1st Mental Health and Psychosocial Support Forum: “Working Together”

Amman- Kempinski Hotel- 31st October-2018

Organized by IASC MHPSS RG and Hosted by MHPSS working group in Jordan, Save the Children and MHPSS.NET

Background:

It was agreed by Inter Agency Standing Committee’s Reference Group for Mental Health and Psychosocial Support in Emergency Settings’ (IASC MHPSS RG) members during the annual meeting in Geneva in October 2017 to have one open day during upcoming annual meetings where members as well as non-members of the IASC MHPSS RG can participate. The aim was to provide relevant stakeholders who are non-members of the group with an overview of ongoing achievements and challenges in the MHPPS field, as well as providing non-members with an opportunity to advise and help shape future IASC MHPSS RG activities or products.

Objectives

- Demonstrate to the audience key achievements and challenges of MHPSS
- Advocate for further investment and scaling up of MHPSS programmes
- Network with other sectors relevant to MHPSS
- Educate wider range of audience on current key issues in MHPSS field
- Conduct consultations with non-RG members on IASC MHPSS RG activities and products

Opening Speech By Dr. Maria Crisina

WHO Representative of Jordan

Colleges and Partners in Mental Health and Psychological Support, representative of international and national organizations, Ladies and Gentleman.

Welcome to Jordan for the IASC reference group on MHPSS in emergencies co chair by WHO and IFRC and the 51 member agencies representing UN, NGOs, ICRC and IFRC.

Thanks to RG who selected Jordan.

For the first time the RG is conveying MHPSS forum where non IASC members as well as agencies active in Jordan are invited to join the RG members in an open forum for mutual learning.
The MHPSS forum day is co hosted and co facilitated by Amman MHPSS working group (co chaired by Jordan and IMC Jordan) save the children and MHPSS.net

The aim of this forum is to provide relevant stakeholders who are non-members of the group with an overview of ongoing achievements and challenges in the MHPSS field, as well as providing non members with an opportunity to advise and help shape future IASC MHPSS RG activities or products.

Objectives include to demonstrate to the audience key achievements and challenges of MHPSS, Advocate for future investments and scaling up of MHPSS programmes, network with other sectors relevant to MHPSS, educate wider range of audience on current key in MHPSS field and to conduct consultation with no RG members on IASC MHPSS RG activities and products.

WHO in Jordan led one of the most successful stories of building back sustainable mental health care system during and after emergencies with was featured in a WHO publication with same title, Jordan was the first country in the world to implement mhGAP to scale up mental, neurological and substance use care during the displaced Iraqi crises, Similarly efforts still on going by WHO and partners to support displaced and vulnerable Syrian as well as the host population, WHO continuing its support to increase coverage of the population community based mental health and psychosocial services to coordinate MHPSS as co chair to scale up access to care.

Note. Isolation of mental sick patient is not helping them.

We welcome you again and wish you successful MHPSS forum and annual meeting.
IMC update for middle East MHPSS WGS

On behalf of the country director

Main activities of the MHPSS WG in 2018

- Strengthening of collaboration between MOH and NGOs on national MHPSS initiative and coordination
- Collaborating with MOH on updating the national mental health action plan (2018-2021)
- Updating the TOR for MHPSS actors in MOH (as per request)
- Updating the 4Ws MHPSS mapping

Achievements in 2018

- Launch updated 4 year national mental health action plan
- Released updated 4WS MHPSS mapping report, Launch of online 4WS (end of Nov.)
- Developed advocacy paper on need for support for MHPSS services for ministry of planning and internal cooperation (MOPIC)
Panel Discussion

Kelley form Save the children welcome the audience

Leslie snider leads the panel

Donners, service users and organizations, how they are working together

Introducing the panellist:

Alison Shafer, dept of MH and SA (researchers)

A technical officer with WHO, dept of mental health and substance abused. Currently leading the WHO project called EQUIP, exploring hoe to provide psychological interventions provided by non-specialist providers.

