IASC
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Report

Information abo
Minutes taking:
WHO Consultan

IASC Reference Group on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings

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Report of Annual Meeting, 4-6 of October 2017

Geneva

Hosted at WHO

Information about the workshop report:
Minutes taking: Roza Copper- van der Heide
WHO Consultant

List of abbreviation

4W	Who is Where, When, doing What
AoR	Area of responsibility
CETA	Common Elements Treatment Approach
CBT	Cognitive Behavioral Therapy
CCCM	Camp Coordination and Camp Management
CVT	Center for Victims of Torture
CFSs	Child Friendly Spaces
CMAM	Community Based Management of Acute Malnutrition
CRRF	Comprehensive Refugee Response Framework
CP	Child Protection
DRR	Disaster Risk Reduction
EASE	Early Adolescents Skills for Emotions
IDP	Internally Displaced Population
IFRC	International Federation of Red Cross Red Crescent Societies
HIC	High Income Countries
INEE	The Inter-Agency Network for Education in Emergencies
INGO	International Non-Governmental Organization
IMC	International Medical Corps
IOM	International Organization for Migration
IRC	International Rescue Committee
GBV	Gender-Based Violence
GenCap	Gender Standby Capacity Project
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Development Cooperation)
GPC	Global Protection Cluster
LMICs	Low and middle income countries
M&E	Monitoring and Evaluation
mhGAP	Mental Health Gap Action Programme
MHPSS:	Mental Health and Psychosocial Support
MHPSS RG:	Mental Health and Psychosocial Support Reference Group
MoH	Ministry of Health
MoV	Means of Verification
PFA :	Psychological First Aid
ProCap	Projection Standby Capacity Project
PSS	Psychosocial Support
PSTIC	Psycho-Social Services and Training Institute in Cairo
R2HC:	Research for Health in Humanitarian Crises
SH+:	SelfHelp+
RG	Reference Group
SGBV	Sexual and Gender -Based Violence
SEL	Social Emotional Learning
ToT	Training of Trainers
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
UN	United Nations
WASH	Water Sanitation & Hygiene
WHO	World Health Organization
WG	Working Group

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Day 1

Welcome

Dr. Mike Ryan (WHO)
Dr. Mike Ryan, the Deputy Executive Director of WHO Health Emergencies (WHE) Programme made a welcome speech to the MHPSS RG and gave an introduction and explanation about the new emergency programme and reform of WHO. The reform intends to shift WHO emergency work to a more operational approach. MHPSS is important on this agenda.

The Co-Chair (IFRC Psychosocial Centre)
https://app.mhpss.net/?get=325/final_agenda_29.09.2017.pdf https://app.mhpss.net/?get=325/1.-introduction_sarah.pdf
A presentation was given on the structure of the IASC secretariat and the MHPSS reference group. The following topics were discussedamong others; priority global level clusters, peer review group Sphere standards (UNHCR & WHO) that will be shared in March 2018; country level MHPSS coordination groups, focus on humanitarian emergencies and migration emergencies (IDP emergencies, refugee response and migrants).

The MHPSS RG is unique as there is a high number of INGO's involved. A summary was given on the Inter-Agency trainings, global working groups and emergencies. The updates per country will be shared later.

The following challenges were shared; the absences of MHPSS coordination groups in emergencies receiving less attention and also how to better advocate for these emergencies (such as Yemen and Chad); country level MHPSS groups are held in local languages but this means all the tools, which are predominantly in English, are not reaching these groups; there is a need for more budget to translate, disseminate and reach these groups; there is a need for capacity building on know-how to translate theory (of the IASC Guidelines) into quality programming.

There is a documentation of requests from countries (working groups), the following was shared; explanation on type and theme of requests, most requests are technical support requests; support missions, 3 in total this year and one is coming up; capacity building initiatives and emergency toolkit for MHPSS is currently being developed.

Co-sharing: WHO and IFRC offer to continue for 2018-2019.

Co-Chair (WHO)
WHO took over the Co-Chair responsibilities from UNICEF in July 2017. Currently there is a review ongoing by the IASC Secretariat regarding all the subsidiary bodies including MHPSS RG. The IASC Secretariat has said that the MHPSS RG is doing well so far, this group is well appreciated because of its field relevance and engagement.

