisation* of the Guidelines & programming in line with the Guidelines requires a stronger level of MHPSS capacity throughout the humanitarian system.

**What would we like the person to do?**

- Assessments/ Situational analysis
- Convene MHPSS WGs
- Support MHPSS WGs
- Capacity building initiatives
- Advocate for MHPSS with clusters/ sectors
- Strategy development – MHPSS in HRPs
- MHPSS referent point
- Mentoring

**Overview of mechanisms**

**ProCap/ GenCap**

- Deployed to support whole humanitarian system and HCTs.
- Managed through NRC OCHA Secretariat & Steering committee.
- Longer deployments, possible throughout the year.
- Deployed to a UN Agency.
- Senior level staff focusing on strategy development & policy
Rapid response Teams (RRTs)

• Cluster function – Unicef.
• Mixture of INGO & UN agencies.
• Deployed for 4-12 weeks
• Very rapid deployment to do assessments and strategy (HRP, flash appeals).
• Can be deployed as a team to Unicef at country level.
• Programming staff

Standby partner capacity rosters (RedR, Canadem, NRC, DRC)

• Govts and separate agencies with rosters of various professions.
• Agreements with UN agencies & INGOs to send staff.
• Hosting & technical supervision done by receiving agency.
• Overall management by standby roster agency.
• Programming staff

The options

A Consortium project by RG member agencies
• Capacity building component of roster members
• Maintenance of roster members
• % time of Technical Advisors contracts dedicated to deployment
• Hosted by project RG member agency in-country
• Request made by in-country MHPSS WG
• Request from IASC MHPSS Co-Chairs

B Agreement with existing standby partner rosters e.g., RedR, NRC, DRC
- Request made by in-country MHPSS WG
- Request from IASC MHPSS Co-Chairs
- Capacity building component & maintenance of roster

(separate project)

**Criteria to review mechanisms**

- Multiple contexts (refugee, IDP & migration).
- Multiple types of emergencies (natural disasters, protracted, conflict, rapid-onset, infectious diseases).
- Allows for quick deployment
- Long (3+ months) and short (4-12 weeks) deployment lengths
- Set-up time
- MHPSS RG input & ownership
- Cost to set up and cost to sustain
- Neutrality
- ‘Host’ agency services?
- Legal bottlenecks
- Vetting roster members

We need more qualified bodies at the county level, if we need to push forward

If there is no MHPSS in the county, we need some to start.

what groups do you want to add?

Capacity building
Donner engagement
Staff care UN Rapid response
2018 Thematic Groups

• Advocacy (Save)
• Community based MHPSS (IOM & REPSSI)
• Disability & inclusion (Health Works, HI, WHO)
• Disaster risk reduction (MHPSS.net, WHO)
• Disaster risk reduction (MHPSS.net, WHO)
• Monitoring and Evaluation (WHO)
• Peacebuilding (IOM, WTF)
• Staff and volunteer care (GIZ, HIAS, Save)
Community-Based Approaches to MHPSS Programs- A Guidance Note

IASC

Background

In the occasion of the face to face annual meeting of the IASC reference group on Mental Health and Psychosocial Support in Emergency Settings, in October 2016, a side-meeting on community based MHPSS was convened.

The participating agencies discussed the necessity for the elaboration of a two-pager (in fact 8-12 with pics) guidance note on CB MHPSS. The proposal was endorsed at the plenary MHPSS reference group meeting.

Purpose

Specifically, the aims of the MHPSS Reference Group are as follows:

1. To elaborate a guidance note on CB-MHPSS;
2. To foster collaboration amongst agencies and diverse stakeholders (such as governments and communities) on the above-mentioned issue;
3. To further develop relevant tools and training materials linked to the guidance note;
4. To encourage individual agencies to institutionalise the guidance note;
5. To share experiences of implementation among countries;
6. To facilitate printing, dissemination and language translations of the guidance note.
Structure

Co-Lead by IOM and REPSSI

Picture below from slide with scratches

IFRC PS Centre
Terre des Hommes
Church of Sweden/ ACT Alliance
Center for Victims of Torture
Action Contra La Faim
Unicef

IsraAID
PSTIC

Save the Children
MERCY Malaysia
International Rescue Committee
World Vision International
International Medical Corps
UNHCR
CARE Austria
War Trauma Foundation
FOLLOW UP

Dissemination

Training?

IOM is developing a manual on CB MHPSS that will operationalize the guidance for IOM MHPSS managers.

The manual will be open source and 30 experts and different organizations are involved in its making. We are looking forward to receive additional comments and eventual endorsement by members of the IASC Group in January.