Christene Ogaranko, Open society foundations (Donner)

Program officer with OSF, mental health and rights program based in Berlin. Work on migration and mental health, Providing technical and financial support.

Carmin CBM

MH technical advisor for CBM. (Policy field)

Iman Aqrbawi

Jordan river foundation (local organization)

Worked for over 15 years with the organization, worked in protection field, now a manager for all relevant services to protections at JRF including the case management,

JRF is a non-profit nongovernmental organization.

Amera Al Jamal (service user)

Founder and president of the first national service users association in Jordan. She is a service user herself. Activist for the rights of people, trainer for human rights,

Nominated to sit on the board of the higher council for the persons and disabilities affairs.
Q1, from your prospective, what are the recent key achievements in the MHPSS field?

Alison:

We have come a long way from quick therapy, we non specialist provider can deliver the good service, we need more skilled people non psychologist.

We need the clinical level to support high level care and support the non specialist work force.

Christene:

Awareness for the need of MHPSS at the time of people coming to the host country and after migration and displacement, we cannot create support silo.

For mental health we need all of us to work together.

Carmin:

Policy is a feedback from people who worked at the ground, we are able to list to the organization the policy we made.

Amera:

God bless you, honestly, I think most important are the disabled and diseased people that undertake the service, nice service and I am happy to be an activist and making the national policies.

This is very helpful locally, we put the national role map and national plan.

Achievements:

I thank WHO and MOH. We are the targeted and I am moving toward the activity needed and there is a law in Jordan (personal rights of disabled people) was ratified and this is very reassuring.

This will affect the psychological wellbeing in Jordan,

Iman:

As service provider, from my view, we achieved allot in 5 years specially in emergencies. We try to meet the demand and needs and will try to use available resources. We try to have new and developed programs to deal with the group. We need more effort and development to enhance the quality of the service, we need more effort for new programs to meet our clients,

I think one of the biggest achievement that anyone can provide is PSS, family, neighbours, anyone.

There is a challenge of how do we begin to implement programs as funding coming and how are we listening to the voices to helping our action plans.
Q: from your prospective, what are the main challenges for MHPSS today?

Iman:

We need more capacity building, programs, to provide qualified services, we should know more about the impact of the existing programs, is it sufficient?

According to the feedback, we build the future work and proposals

Carmen:

We learned allot, we have very nice policy briefing. We build policies

- Great policy,
- great materials,
- that means we know what to do.

This three points need to be connected. And connection to what’s happening next

Christene:

Wonderful research and nice resources,

Everyone require specialized trauma treatment, it is really heavy on one side, the contrite system don’t have the capacity to meet the needs.

Interpreters and public mediators are not present, we need them.

Alison:

There is a lot of changes, psychological intervention and treatment is further ahead than community based PSS. We need to understand how we implement health and PSS, we don’t have to research everything, something are human rights that everybody needs, like family, friends, good relations in work place, all of us do need that.

Do we need random control trials, we need to direct the limited funds to there right places, we need to be selective on what we need to research.

Amera:

When you put your programs and research- you consider us?

I think what you see is not what we need, you are working in what you can see. The people that are scared, in home, where are they in your study? (in your program)

We need you to understand, I don’t wanna say you don’t feel, but you don’t know it all, we have problems in work, we cannot say we have mental issues or we lose our jobs, we have rights but I cant find the definition in the low for people with mental issues.
I need medications, when Medicine are off I am destroyed. We have cancer patient among us, children,...etc.

When I go to doctor, they are treatment me like a computer, when I see the prescription already written it is a NO NO. I don’t live 15 years with the same medicine, do we need support or treatment, where is the support?

Thank you for your services.

Why you make special hospitals, this is a stigma, in the hospital, for example there are no carpet as some patient urinate, why don’t you clean them ? no get some helpers

I took 150K, and 90K in funds but so much more money going away in its not right places,

Iman:

I completely agree, we need to hear from beneficiaries, that’s why we need researches.