Updated R2HC meeting (R2HC & WHO)

Anne Harmer and Mark van Ommeren
https://app.mhpss.net/?get=325/r2hc_oct-geneva.pdf
https://app.mhpss.net/?get=325/iasc-rg-mhpss-r2hc-meeting-summary.pdf

This session included an introduction of Elrha (hosted by Save the Children UK), whose focus is research and innovation and their objective is to improve the humanitarian outcome. It also covered a presentation of Elhra's R2HC's funded projects which were discussed with researchers and practitioners at WHO on 2 and 3 October, 2017.

Q&A:
UNHCR: it was mentioned that within the current researches that have been funded, there is a strong focus on layer 3. Is there a plan to change this and also to focus on layer 2?
Answer R2HC: there is an open call for proposals and an independent committee. The only way to focus more on layer 2 is if more strong, fundable research projects with topics from layer 2 will be submitted. R2HC can only inform the committee that there is a need for research in this layer but still there will be a selection for the best research proposals. The next call for researcher: June 2018

Cluster interaction and updates

Each of the following clusters presented their ongoing work and their interactions in relation to MHPSS.

Protection - (UNHCR GPC Staff)

The work plan of 2017-2018 focused on continuing the implementation of the strategic framework and engaging new partners and providing operational support. In 2017 there was a focus on a number of initiatives, including; developing a protection mainstreaming toolkit; engaging with other clusters to mainstream protection in their work and community of practice site on the GPC website.

UNHCR indicates that there is a need for collaboration as the protection cluster has strong linkages with MHPSS. Their key operations include PSS interventions, community centers, CFSs spaces etc. UNHCR says it's important to look how the clusters better can collaborate, through info sharing among others. Many operations have many questions on MHPSS and require support and guidance.

Q&A: How can we collaborate in the future on this?

Child Protection - (Terres des Hommes, UNICEF (CP AoR), World Vision (International) & Save the Children)

Child Protection Area of Responsibility (CP) (AoR): within protection cluster, led by UNICEF
There is a Rapid Response Team (RRT) which includes 10 people, and the teams consist of: Swiss Agency for Development and Cooperation, Danish Refugee Council & Save the Children. Currently the focus is on 23 countries (also sub nationally). They provide surge support, send team for up to 3 months, plus remote support to stay connected. Additionally, there is a global help desk aimed at linking people with each other, to document and track requests to be better able to be informed and better able to focus on their resources (what is missing and what are the difficulties), also within the case management there are lots of MHPSS requests.

Going ahead and considerations:
The group does consultations on the localization of country based groups, in particular coordinators.

There is a MHPSS representative in majority of settings as it represents a huge part of what CP group is doing. Field coordinators made it clear that they want to know how it is coordinated on the field level and to clarify where MHPSS fits. Also the focus will be on making sure to have the right IASC groups per country and looking for possibilities to expand the RRT. Also the Global helpdesk will be decentralized so that they have 3 regional desks. The group will also develop peer to peer support in local languages. An important focus will be on working with local partners and governments, including capacity building. The group indicates that it is complex to work with governments when they are leading and asks the group how they deal with these complexities. It need to be more linked with GBV AoR. For example: who is responsible for child survivors, we are all responsible.

Taskforces:
CP minimal standards is under review, there are major changes on how MHPSS is defined. There is a taskforce dedicated on PSS for caregivers. There is a need for PSS to be in any taskforce, and MHPSS is coming up more and more. Additionally, there is a need to do more M&E and evidence based practices, especially on level 2.

GBV- (IFRC PS centre)

This cluster is led by UNFPA (UNFPA has not been so active within the RG although they have a few members on the mailing list, there is a need to include them again)

The group has developed GBV guidelines with a large roll out and it includes a section on MHPSS for GBV survivors, now it is only focused on PFA but it needs to have something else for them as well. There is lot of focus on documentation and not on the response side. There is often an overlap between MHPSS and GBV case management, and there is a need to have something else for GBV survivors and equip case managers to support survivors and persons with MHPSS problems. GBV case managers should be able to provide psychological support for GBV survivors without referrals, unless specialized services are required.