For more info please contact: gschinina@iom.int

Or IOMMHPSS@iom.int
IASC MHPSS RG
Working Group

Disability & MHPSS

4 pillars of actions

• Conduction of MHPSS actors mapping including Disabled Persons Organisations (DPO)
• Conduction of the desk review on existing research linking MHPSS and disability

• Participation on development of IASC guidelines on inclusion of persons with disability, representing IASC MHPSS RG expertise
• Discussion in order to reach consensus on terminology regarding MHPSS and disability

Organisations committed & involved

• Health works
• WHO
• MHPSs.net
• CBM
• UNHCR
• Unicef

Achievements and Success in 2018

• Anita Marini – our IASC MHPSS WG representative deeply involved into the development of the IASC guidelines on inclusion of persons with disability
• Webinar on MHPSS and disability : Salam Gomez DPO’s representative of persons with psychosocial disabilities & Julien Eaton (CBM)
• On going discussion on terminology among stakeholders, including inputs from the global movement on disabilities represented by Catalina Devandas as special rapporteur of person with disabilities or the work from the OHCHR.
• Provision and revision of case studies to ensure MHPSS approach to be included into the future guidelines
What is still on track:

- Mapping did not happened nor the desk review yet.
- Advocacy for DPO’s representative of person with psychosocial disabilities into the core group of Task team / process has been launched on International Disability Alliance ‘s side
- Advocacy notes, supported by UNICEF to ensure that MHPSS will be mainstreamed on the guidelines on inclusion of person with disability.
- Project on provision of an additional action sheet on inclusion of person with disability into psychosocial activities in the MHPSS guidelines.

Backbone of communication:

terminology

Mental illness

Mental disorders

Intellectual impairment

Mental conditions and psychosocial disabilities.

Mental and /or intellectual disability

Mental Health conditions

Psychosocial disabilities:

toward a definition (WHO, Quality of right)

- Refer to people who have received a mental health diagnosis, and who have experienced negative social factors including stigma, discrimination and exclusion.
- People living with psychosocial disabilities include ex-users, current users of the mental health care services,

as well as persons that identify themselves as survivors of these services or with the psychosocial disability itself.

Human rights based approach

- ...describing situations not in terms of human needs, or areas of development, but in terms of the obligation to respond to the rights of individuals. This empowers people to demand justice as a right, not as a charity.

- OHCHR definition:
Persons with disabilities include those who have **long-term physical, mental, intellectual or sensory impairments**

which is/are in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

**How to ensure the guidelines will be in line with the MHPSS approach?**

- Human right based definition does not including temporary impairment. It is agreed that person in distress is not in a situation of a psychosocial disability...but will face barriers!

- Many question are still under discussion : *What happened to someone exposed to severe stress? What happened in area with no possible of diagnose? That person might consider her/himself with a psychosocial disability, but what if it is temporary?*

**Coordination & collaboration**

Members of this WG did not act as representative of organisations, spoke as IASC MHPSS RG members.

Recognised as the WG which has been the more involved with another body of the IASC, playing our role to facilitate communication and ensuring MHPSS approach

This Working Group remains Open to members,

please join & bring new perspectives,

share good practices
IASC Staff and Volunteer Care WG

by Andreas Löpsinger & Myriam Goldenstedt

Introduction

In 2017, the IASC RG MHPSS decided on setting up a Staff and Volunteer Care Working Group

Co-Chair: currently GIZ, HIAS, Save the Children

Mandate: 2 years (initially until DEC 2019)

Purpose: Gain a deeper understanding of current staff care approaches, needs, challenges and best practices that humanitarian aid workers face in their daily work

Final product: Guidance note on Staff and Volunteer Care

Initial Roadmap

• Compile a list of resources and to review literature
• Design staff survey and assess approaches and needs
• Present findings to IASC MHPSS RG
• Produce a guidance note on staff, partner staff and volunteer care and wellbeing

Research project on staff care

• Joint endeavor between the Sigmund Freud University Berlin and the International Psychoanalytic University Berlin
• Development and piloting of REST-Tool (Responding to staff care needs in fragile contexts) (Phase I - completed)
• Implementation of REST-Tool in local NGOs in Lebanon, Jordan, Turkey, Iraq (Phase II – upcoming)
Research project on staff care

What REST is

- A tool to enable teams and organizations to find out what their specific staff care needs are
- It enables teams to develop a practicable staff care plan → not an instrument to answer all questions but to ask the right questions
- It places the individual and its relationships within the team and the social and organizational context at the center of the discussion

What REST is not

- The tool is not a staff care tool as such: it does not provide a summary of techniques such as stress management
- It does not provide an answer to all questions

Key messages

- Staff care is an essential part of doing no harm and conflict-sensitive project management
- Staff care can be self-contained but initially needs external guidance
- Staff care must focus on all staff
- Staff care in areas of conflict and war cannot assume to achieve wellbeing → helping to maintain a balance between strength and vulnerability
- Staff/volunteer care is a process not a one-time activity
MHPSS and Peace Building

IAAC

Background

Chair: War Trauma Foundation. Withdrew. Process of development of guidelines now owned by a consortium of NGOs not represented as such at the MHPSS Group.