Most programs are according to the donors needs,

Leslie:

We need human centre design project, donors like to know what they are funding’s.

Christene:

The way we approach is NGOs, we need flexibility, research, to contextualize to meet the needs of the people

Amera:

We are there all the time if you need any information, we are there to give you any details you like,

Refugees affect the mental health institute, what will happen when all the refugees are back, 70:30 Serina to Jordanians in our program, we hope to continue the work.

Iman:

I don’t think all people hear are ready to work with each other, re visit the programs and plans, I identify the needs and plans to enhance what we have.

Q. from the online audience

Can the panel comment on the need to PSS national strategy for Jordan?

Iman: I don’t have enough information, there is Jordan response plan started 3 years ago
One of the audience: Jordan already have a policy and updated plan in April 2018 for refugees. Available on the UNHCR platform with senior refugees’ response, google to find it.

We hope that there was an actual donner to listen to us and we listen to them,

Christene: we do have more flexible approach compare to other donors, we have rules for us

1. do no harm
2. whatever we do we contribute to the national needs.

My wish donors need to come together, we are not on the same page and no one donor is enough

It is our responsibility to deliver our message, I like to see more donors together,

Q, Stigma and access of specific target group who are in need but they cannot access because of stigma.

If a woman goes, she is targeted and feels shame. For men it’s the same, we have experienced, is there any new approach for this target group?

A. we know you need a 3-legged program

1. stigma control
2. programming
3. advocacy

need to work together, we need some learning from development sector.

Iman:

When we talk about mental health, its not about intervention and response, we don’t have sufficient programs, it should be addressed, unfortunately some practitioners have bad attitude and need to be ready first

Q. from the online audience, since the panel working together, what is one key strategy that makes it different.

Iman: the plans of working together are there, but implementing take time and not correct

Many things we can do, as a community we need to continue building our trust with each other, massive duplication of training programs, some people are re trained, there is a lack of trust among each othere, we need to start respect and trust each other allot more.

Christene: we are working very inclusively, we are doing that.
Rebuilding Lives

Addressing Needs, Scaling-up and Increasing Long-term Structural MHPSS Interventions in Protracted and Post-Conflict Settings

The meeting content, sessions and content, built on findings from:

- The Hague and Wilton Park meetings.
- Key literature on MHPSS gaps and priorities

- “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”

Expected Outcome

An advocacy document to promote institutional uptake by participants and their partners

Beginning of a process for developing a roadmap for commitments by donors, policy makers, MHPSS practitioners, and researchers

A Message from Dr. Elke Löbel
BMZ Deputy Director General and Commissioner for Refugee Policy, Vidoo played

https://youtu.be/ZWXXgbCCxyE

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 (especially, governments and UN agencies)
- implementing agencies
- researchers.
- And other stakeholders identified by the WGs during the meeting (e.g. coordination bodies)

How were the working groups divided?

Gaps in knowledge & action-oriented recommendations
Identified through a thorough review of discussions & findings from the Hague and Wilton Park meetings

Structure of expert engagement

WG's give attention to promoting inclusion of all people across age, ability, gender, and living situations in the recommendations.

**Working Groups by Thematic Area**

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<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>
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<td>WG2. Persons with physical &amp; developmental disabilities</td>
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<td>People on the move</td>
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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 Berlin, 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.
around draft version of the recommendations and actions from the initial meeting in Berlin- Ongoing through end of November 2018.

Final Technical Revision led UNICEF and BMZ with support from co-chairs of the WGs at the Berlin

Summary of Recommendations from the 4 Working Groups

Key recommendations “Children and Adolescents/Youth”

- Ensure that the social ecology of the child serves as the framework for all MHPSS interventions.
- Build MHPSS capacity within communities among the MHPSS workforce and among carers and community members.
- Improve inter-agency and inter-sectoral coordination as well as accountability of stakeholders to children, families, and communities supported through MHPSS services and delivery.
- Translate available evidence on healthy development of children and youth into programmatic language and guidelines while systematically pursuing implementation research to improve the effectiveness of programmes.