Q&A:
A SGBV handbook/guidelines was developed and emphasized the importance of re-circulating existing clinical tools and to make sure there is no duplication of work.

→WHO: yes there is a handbook on clinical management SGBV, guidelines has been disseminated by IASC. PFA is included in this handbook.

Health – (WHO)

WHO has been leading the health cluster and a previous meeting on 7th of April was a good opportunity for advocacy on MHPSS. It was held coincidentally on World Health Day and the focus of the day was on depression. The Health cluster had their own campaign on depression in emergencies and they have talked about depression in emergencies, they had 8 case studies from emergencies and all materials are available on the new health cluster website.

There is still an ongoing reform within WHO in the area of emergency responses. A reform comes with challenges and opportunities. There is a need for continuous advocacy to ensure MHPSS plays a key role.

The WHO Department of Mental Health and Subtance Abuse will be working with the Health Cluster on identifying mental health roles for emergency medical teams. Their minimal package for health

humanitarian response should include a mental health component. The health cluster shared a survey with 500 humanitarian workers from health sectors within WHO, health cluster and other (I)NGOs in health. Results from the survey indicated that IASC MHPSS guidelines and mhGAP materials were identified among the most known and used by humanitarian health sector responders.

CCCM - (IOM)

There is a booklet on 'MHPSS in emergencies what CCCM actors should know' which is published and included in all trainings of IOM in the field. There is a training on mainstreaming MHPSS in CCCM and IOM looks for a shorter version of the training. Additionally, IOM is now testing new training tools and creating a companion for the triangulation between GBV, CCCM and MHPSS. It is being tested in South Sudan and Nigeria. This training package should be ready by the end of June 2018. A remarkable result from Nigeria's guidance note was that when PSS was not available then the guidance was to keep providing PFA, there were no other follow-up interventions suggested.

Lastly, IOM is currently developing an article that summarizes what needs to be done with regards to MHPSS in CCCM and this will be published in June 2018.

Education – (Save the Children (Denmark) & IsraAid)

Social Emotional Learning (SEL) and PSS are complementary approaches, PSS can be preventive and SEL is specifically for the education sector. They have established two papers; one background paper and one guidance note guidance note on PSS and SEL in crisis and fragile settings. There is still more work for the guidance note and they hope to complete the final version in January. There will be an online training on the use of the guidance note. INEE requested the use of the word SEL instead of PSS in the education sector, therefore this was an important process.

➔ The education cluster is looking for new memberships for the advocacy group in education

Nutrition – (Action Contre la Faim)

Currently a new tool is being developed, the Community Based Management of Acute Malnutrition (CMAM), which is a nutrition treatment for the health system. Additionally, it's being discussed with the government on how to combine the mhGAP with nutrition. It is challenging to translate it from French.

The following action is done to mainstream nutrition:

- Child health: There is a new research on nutrition, health and maternal health care and integrating families
- Gender and GBV and nutrition: They are working together and they see an opportunity for MHPSS. Nutrition works a lot with other clusters such as WASH.
- Child protection and nutrition: There is a sharp increase on how to work with child protection and nutrition. They brought coordinators from both cluster together and child protection interventions are linked to PSS.

Presentation from new agencies

Heartland Alliance International

https://app.mhpss.net/?get=325/introduction-to-hai_iasc-mhpss-rg-presentation_10-2017.pdf

HAI is the global arm of Heartland Alliance for Human Needs and Human Rights. It currently has programs in 8 countries: Iraq, Lebanon, DRC, Cote d'Ivoire, Nigeria, Colombia, Mexico and USA (Chicago). HAI's area of focus includes: MHPSS, access to justice and gender. Because HAI works with marginalized and conflict and disaster affected populations, their MHPSS programming integrates a trauma informed approach. There is also an emphasis on partnering with government, local organizations/institutions; capacity building of national organizations/institutions and providers, systems strengthening and developing sustainable programs.

Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)

https://app.mhpss.net/?get=325/giz-ppt-for-iasc-rg5.10.2017pptx..pdf

GIZ is a member since last year and they are a German federal enterprise. They are owned by the Federal Republic of Germany and supporting the objectives of the German Government. They have operations in over 120 countries, across a broad range of sectors with more than 18,000 employees worldwide. They have joined the IASC RG as they are more connected to humanitarian and transitional aid community since 2014. The migrant crisis triggered the change in their portfolio and consequently there has been an enormous growth of MHPSS programs/activities in emergencies within the organization. They have a focus on refugees and receiving countries and rarely have MHPSS as a standalone program. The Regional Program for PSS has coordinated the elaboration of a guiding framework on MHPSS in development cooperation which is now validated in the Middle East with practitioners and on policy level.