Supporting Co-Chair: IOM. Joined the consortium above, but does not have the capacity to meaningfully take on the substantial chair of another group.

During the year/activities by members


b) Elaboration of a training package (Church of Sweden)

c) An international conference for the International Day of Prayers for Peace (ACT)

d) Two publications (IOM-Intervention-Scuola Sant'Anna)

IOM, Lebanese University, Scuola Sant'Anna

3 articles analyzing the theses of the students of the two editions of the Executive Masters in Psychosocial Support and Dialogue

Theses-fieldworks conducted by a total of 58 MHPSS practitioners, mainly active inside Syria, and Lebanon, working for 30 different organizations

Chapters looking at

- psychosocial perspectives and support,
- conflict mediation
- use of art and drama

Arabic version will be launched in January

Available for free on IOM bookstore.
Intervention Special Section-current issue

IOM-Social Sciences University of Ankara

5 best fieldworks of the diploma in psychosocial support and conflict transformation (32 students-25 different organizations)

and an introduction

Art intervention with elderly Syrian women

Oral history with male Syrian refugees

Social theatre with Syrian students adapting to the new educational system in Turkey

Non violent communication and Theatre of the Oppressed with women in livelihood support programs

Emotional control awareness through art and drama with Syrian children
Monitoring and Evaluation (M&E) Working Group for
Means of Verification (MoV) for the IASC MHPSS Common Monitoring and Evaluation Framework

2018 Update and 2019 Plans

The M&E - MoV Working Group Members (11):
IRC; UNICEF; WHO; IMC; World Concern; GIZ; ACF; IFRC; CARE; War Trauma Foundation; MdM

<table>
<thead>
<tr>
<th>Approximate timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
</tr>
<tr>
<td>• Based on literature reviews and analysis of MHPSS evidence-based, the IASC formed a common M&amp;E Framework</td>
</tr>
<tr>
<td>• OFDA funding received by UNICEF and jointly led the group, with World Vision</td>
</tr>
<tr>
<td>2014-2016</td>
</tr>
<tr>
<td>• Development of the Common M&amp;E Framework without MoV</td>
</tr>
<tr>
<td>• IASC MHPSS RG - Agreement for M&amp;E Working Group to begin work on establishing MoV for 6 x IMPACT indicators in the framework</td>
</tr>
<tr>
<td>Nov. 2016-Mar. 2017</td>
</tr>
<tr>
<td>• Brief UNICEF Consultancy to explore prospective MoV</td>
</tr>
<tr>
<td>Jan. 2017</td>
</tr>
<tr>
<td>• Formal publication of Common M&amp;E Framework</td>
</tr>
<tr>
<td>2017</td>
</tr>
<tr>
<td>• Working group discussions about MoV and potential approaches. Decision on indicator framework</td>
</tr>
<tr>
<td>Mar. 2018</td>
</tr>
<tr>
<td>• WHO received OFDA funding for MoV work – review prior consultancy work</td>
</tr>
<tr>
<td>• Working leadership change from IRC to WHO</td>
</tr>
<tr>
<td>May 2018</td>
</tr>
<tr>
<td>• RFP for University partner – contract won by JHU</td>
</tr>
<tr>
<td>Jun. – Aug. 2018</td>
</tr>
<tr>
<td>• Literature reviews, MoV extraction criteria confirmed by working group and categorised</td>
</tr>
<tr>
<td>• RG Members invited to participate in MoV consultation in Geneva</td>
</tr>
<tr>
<td>Sept. 2018</td>
</tr>
<tr>
<td>• Recommended MoV selected for impact indicators</td>
</tr>
</tbody>
</table>
45 INDICATORS:

- 6 x Goal Impact Indicators
- 8 x Outcome 1 Indicators
- 8 x Outcome 2 Indicators
- 11 x Outcome 3 Indicators
- 4 x Outcome 4 Indicators
- 8 x Outcome 5 Indicators

The MoV indicator framework:

- No more than 3-5 MoV per area
- Recommended approaches to include quantitative and qualitative MoV
- Evidence based measures that meet criteria

Data Sources

Purgato et al. (2018) Cochrane Review

“Psychological therapies for the treatment of mental disorders in low- and middle-income countries affected by humanitarian crises”

Haroz et al. (ongoing) systematic review

“Scientific evaluation of psychosocial support programs in low-resource humanitarian settings”

Bangpan (2017) systematic review

“The impact of mental health and psychosocial support programmes for populations affected by humanitarian emergencies”