We invite you to rank the recommendations in thematic area 1 by priority (1 is highest priority)

Key recommendations “Individuals with physical and mental disabilities”

- Prioritize people with disabilities to lead the mainstreaming of disability inclusion at both the international and advisory levels, and during field implementation.
- Create accessible, targeted and tailored MHPSS interventions that are inclusive in emergencies (e.g. gender-based violence and disabilities).
- Create awareness and mainstream actions for individuals with physical, psychosocial and intellectual disabilities in the MHPSS sector.
- 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.


We invite you to rank the recommendations in thematic area 2 by priority (1 is highest priority)
Key recommendations “Gender Based Violence Survivors”

- Ensure that the design and implementation of gender-based violence (GBV) prevention and response services is based on an analysis of the prevalent forms of violence, their impacts on survivors across the life-cycle, and factors affecting accessibility within the social, educational, cultural, economic and political context of each setting.

- Ensure that MHPSS services, referral and integration within GBV services are delivered as part of a broad prevention and response strategy.

- Create accessible, inclusive and tailored MHPSS interventions within GBV services.

- Adapt current guidance and standards to support the integration and coordination of MHPSS services and approaches within GBV prevention and response.


We invite you to rank the recommendations in thematic area 3 by priority (1 is highest priority)

Key recommendations “Refugees and Internally Displaced Persons”

Coordination

- Include and involve national governments and authorities in MHPSS coordination.

- Strengthen donor coordination to support complementary humanitarian response and development programmes.

Capacity building

- Support broad and long-term capacity building that includes governments, academic institutions and civil society.

- Recognize that establishing quality, sustainable national MHPSS services and systems is a long-term commitment and that emergencies also present new opportunities to strengthen MHPSS systems.

Provision of MHPSS services and activities

- Ensure accessibility of MHPSS services and activities for all.

- Track and support the implementation and scale up of effective (and cost-effective) MHPSS interventions.

Staff care

- Recognize that staff and volunteers are also affected by emergencies and need adequate support systems.
Research and *monitoring evaluation, accountability and learning* (MEAL)

- Ensure accountability and oversight when conducting research.
- Monitor programmes and ensure flexibility to meet the needs of the affected populations in line with ‘do no harm’ principle.

Integrating MHPSS in different sectors

- Ensure that MHPSS considerations are included in programming by other sectors.


We invite you to rank the recommendations in thematic area 4 by priority (1 is highest priority)

**Let's see the results of the prioritization exercise**

*Found in the result PDF folder*
Vulnerable Peron Group.

Facilitator: Marcio Gagliato

Hadeel: WHO country Office

MHPSS.NET

Introduced my self and asked if it is ok to record and take notes (1.15pm)

Q. do we need translation

A. yes from Arabic

Introduction: Brain storming about our works in challenges and achievements.

Facilitators: Marcio

People introduce themselves and organizations, I will mention some as there was no Microphone

Anna: Image PSS coordinator, Ukraine

Sara Haddad and college: Danish Institute against torture.

David: GIZ

Ann: Health mental bure.

Sara and valaria: intersos.

Coden: IOM Sudan

Paul: center for victims of torture, USA

Feona: World vision International

Sara: GIZ

Ahmad: UNICEF

Christean: GIZ

Areej: family institute for health

Lina: Noor Alhusain foundation

Fatema: CVT amman
Today’s Topic: Most vulnerable child/ adult survivor JBV.

Q. who is the most vulnerable in your agency?

A.