IsraAid

https://app.mhpss.net/?get=325/israaid.pdf

IsraAid is a member since last year. It's a non-profit, non-governmental organization and founded in 2001. They have a Community based approach such as community theatre in order to create social cohesion, community empowerment among others. They also have MHPSS in education and MHPSS in emergencies.

Country level MHPSS Coordination Groups/ emergencies

Ukraine - (IMC)

IMC is co –chairing this group since 2 years and they are currently looking for other co-chairs. IMCs fudinng for the project supporting this coordination role will end by the end October 2017 and they are now looking for continued funding.

In Ukraine MHPSS 4Ws mapping exercises have been conducted in different regions and guidelines have been translated such as several IASC MHPSS guidelines and PFA guidelines and training materials. Additionally, a guidance note has been developed and a conference has been organized (with local, national and international actors) . Also, an assessment has been conducted on how partners use the IASC guidelines, a ToT based on IASC guidelines and PFA has been developed (with support from many people such as the Co-Chairs etc.). Lastly, IMC has developed and online simplified a mapping tool for reginal mapping of MHPSS services and activities.

Q&A

It is challenging to work in areas where the government has no control, how does the WG deal with that? Answer: Institutionalizing the guidelines and coordination remains in need in these areas

Syria - (WHO)

Discussions on Damascus, Amman and Gaziantep Hubs

Damascus MHPSS WG (WHO, IMC & UNHCR):
General note: there is an ongoing discussion about referrals and also about collaboration with the government. There were difficulties in the Damascus-based group itself which is now resolved as the group decided that leadership needs to be rotated among the organizations.

Amman-Cross border to South of Syria (IMC, IRC and WHO)

This is a new group, there was a main focus on mapping and joint assessment and a joint capacity building plan. The group has only 6/7 members.

Gaziantep Cross border to North of Syria (WHO, Syria Bright Future - a local NGO)
There are lots of activities such as staff care for humanitarian supporters.. There was also a workshop on IASC RG Referral tool, coordination of Capacity building and working together with Ministry of Health (Turkey side).

There are also sub-working groups focusing on Syrian refugees (Syria refugee response):

Lebanon (MoH and WHO)
Task force in the south of Lebanon and Beirut.
There are meetings in south and north Lebanon, Beqaa, and Beirut and there are around 60 organizations involved. There is an annual action plan and currently there are tools developed such as a reference document to ensure continuum of care and protocols for non-frontline health workers on topics such as how to refer etc. Also, capacity building for child protection and protection sectors, to train people on how to identify and refer mental health disorders. Currently the group develops an online 4W platform to facilitate the mapping and enhance referral and communication between organizations.

Their current strategy: strengthening all levels of coordination, coordinate with ministry of health and also follow the guidelines.

Jordan (WHO, IMC)
Taskforce in Zaatari camp

Challenges in Syria:
One of the challenges is that the different Syrian hubs rarely talk to each other because of the inherent mistrust between the hubs and certain hubs relationships with the Government. Maybe the global level reference group can help to strengthen the communication between hubs.
Communication is key, for example during the fight in Aleppo there was a need to support the residents of the psychiatric hospital to be evacuated to safer territory, there was no way without communication (and the patients remained stuck).

Iraq - (UNHCR & IMC)

UNHCR:
There are 5 coordination mechanisms in Iraq; Irbil, Sulaymania, Dohuk, Mosul, and Baghdad. The

communication among these working groups is not strong, each governorate has their own coordination mechanism. The focus of the groups is on refugees and IDPs.

Dohuk:
Dohuk is seen as the strongest working group. In this area Médecins Sans Frontières (MSF), International Medical Corps and Save the Children are strong actors. They mainly focus on refugee emergency setting related problems, however it is now more a protracted situation in Dohuk. The current focus is on integrating mental health in existing systems.