Gadeberg (2014) systematic review
"Assessing trauma and mental health in refugee children and youth: a systematic review of validated screening and measurement tools“

Siriwardhana (2014) systematic review

“A systematic review of resilience and mental health outcomes of conflict-driven adult forced migrants”

IASC member documents

Results

<table>
<thead>
<tr>
<th>Means of Verification</th>
<th>No. Quantitative</th>
<th>No. Qualitative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functioning</td>
<td>19</td>
<td>7</td>
</tr>
<tr>
<td>Subjective well-being</td>
<td>29</td>
<td>6</td>
</tr>
<tr>
<td>Distress</td>
<td>69</td>
<td>9</td>
</tr>
<tr>
<td>Coping</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>Social behavior</td>
<td>28</td>
<td>5</td>
</tr>
<tr>
<td>Social connectedness</td>
<td>16</td>
<td>7</td>
</tr>
</tbody>
</table>
MoV Inclusion/Exclusion Criteria

MoV Metrics Rating Criteria

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>Yes</th>
<th>Available online or by contacting author</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Resources or instructions easily accessible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No financial cost associated with using MoV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Available without data sharing requirement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Available without copyright restrictions on existing versions (copyright restrictions may exist on adaptation or translation)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Not available online or by contacting author</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resources or instructions not easily accessible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Financial cost associated with using measure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Available with data sharing requirement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Available with copyright restrictions on existing versions</td>
</tr>
<tr>
<td></td>
<td>Unclear</td>
<td>One or more criteria for Yes/No ratings cannot be assessed</td>
</tr>
<tr>
<td>Relevance</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>----</td>
</tr>
</tbody>
</table>
|           | □ Whole measure or a subscale clearly overlaps with one impact indicator  
          | □ Developed or used in at least one UN language (Arabic, Chinese, English, French, Russian, Spanish)  
          | □ Used in one additional language beyond the language in which it was developed  
          | □ Used in at least one low-resource or humanitarian setting (including low-resource settings or among migrant groups in HICs) | □ Whole measure or subscale does not overlap with any impact indicators  
          | □ Whole measure or subscale overlaps with more than one impact indicator  
          | □ Was not developed or used in at least one UN language (Arabic, Chinese, English, French, Russian, Spanish)  
          | □ Has not been used in one additional language beyond the language in which it was developed |

<table>
<thead>
<tr>
<th>Feasibility</th>
<th>Yes</th>
<th>No</th>
<th>Unclear</th>
</tr>
</thead>
</table>
|             | □ Maximum amount of time to administer < 10 min (≤ 30 dichotomous or categorical items)  
              | □ Existing guidance on scoring available and if applicable, describes handling of reverse-scored items  
              | □ Clear interpretation of final score or thresholds available | □ Maximum amount of time to administer > 10 min (> 30 dichotomous or categorical items)  
              | □ Existing guidance on scoring is not available or, if applicable, does not describe handling of reverse-scored items  
              | □ No clear interpretation of final score or thresholds available | □ One or more criteria for Yes/No ratings cannot be assessed |
Results

<table>
<thead>
<tr>
<th>Psychometric properties</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Acceptable reliability identified in at least two settings:</td>
<td></td>
</tr>
<tr>
<td>□ Internal consistency &gt; 0.70</td>
<td></td>
</tr>
<tr>
<td>□ Test-retest: Correlation &gt; 0.70, kappa comparable to values on other similar scales</td>
<td></td>
</tr>
<tr>
<td>□ Inter-rater: Correlation &gt; 0.70, ICC &gt; 0.50, kappa comparable to values on other similar scales</td>
<td></td>
</tr>
<tr>
<td>□ Acceptable validity identified in at least two settings:</td>
<td></td>
</tr>
<tr>
<td>□ Content validity assessed</td>
<td></td>
</tr>
<tr>
<td>□ Construct validity supported (e.g. through factor analyses, correlations with other measures, etc.)</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>□ Criterion validity supported (e.g. sensitivity, specificity, positive- and negative-predicted values)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Epistemology</th>
<th>Theoretical perspective</th>
<th>Methodology</th>
<th>Methods</th>
<th>No. data sources using this approach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NB: Epistemology: theory of knowledge inherent in theoretical perspective; Theoretical perspective: Philosophical approach providing context for methodology; Methodology: Strategy, plan of action, process, or design lying behind choice and use of methods; Methods: Techniques or procedures used to gather and analyze data related to a research question or hypothesis (Crotty, 2003)