- People who are difficult to access.
- Patients with mental problems with bad social situations, (family and property lost, the lost mental capably).
- People with AIDS and HIV.
- Sex workers.
- Albinism.
- Elliptic people.
- Family of people with mental disorders.
- Families of prisoners
- Youth exposed to pregnancy. Missing schools, early marriage
- Women
- Men who have psycho social problems and needs
- Men and women who experienced DPV.
- 2 types structural who are less protected

Demographically well located but for personal reasons.

- Human rights: people with disability and mental problems people with no legal papers.
- UPP. Defined vulnerable: illiterates, women facing domestic violence without access to services

Obviously, no clear definition to the group

- Two types of refugees, urban and camp, some urban refugee’s losses there UN mandates.
- LGBT, homophobic people don’t want to work with them,
- Tortured people are vulnerable, People who don’t know there human rights, especially youth who don’t know they are under bad circumstances.
- People who have less access and have barriers
- Single mother,
- Care giver who abuse the child.
- Children of separated parents, it is difficult to respond.

A dream come true for the website as we are re helping the voice of local people to get heard
Q. think about your activity in the last few years, what are the key lessons learned on trying to reach the vulnerable groups?

A.

- 2 things, sometimes we think that some people are vulnerable when they are not, the risk is our perceiving is not the same as the people perceiving’s.
- You first need to work with people and to know how to support them,
- Working with the children that might not be effective.
- CFS might not be adding value to the children. They need schools, it should not but SFS for 6 months, let the children play.
- sustainability is a key we need to sustain our service.
- Tring to get people from different back ground and having them living together is a big challenge, try to talk to local people and communities to get the right impression.
- Foundation and education is crucial.
- Restoring the dignity, give a space
- Reliance components, elderly can be of so much help and have strength, so look at your resources.
- We can improve the family and the community and PSS services, that will improve the personal level.
- Empowering youth, give safe spaces.
- We do no harm, but acutely we do a lot of harm
- Pointing fingers on persons and families.
- One of the main challenges is to become aware of true emotions and try to let them feel safe.
- Man is protecting and in power, we come to talk about equality, that will affect man
- Traditional healers sometimes do have results

Q. what is the resilience and the capacity?

A.

NGOs. Need to work together for the best results, support needs to be within the community not from top down approach, we all very similar, so our main tools is our ability to see others and relate to others, that’s the best tools.

Don’t project your experience on others, and be blind folded against others experience.
Q. Challenges on working together?

A

- Timing of response is different, organization settings are different, so cooperation is different.
- You don’t the exact needs and what you are coming up with, so we should carry together advocacy,
- We need sustainable and relevant donners.
- Taking much more risk, so we need to change the way we program.
- The obstacle is funding, especially at emergencies.
- Good network to provide appropriate services.
- 3 pillars

  Donor – prioritize PSS.

  coordinator

  intervention

- How to fix coordinators task shifting from Psycho social to intervention.
- Trying to support but as long as the main pressure remain, it spoils our work.
- Helping to improve there shills.
Thematic Group #2

How do you perceive "most vulnerable"?

- Can't access services
- Physical disabilities coupled with psycho-social stressors
- Family members
- People who can't claim this right
- Men exposed to GBV
- People who don't have legal papers
- Survivors of human trafficking
- Double/complex discrimination
- LGBT community

- Youth
- People unaware of their rights
- People who assume it is "normal" to deal with the situation
- People who have no access to healthy WASH needs
- Single mothers/pregnant/lactating women
- People accessing services of not good quality

Key lessons learned:

- Work with the people/communities to identify vulnerable groups
- Structure the work of (CFs), consider programs (education) after 6 months
- Evidence-based practices
- Sustainability
- Appropriate context

- Hire locals in programs
- Ensure people are aware/educated to enable them access services
- Human Rights-based approach
- Provide space for participation
- Never overlook resources/resilience/coping strategies
- Engage service users in planning/discussion/programming
- Effective coordination
SCALING