Mosul:
Mosul is technically still a sub-working group, but as soon as it is stable, they should move to a full working group and be based in Mosul/ Ninewah Governorate. There is lots of attention for specific groups, but there is a need for a stronger overall MHPSS response, as it is still fragmented. The vast majority of affected personsare not in the camps and the focus is still on camp-based responses.

IMC co-chairing in Iraq Erbil (UNHCR) and Mosul (IOM)
There is now more focus on local actors however there is still a need for more. The 4Ws mapping exercise is completed in August, with support from coordination groups. In Erbil, a training has been conducted on what aspects are considered MHPSS.

Q&A
- Should we Should we shift to work more with government?
- There are some missions that are trauma focused
- There has been lot of capacity building going on
- more focus on advocacy
- There is lots of experience in the country

Uganda - (UNHCR & TPO Uganda)

Overall situation:
Uganda has emerged as the biggest refugee hosting country in Africa. The number of South Sudanese refugees is around 1 million. Additionally, there are also 250.000 refugees from Congo and around 110.000 other nationalities. This is a huge operation for a poor African country that is not big.

Update group:
The coordination is not very strong in the reference group. It is very much health focused (MHPSS is part of health cluster) and Protection doesn't come to these meetings. Protection and Child protection working group have their own PSS topics in their meeting. UNHCR had planned a mission in Uganda in August but it did not happen. There should be a focus on advocating for improved communication between protection and health actors. Playing to Live, is an INGO, who have conductedan MHPSS children's assessment and a comprehensive 4Ws mapping. Uganda is, also, a pilot country for UNHCR Comprehensive Refugee Response Framework (CRRF), where UNHCR seeks to collaborate more with other actors.

Q&A:
The mhGAP training was in December last year, they have not been able to find funding for this year, hopefully it will resume again next year.
Is there a formal regional coordination for South Sudanese refugees, an advocacy point?
→The Juba (national) MHPSS coordination group in South Sudan is linked with the Northern Uganda

refugee response MHPSS group under TPO Uganda & UNHCR, however there is nothing formally at the regional level

South Sudan - (IOM)

The MHPSS coordination group was formed in June 2016 after a Co-Chair support mission. A full time coordinator was recruited by IOM to coordinate the functions of the group. There is also a steering committee comprising of IOM, IMC, WHO and Handicap International. However over the past few months, the child protection-PSS actors created their own separate group (called the National PSS WG) which is now 'competing' with the National MHPSS coordination group. There are tensions between mental health/ health actors and protection-PSS actors that still need to be resolved. A joint MHPSS-CP AoR support mission is in the pipeline.

Nigeria - (IOM)

There is a coordination group since the beginning of 2017 and it is chaired by MoH, and IOM and they have a good relationship with protection and health. The group was not very active so now they are scaling up, the first training on the IASC guidelines is mid-October and there is a significant need for capacity building. The situation in Nigeria is challenging as many people are coming back to Nigeria and there is no support in rural areas, therefore there is a need for local actors and support. The child Protection sector (led by UNICEF) is doing PSS work but MHPSS WG should be more involved. Coordination on the field level is the real issue, there is not really something organized on regional level, there is only one for child protection. There is also a tendency for local coordination groups, local actors talk to each other and coordinate together.

Co-Chair, WHO is visiting North East of Nigeria in October and will meet with working group coordinator and members.

Q&A: One possibility is to merge the groups?

Greece & 3 coordination groups - (International Rescue Committee (IRC)

The organization Babel, which is a semi-public, semi-private entity loosely linked to the Ministry of Health, is co-chairing in Athens. They provide mental health services for refugees and migrants in multi-disciplinary centers. There is a tendency to downsize agency operations in Greece.

The aim is to support local actors in order to prepare for big transitions in the near future since there is a tendency that Mental Health support is more available for the refugee population than the local population. IRC and other actors aim to help local actors to make a shift which is not too dramatic and to see what support is needed.

Q&A: How to involve informal groups and volunteers who don't want to collaborate with IRC and other international agencies but may be doing good PSS work? How do we connect?

Tanzania - (International Rescue Committee (IRC)

IRC Co-chairs with UNHCR.
There is a good communication with other groups such as education, additionally the 4W mapping exercise will be launched soon and MHPSS providers are all working through camps. IRC is doing a research project together with WHO which will be discussed later.