Results

<table>
<thead>
<tr>
<th>Impact Indicator</th>
<th>YES</th>
<th>UNCLEAR</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functioning</td>
<td>1</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Subjective well-being</td>
<td>2</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Distress</td>
<td>10</td>
<td>17</td>
<td>42</td>
</tr>
</tbody>
</table>
The Geneva Workshop - 25-26 September 2018 (16 people/12 orgs):
WHO; UNICEF, MSF, MdM; War Trauma Foundation; TdH; GIZ; ACF; IMC; HI; IFRC (& JHU)

Analyses & Recommendations

Quantitative Measures

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Functioning</th>
<th>Subjective Wellbeing</th>
<th>Distress</th>
<th>Coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6-11</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>12-17</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>16-19</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>20-25</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>26-59</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>60+</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
</tr>
</tbody>
</table>
**Analyses & Recommendations**

**Qualitative Concepts**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Functioning</th>
<th>Subjective Well-being</th>
<th>Distress</th>
<th>Coping</th>
<th>Social Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>How do people care for themselves, others, and their community? [For &lt; 5 how are they meeting developmental milestones?]</td>
<td>What is perceived as well-being? How is that perception of well-being experienced? [Only for &gt; 2 years]</td>
<td>How is distress perceived, described, and addressed by individuals and communities?</td>
<td>What do individuals, families, and communities have [e.g. resources, skills] and do [e.g. strategies] when faced with adversity?</td>
</tr>
</tbody>
</table>

**Key gaps identified**

- No measures for substance use and neurological conditions (due to nature of indicators)
- Notable gap in available measures for the 0-5 age group.
  - *Recommend a separate literature search focused on ECD*
- Notable gap for older adults (ages 60+)
- A measure of mental health stigma needs to be included in the list of quantitative MoVs
  - *But which indicator this would fall under?*
  - *Does it need to be quantitative as well as qualitative?*
Some measures not identified in the review were noted for further review - Ages and Stages Questionnaire; Washington group questions to assess disability (Handicap International); PSYCA measure (MSF)

MoVs for social behavior for young adults (18-25) did not truly capture the scope of this indicator (given focus on problematic behavior not pro social behavior).

- A targeted search recommended

Social connectedness measures were lacking for 6-11 and 12-17 ages

- A targeted search recommended

Unclear if K10 and PHQ-9 had been validated in humanitarian settings for use in adolescent populations and needs to be checked.

MoV Guidance

1. Introduction
   a. Information about document development
   b. Linking to the M&E MHPSS document
   c. Define quantitative, qualitative, and mixed methods
   d. Overview of how measures were selected
   e. Use of promising measures
   f. Limitations and explanations of excluded topics (substance use, neurological conditions, etc.)
   g. Common language and key terminology

2. Ethical considerations
   a. Principle of “do no harm”
   b. Focus on clinical monitoring only if clinical support is available
   c. Have referral pathways available in case of need
   d. Clear communication about the purpose of the exercise and use of information (handling expectations and feed-back results to participant, accountability)
   e. Preparation for handling signs of distress during measure administration
   f. Confidentiality, informed consent and data protection
g. Communication skills with different age groups
h. Concerns when producing clinical diagnoses

3. Guidance for selecting a measurement tool
   a. How do I choose a measure?
   b. How do I define a sample?
   c. What resources and capacity do I need?

4. Preparation for administration
   a. Adaptation
   b. Copyright
   c. Contacting the author
   d. Language translation
   e. Creating your own measure
   f. Communication (internal and external)

5. Data management
   a. Training enumerators
   b. Surveyors
   c. Measures per age group, disaggregated reporting
   d. Modalities for data collection
   e. Scales for screening versus scales for follow-up
   f. Triangulation

6. Data analysis
   a. Reporting
   b. Best practices for communicating findings

Appendix
   a. Full selection process
b. Checklist for ethical considerations

c. Implementation requirement checklist

d. Summary of selected measures with key descriptions and details, link to Dropbox for full package of measures

e. Practical example of administration (informed consent, purpose of exercise, how the data will be used, managing expectations)

f. Glossary

Proposed next steps

• End of 2018 – complete additional literature reviews. Working group fills in ‘gaps’

• End January 2019 – Working Group Draft of MoV guidance document
  
  • End February – Working Group agreement on Draft MoV guidance document for RG / peer review input

• March – May 2019 – Draft MoV guidance document RG / peer reviewers
  
  • Draft 1 Written Consultation with WebEx consultation (2 weeks)
  
  • Draft 2 Written Consultation (2 weeks)
  
  • Final RG / peer reviewer written consultation for sign off (2 weeks)

• June – July 2019 – Artwork (inputs by working group)

• August – Sept 2019 – Publication of field test version and launch

RG Consultation – 1 November 2018

• Are there concerns about process?

• Can you see anything that was missed?

• What needs to be considered in the ‘write-up’?