MHPSS actors know how to scale-up quality MHPSS programs for large populations, but collective and systemic implementation remains a challenge. #assess #adapt #equip #support #repeat #quality #scalingup

Global and national MHPSS actors mapped and identified successes, challenges and solutions to scale-up quality programs to support more people. #MHPSS #integration #coordination #fightstigma #inclusion

To scale-up we need more coordination and collaboration among key international & a local #MHPSS actors. #MHPSS4all @WorkTogether

INTEGRATION

Humanitarian colleagues, we missed you today at the 1st Global MHPSS Forum in Amman. Together let us improve psychosocial wellbeing for all (#bettertogether, #integrated approaches to programming)

MHPSS can enhance the quality of all humanitarian work. We need to join forces and develop holistic approaches. No humanitarian programming without MHPSS!

REACHING THE MOST VULNERABLE

“Reaching the most vulnerable” starts by looking to the most unseen, listen to the most silenced, and reaching the least accessible. MHPSS good practices reminds us to drop labels, and listen to communities.

“Reaching the most vulnerable”: loud and clear, seriously engage community in everything, planning, discussing, contextualizing, evaluating. They must have the ownership not at the end, but from the beginning. #notjustwords #thisisaprinciple
Panel Discussion

PANLEST:

Nana Wideman, of the IFRC psychological reference center, Denmark
Claire Whitney, IMC Jordan
Peter Ventevogel, UNHCR Geneva

Peter: the objective of this briefed session is to illustrate the potentials of collaborations between different organizations, in different locations, with different targeted groups, but united in one goal to develop a scalable psychological intervention.

What is strengths?

- PM+
- Adapt, test and scale up
- Different forms, - individual (by refugees) – group – adapted for youth – e versions
- Different locations

What do we need?

Cultural adaptations, depend on the language and if you get It right.

How to understand the culture and the context.

Adapted materials need to be tested,

Different partners:

- 15 partners +WHO

NGOs: IMC, WCH

Universities: Netherlands, Germany, Switzerland’s, UK, turkey and Australis

Local NGOs: RASASA Istanbul, IPSA in Netherlands, and Noor Hussain in Jordan

International organizations: IFRC, UNHCR, (collaborating with WHO).
3 elements (Adapt, Test and scale up)

Adapted materials need to be tested.

Does PM+ work in its adapted form, are we able to engage man and women,

3rd part is scale up

Peter:

- Situation analysis of responsiveness of the health system (London school of hygiene and tropical medicine)

Very different context

- Collect data about COAST (London school of economics)
- Make models for theory of changes. In Lebanon, in Turkey and in Netherland
- One of the 8 workplaces is on synthesis and dissemination: UNHCR war trauma foundation and Danish red cross
- Newsletters (sign up)
- Web site
- Workshops next year to engage steak holders
- Training packages for organizations who want to start using the adapted materials

Q, how was PM+ chosen?

A, because it was a promising intervention, it was likely to work, Pm+ based on things that we know it works, so we are interested to see if we can take it to scaling.

Q, inclusion criteria?

A, adult with mild to moderate stress, excluding children.

Q, costing components?

A, some trials where the coating is involved, it is about activity you do, you know how many staff you trained. It’s not coast effectiveness, its coast of scaling up. We need to write down the time we spent, talking and arranging training. In research you can make it work- in real life coast is an issue.

Group pm+

We are aware of the studies in Kenia and Pakistan.

For a solid evidence, you need to have evidence from different context.
For cultural adaptations, we are still building the evidence base, we are trying to build on evidence and scale.

Q, to what extent you are documenting the process?

A, PM+ TOT in Cairo, we are talking to joining forces and share recommendations and address challenges together.

Adaptation and documentation will be available.

Wrap and field visit

IMC health clinic, mental health clinic

Closing remarks,

Ahmad, appreciating from MHPSS for this work group, it a great opportunity,

IFIC: this is the best open forum on MHPSS. Next year if it happens it will be in different county