Q&A: Do we compare Uganda and Tanzania?
→Tanzania refugee crisis is pressuring far less than Uganda. Apart from research, there are no links with engagement with government health service.

Rohingya refugees - Bangladesh (UNHCR)

The crisis is unfolding in huge proportions, the context was already complex with refugees who were not legally identified and registered as refugees. There were 2 official camps and many people were staying outside the camps. The new arrivals are on top of the pre-existing 300,000 refugees, and the situation is devastating. There are some opportunities to collaborate strongly. The MHPSS WG is chaired by Action Contre la Faim in Dhaka and Action Contre la Faim and a local NGO (Reach Out) on the Myanmar side. The legal status is still unclear, but there is a tendency to treat the beneficiaries as refugees. There is a new camp created for 150.000 new arrivals and the focus is on life savings as there is risk for infections, cholera, malnourishments. The shelters are bad and on top people are really distressed, PFA is already conducted.

WHO has recently sent its Regional Advisor for Mental Health and Save the Children will send someone there as well. Currently a needs assessment is being conducted by Save the Children. IMC: The IMC Public health advisor is also doing a needs assessment which includes Health & MHPSS. Current gaps are identified and PFA is already done. There is not enough psychiatric help and more therapeutic work needs to be done.

Myanmar & Bangladesh (Action Contre la Faim & IOM)

Action Contre la Faim (ACF): It is classified as a Level 3 emergency, with predications for the situation to deteriorate further. ACF sees a challenge for the coordination as many new organizations coming in to provide support. There is an alert for staff and volunteer care as they are very much affected by the situation. Additionally many beneficiaries are confused and have no idea. Perhaps one of the priorities should be on information provision. However, this is combined with a political challenge as the information changes by day (for example one day is said refugees can't work, other day is mentioned that they can etc.). ACF emphasizes on the idea of sharing ideas also for appropriate programs and not re-inventing the wheel.The conference call organized by the Co-Chairs was very helpful, and ACF would like to have more of such calls.

UNHCR has money to hire a consultant who will work on Culture and Context of MHPSS for the Rohingyas in Myanmar, Bangladesh, India, Indonesia and Malaysia etc.

Q&A: How do we ensure safe transportation? We need more information on that

Libya - (MHPSS.net)

The group started in 2014-2016 and was super quiet, most MHPSS was in Tunis. In Libya there are only 17 psychiatrist for the entire country, it is a paradox as Libyan professionals are skeptical about level of support that could be provided by international community, despite knowing that they need all the support. MHPSS working group sees a high influx on MHPSS in Libya mainly through national organizations. In Tunis there is a big MHPSS component without MHPSS experts and they don't know who is doing what etc. Many national organizations do MHPSS but the quality is unsure. Also specialized services is an issue as there is no place to refer. There is a difficulty in movement from and to the south as there are many security issues. Frustration and mistrust is also a big issue and on top there is no clear idea of what are the humanitarian needs for Libya. Lastly there is also lots of competition on the ground observed.

Discussion

As requested by the group, to discuss if MHPSS services needs to be provided in detention centers, yes or no?

Summary of the discussion:
Some participants believed that the RG should take a position together, and decide if MHPSS services should be provided in detention centers when the services are so fragmented. Others, question the efficacy of providing MHPSS interventions in places where the design is uncomfortable in and of itself, since this has a significant impact on the wellbeing of people. However, opponents say that a significant percentage of people in detention centers have psychological problems, so they cannot be excluded from the services. Further discussions were held on the duty that MHPSS workers have to help each individuals who are suffering from MHPSS issues, and that we cannot discriminate. People have the right to treatment and being selective would make it very difficult to decide where to go.

Discussions were held on the notion of whether if as RG members provide MHPSS programmes in detention centres, are we then being complicit in violation of fundamental human rights law and protection principles. There were reflections made on the ethical implications of engaging with groups in a programming sense (i.e., offer general psychosocial support programmes in detention centres, or rehabilitating detention centres through paintings/ art murals etc.).

Additionally many people have requested clearance on the definition on detention centers and where to put the line (prisons, camps with deprivation of liberty of movement, psychiatric hospitals etc.) and many agreed on making the discussion wider, and rather talking about places worldwide where human rights are abused.