• Reflections on MoV Tables

• “Other” comments or suggestions?
The nexus between

Mental Health & Psycho-Social Support and Peacebuilding

An overview of the project to date

Aim of the project

Establish a practice in which both fields are encouraged to work closer together, assuming that enhanced wellbeing and sustainable peace will be achieved through an integrated approach of PB and MHPSS

Milestones achieved to date

2014

*The journal Intervention* highlighted the connection between peacebuilding and psychosocial work

IJR and WarTrauma joined hands

2015

Joint conference held on this topic in order to bridge the two disciplines (50 international invited participants)

2016-2017

Global Mapping exercise of organisations working in one or both fields and a Systematic Literature Review

2017

Expert meeting to develop practice guidelines(GL)

+ *Intervention special issue*

2018

Expert meeting to reflect, review progress and plan the next phase of the project and a reference group formed.
The way forward.

- Advocacy to fellow practitioners, organisations and policy makers in both fields to motivate for more collaboration
- Networking to expand our community of professionals and organisations doing similar work
- A consultative and participatory research process to generate a training process and resource package and to further develop the draft guidelines that have been generated to date
- Field testing the training and resources as part of the research

Publications

- 2014: Intervention Special section: Peacebuilding and Psychosocial Work: [https://www.interventionjournal.com/content/march-2014-volume-12-issue-1](https://www.interventionjournal.com/content/march-2014-volume-12-issue-1)
Disability Inclusive MHPSS

Carmen Valle-Trabadelo
Mental Health Technical Advisor
CBM

Why bringing Inclusion into MHPSS?

Taking a disability perspective helps closing the gap between humanitarian and developmental action:

In post recovery, we will find ourselves having to work in rights and systems strengthening and we will have to use the right language and the right frame (e.g., CRPD). If we use a disability inclusion frame at during humanitarian action, we are setting the ground for the building back better efforts and avoiding having to shift frames and starting again as we transition into recovery and post recovery

Why bringing Inclusion into MHPSS?

Using disability framework allows us to act more adequately in the MH of MHPSS… in the pss side we might be working mostly with persons affected by the crisis who are coping and being supported in doing so and therefore not considering themselves as having a disability, as Anne mentioned. But our work in humanitarian crises needs to be directed as well to those with existing mental health conditions and those who might develop them in crises of long duration (conflicts of many years)

If we are, and we do, responding to the needs of those with such conditions, then it’s important that we acknowledge the framework that is more capable of protecting their rights

It’s also important because...

Why is this important?

Because a) all international regulations, declarations, etc (see Global declaration from ministerial summit, Astana declaration on primary health care, Lancet commission) are calling for person centred services, and for putting at the centre de voices of service users. This includes MHPSS

If we put them at the cnetre, and we listen, they are asking to be protected by the CRPD and they are telling us to use the terminology that will allow this (Persons with PSD and MH conditions)

A few positive experiences of our work on DID MHPSS

Ebola response in Sierra Leone: mention the leading role of the MH Coalition and the association of service users in pushing the government into taking action in the recognition of MHPSS as a key aspect of the response. Also bringing together MoH and MoSW and WHO and UNICEF

Also opportunity to include persons with lived experience as reviewers and contributors to key documents (PFA guidelines, MHPSS care packages, etc)
2004 tsunami: transition from emergency to recovery and strong emphasis in systems strengthening.

Example of the need to look at the MH of MHPSS: those who drowned because of being locked or chained in institutions

Example of the need to bring the rights based/disability approach: years later the community services have transition into lots of work being done in advocacy and participation, social inclusion and access to rights. For that, we need to put people at the center of what we do

Cox’s Bazar: the disability inclusive framework is allowing us to integrate the MHPSS services inside of our inclusive hospital and bus. All disabilities receive services in the same unit and this allows many positive synergies, for example, those coming for orthopedic services (e.g., having acquired an impairment due to violence) being referred to the psychosocial counsellors

Also, as we are working in the host community too, we are having the ability to identify persons with long term conditions, experiencing high levels of disability. Creation of advocacy groups and use of rights based approach (Bangladesh signatory of the CRPD)
The task of CO Chair

To apply some criteria to see which one is working best. The criteria to apply the modules
Set up time, need to be quick and reasonable otherwise it is not applicable
Diploid person have to be neutral, not responding to his agency but the MHPSS

The child protecting worker need to have criminal cheek

Applying the criteria, the mechanism and feedback us on which mechanism to go with

Any criteria to add or comment

Vetting roster member

Donor were very enthusiastic about it and would like to see it happen,

What is the possibility of integrating mental health with PSS

Could it be a task about timing, short or long - what’s next, where are the local and other agencies that could interact with them

We decided to go with one mechanism, one with short term and one for longer time, we need to discuss it with donor.

SILVIA FINAURINI CHILD PROTECTIN AOR RAPID RESPONSE TEAM MEMBER IS OFF AND WE NEED TO TAKE CARE OF THIS POSITION.