Then the discussion shifted whether this is a MHPSS question or more protection related. Some people believe this is more for protection specialists and others say that the situation of detention centers has an impact on wellbeing which also makes it an important issue for MHPSS sector. Othes commented that it's the role of this group to give a clear statement on this as it is part of the mandate and it will highlight these issues and will encourage other sectors to take a position as well. While others suggested to create guidelines for working in such places rather having one statement as a group since every agency has different views.

It seemed difficult to find a mutual agreement and people opted for a taskforce to create guidelines, together with protection and human right experts, to continue the conversation and discuss in more details. People opted the idea that this should be a taskforce for only IASC RG members as it is a very sensitive and political issue, they could gather information from other experts but make the guidelines themselves.

There was no mutual agreement on what the taskforce should realize as some opted for creating guidelines, others said key considerations is more realistic and others just wanted to have an open discussion around this topic

- ➔ Action: No members showed interest to be part of this working group. This will be a pending issue for one month, if no one is interested, then we remove it from the work plan.

New tools 1: MHPSS Emergency Coordinators Tool & 4Ws tool for MHPSS WGs (MHPSS.net)

https://app.mhpss.net/?get=325/20171003-mhpss.net-update-on-new-tools.pdf

MHPSS Emergency Coordinators Tool:
This is a toolkit for emergencies to provide easily accessible information on MHPSS. Different types of materials that exist and that can be downloaded are put together. It is ongoing work, and a living document which needs constant updates of new resources and documents. The target audience is field workers in MHPSS and MHPSS WG Coordinators/ Chairs. The toolkit is divided in 3 parts: 1. General technical guidelines and resources, 2. Assessment and mapping guides and 3. Program implementation. The toolkit is now circulated for feedback.

Online 4Ws tool for MHPSS WGs
This tool is piloted in Jordan and Libya. This is an online version of the paper 4W's mapping exercise. Everyone can open it online for an emergency context, and then share it with all involved organizations/actors. It has been adapted it to the local context, translated it to Arabic and conducted a training workshop in Tunis. All the information is shared on the MHPSS website where there is an overview of the mapping exercise, in total 197 organizations are identified. It is hard to access Libya, therefore there are many implementing partners

Q&A: One comment was that budget makes people suspicious, and there is a need to adapt it so that people can easily fill it out to not have delays etc. Also it was suggested to do the 4W's less detailed but to make bullets instead of so much information. But sub activities are very important too.

Also the question was, how the online 4w's overlaps with the MHPSS WG cluster and that there is a need for an overview of what is already done. MHPSS.net replied that limitation of the online tool is also the limitation of the paper version

Also it was questioned if this tool helps to facilitate referral pathways, and the answer was that this is a snapshot, which means better than before but not enough for proper referral. Some comments were made on how to make sure that this is only once done as people are drowning in information.

How to advocate for MHPSS internally within our own organizations (USAID)

https://app.mhpss.net/?get=325/internally-advocating-for-mhpss.pdf
Important steps are: 1. Identifying hooks, what is your mission, and align with MHPSS goals. This includes talking with people and show how MHPSS can be integrated in their work and also plan sessions in your work plan; 2. Identify champions, and involve them; 3. Launch internal education; 4. Measure success; 5. Push for system integration and; 6. Rinse and repeat. Good examples are Center for Victims of Torture (CVT) and World Bank.

Q&A: What has been an added value for CVT?
CVT answers that it has been good as they are now part of IASC RG. They now get support in countries where they have the lead and there are not many other actors. CVT now gets support from IASC RG

Red Cross movement: IFRC, provided an example of their experience in advocating internally on the process to create an MHPSS Red Cross Movement wide policy. In 2003 the first policy was developed, it has been a dream to have a joined MHPSS framework across all different Red Cross Movement components (National Societies, ICRC and IFRC). By November 2017 they will have a resolution focusing on MHPSS in emergency situations. They now have suggested to move forward and to not only have a joined framework for MHPSS, but also national societies would invest more resources in MHPSS. They now have 2 years to develop this idea.
More stories were shared from agencies in how they internally advocated on MHPSS.