Feedback from different groups

Advocacy Group:

One of the most active group this year,

Going forward with this entity, wo we want to take it forward?

We do have support from SC

We do have very active advocacy group, it is important, and we would like to see it there

We are going to have an advocacy position; the group is helpful. We need people active participation.
we don’t need a group to do this unless we have a very clear coast.

We are talking about past years, later we will discuss the future.

All the groups needed in the next 3 months to develop TOR for all the working and thematic groups. manual will be open source.

IOM and UNICEF documents are all fitted together

This is a participating project for all agencies that worked on this project

Issue,

UNICEF is the child protection comity for us

This is an inter-agency process. Agency specific

Interagency tools 12 pages reference.

Terminology is an issue, what is the right terminology to use.

We build bridges and we are having clangs, that’s why we are inviting other agencies to join

This is very strategic issue

We already developed the guide lines for UNICEF.

We had a range of issues, we could link with UNFPA to join efforts

**Disaster risk reduction** DRR

It is growing win no well-established MHPSS component

TOR of our group (WHO, SC, MHPSS.net and others

We are mapping all initiatives, we are engaged with one larger project.

DRR project by UNDP, is a massive project with the Indian government, all different sectors will be involved.
Aim, to develop an action sheet which will be presented by next annual meeting.

Try to integrate DRR component in the simulation exercise.

Dominica Example,

MHOSS integrated in DRP after the hurricane in Dec 2017, on Dec. 31 all the kids have access to school, we integrated 4 PSS. We went into 73 schools. Created child friendly spaces, train youth to run those centers, training of PSS to teachers, it was a very good example.

After a disaster, we are open to improve the system, prepare for the next Huracan. This is good and rare example we need to do work on preference,

We must think of risk and prevention aspects.

Simulation exercise next year

Climate change impact on those fields is also there.

**Piece building Group:**

No of members in this group

**IJR**

The nexus between mental and health and psychosocial support and peacebuilding.

Piece Building:

It is about how to get piece necessary for humanitarian development together

How do you bridge and overcome the trauma like Syria, Iraq and Yemen?

UNFPA, GIZ .SC and HIAS want to join this group

Face to face interview and group interview. Semi standardized, open environment with easy gestures, people will tackle the problem themselves, people will come with he problem.

Workshop is to dig deeper, build some trust and discuss about problems and challenges.
M And E

45 indicator, only 6 goal impact indicator
Recommended mean of verification, you can use other if you chose
Quantitative and qualitative approaches to those methods
Working with John Hopkins now, 236 measures identified, mapped according to the 6 goals indicator.
Psychological distress was the bulk of the measures
Accessibility criteria, open for public and in one of the UN languages
No stigma measure here
How are you going to propose the tool?
It need to be assessed in at least 2 different countries and 2 different languages and to see if they can be culturally adaptive or not.
Every now and then, measuring and evaluation of the tools, and if you have more agencies using the tools then we have cross evaluation.
How do you tailor maid tools for specific criteria?
We don’t anticipate that this is the only measures used, use your own measures if you have one
Stigma measurements, is not present and we don’t have stigma scale

Methods of developing scales:
The challenges we have to decide, we have to have strict criteria to validate the method,
Tailored made scale are only for the tailored people.
John Hopkins developed a functioning scale in Jordan
Sub scales where included in the search of our measures
GHQ was not used but PHQ
The tools are accessible, feasible, usable and translatable.
We are only measuring goal impacting indicators
thematic groups for 2019 suggestions:
the activity of those groups should be focused on ? do we want these groups?
5 agencies minimum for a group to become a reference group. First, we agree on the group, then decide about involvements, true involvement of your agency not only words

Should we have a group of research?

Support man and boys- its their at IOM website

It should be tooled based not guidance based

- Group on material, might be needed- sub group ro upgrade of what we already have.

  Work with torture survivors, can it fit in other group

  Note, no group does not mean the topic is not revised.

Financing for MHPSS suggestion by UNFPA

Children and family proposal came from Berlin meeting recommendations
VOTING

Each agency is only one vote,

Vote if you think is important even if you are not involved,

Vote if you want this group to move forward

Then sign your organization to the group that you want

2018 Thematic Groups and we will vote on new suggested groups

• Advocacy (Save)
• Community based MHPSS (IOM & REPSSI)
• Disability & inclusion (Health Works, HI, WHO)
• Disaster risk reduction (MHPSS.net, WHO)
• Disaster risk reduction (MHPSS.net, WHO)
• Monitoring and Evaluation (WHO)
• Peacebuilding (IOM, WTF)
• Staff and volunteer care (GIZ, HIAS, Save)

Advocacy
Made it

Community based MHPSS
Made it

Disability and inclusion
Made it
Disaster risk reduction
Made it

Monitoring and evaluation
Made it

Piece building
Made it

Staff and volunteer care
Made it

All 2018 groups will continue, now the new groups:

Program for man and boys
Made it

Gender (to focus on women and girls)
Made it

Children and families
Made it

Minimum service package
Made it

Survivor of torture
Did not Make it

Materials and tools consolidation and updating them
Did not Make it

Deliberate event chemical and biological weapon
Did not Make it
Urban context

Made it

Voting finished, activity, what you think each group should focus and put it on the flip chart and sign your organization to the desired group.

Then divide yourself into 12 groups and chose the leader of each group according to the agreed upon groups.

Community based

MHPSS

Finalization, dissemination, promotion of the guidance notes.

Share lessons learned, good practice from the field.

ACF-> cochair
IOM -> chair
Church of Sweden
REPSSI
IMC(?)
PLAN
Tdhh
M&E

Church of Sweden

WHO-lead

War trauma

MdM-france

ACF

Tdh

IMC

UNHCR

1) update WG-toR (1year onlt)
2) ongoing MoV Guidance Doc
   - include sel-developed measures
   - how to adopt new and existing tools (culture, context, language)
   - how to use measures

Staff and Volunteer Care

MHPSS.net

VT

Infer for victims of torture

Jesuit Refugee Service (JRS)

International Rescue Committee (IRC)

- peer to peer support

- develops tools

- how to mentor?

- self care: what managers need to know
- continue the great work in researching staff needs, complete data with other organizations
- defining and attaining new areas related to staff care
- minimum standards for staff care

HARG – University of Denver
JRT – lit. review
Institute of global health and development (Queen Margaret University, Edinburgh)

**Children & Families**

UNICEF and the MHPSS collaborative
IOM
REPSSI
PLAN
SC
ACF

Social and emotional learning program (children, parents, teachers, roles models)

- work on relationship-couples isss (cut)
- UCD

**Minimum Service Package**

UNICEF
IFRC
SC
MdM france
Medair
MHPSS.net
IMC
UNICEF-lead
WHO-lead

CP
MSP
TOP
Piece Building

Lead UNFPA

IOM

GIZ

Church of Sweden

PLAN

JRS

War trauma

Isra aid

Save the children

Health work

TOR

LAAFAG

Engage FBOS AZZa UNFPA

link with social cohesion... etc.

Disability and Inclusion

UNFPA

- review of the BMZ- UNICEF recommendation based on your experience with your specific ...
- HI
- HW, WHO-lead (C.B.M.)
- MHPSS.net
- Mdm- France
- UNICEF
Disaster Risk Reduction

UNICEF
WHO-lead
UNFPA
MHPSS.NET
Isra Aid

1) finalize mapping tools with Brandon
2) develop list for Brandon for mapping exercise
3) look for individual with DRR expertise – specifically in theory and history

Urban Context

SC
Idh
IOM
PSTIC-lead

Urban guidance
Link to DEV initiative
Building community in urban context

Advocacy and Finance

Tdh is organization
SC
UNICEF
WHO
MDM
SPAIN&MDM
H.W
MHPSS.NET
TDH

ToR
Adv. Position
Identity goals
Gender/Women

ACF
UNFPA
WVI
MDM

1) Draft ToR
2) FOCUS GUIDELINES
   - review (IASC,...) mapping of existing resources
   - gender and age markers in MHPSS
   - women and girls friendly spaces
   - related to integration (not really mainstreaming)
   - links with DBV, ToR and other sectors

3) FOCUS TOOLS (men-boys. Women-girls)
   - review existing tools (intervention/ concrete)
   - target: (S)GBV survivors
     forced marriages
     ex-wives of terrorist fighters
     sex workers
     LGBTIQ
   - checklist

Men and Boys

UNHCR, IOM and UNICEF
TOR, guidance note to inclusion program for JBV
To appear on reference group work plan

- advocacy:
- community based MHPSS
- disability and inclusion groups
- disaster risk reduction
- monitoring and evaluating
- piece building group
- staff and volunteer care

All groups will continue

New groups
- program for men and boys
- gender (to focus on women and girls)
- survivors of torture (X)
- materials and tools consolidation and updating terms (X)
- deliberate event chemical and biological weapons (X)
- urban context (agreed on second round)

Closing Session

Drugs will be stopped
Announcement from the WHO at the end of this year
Long acting antipsychotics

Fluphenazine

Any issue for now:
WHO WOULD LIKE TO HOST

Do it again in a location where there is human crises (like Uganda)
Also in one hotel is great
If local NGO does it then it needs a financial sport

UGANDA (TPO & REPSI)(NGOs)
BRUSSLE

Thank you.