Day 2

Sphere handbook 2018 revision process (UNHCR) & (WHO)

https://app.mhpss.net/?get=325/ventevogel-van-ommeren-sphere-update-oct-5-consultation-webinar-vs2.pdf
The sphere handbook is among the most used handbooks in the humanitarian field and covers all sectors. In 2004, all MHPSS related information was structured under the health sector, this was criticized as people didn't read the MHPSS related info if they were not working in the health sector. In 2011, MHPSS was also covered in the protection chapter and PSS was infused in more chapters. There was also a separate mental health standard. UNHCR and WHO staff have been leading the MHPSS text revisions for the next edition (2018). Most remained the same (the humanitarian charter is the same and core principles remain visible thorough the handbook). There are a few major changes such as the core standards have been amended and are now called humanitarian standards, secondly there was a wish to make the handbook shorter and more readable, which is a challenge as normally it becomes bigger and bigger in every new edition. Lastly , in the last 7 years many developments have happened, therefore there was a need to focus more on urban settings rather than only focus on camps and also more focus on CASH (sources on a high level have shared that 50% of the budget will be spend in the future on CASH programs).

WHO and UNHCR, thematic experts, were asked to make revisions regarding MHPSS topics and to write the mental health standards. They have been involved in consultations on MHPSS, faith sensitive PSS, feedback from other people, review etc. The new draft should have been ready in order to discuss at the meeting, but it is delayed. Therefore, some important elements and the major changes regarding MHPSS were shared. Firstly, there was lots of PSS in the first draft of the new introduction chapter, this was too good to be true. The Introduction was re-written and lots of PSS was written out. There is a broad picture of MHPSS needs in humanitarian sector and the pyramid is mentioned across the handbook without showing the pyramid.

In the new draft there were some changes under the protection principles. Firstly, there are now 3 areas which include prevention, response and remedy. Most likely PSS will fall under the area response, however there is some unclarity the location of the pre-existing conditions would fit. The

PSS thematic experts from WHO and UNHCR have advocated a lot for MHPSS (for example to not only have a focus on violence but to cover threats broadly in the protection part).

Within the core humanitarian standards, there is not much MHPSS in WASH and shelter, only some changes in the language that was not appropriate according to IASC guidelines. Within the health action standards, they had advocated for a sentence on cross sectorial coordination groups and also faith sensitive programming is included. The new faith sensitive guidelines may be included in the Sphere Handbook revision.

A summary on what has been decided on mental health; there are 9 key actions instead of 7; a key action on coordination is added as this always goes wrong; number of indicators has been reduced from 8 to 5 and indicators that shows a change as result of a key action were preferred.

UNHCR and WHO, as thematic experts, communicated that they can only advocate, as in the end the SPHERE committee decides. Additionally they do not have the time to read all the text line by line, therefore they request to divide the tasks among the reference group members to read everything together and provide feedback.

Q&A:
There were some comments and suggestion, for example changing vocabulary, such as the word sex should be gender, culturally appropriate should be culturally relevant and sensitive beliefs and it was suggested to talk about vulnerabilities rather than threats. Also people were asking about the term psychosocial disability, WHO & UNHCR thematic experts answered that there is a consensus to use it within the disability sector but they find it challenging to use it in health sector. Additionally it was mentioned that coordination needs to be done with local actors.

Then there were many questions about the process and it was explained that there were two ways to provide feedback: firstly an online consultation sessions which can be done individually (individual voices do count) or a second option is revising the draft or a subsector. An idea is to develop a mechanism, such as a webinar and divide tasks. A last option to influence the process is if you are on the Sphere Board such as World Vision International. RG members could help by reading the part that is of their interest and make suggestions instead of only commenting and use track changes to make it as easy as possible for the SPHERE committee.

There were also comments on pre-existing conditions, and WHO & UNHCR thematic experts mentioned that there will be a chapter on vulnerability in the introduction (women, children, and other potential vulnerable people) and the concern will also be highlighted at the Sphere commitee.

MHPSS centre (Leslie Snider & Save the Children) & new training PSTIC & Roundtable discussion (Save the Children UK)

MHPSS centre:
https://app.mhpss.net/?get=325/20171004-mhpss-centre-ppt-for-external-mtgs-final-13.9.2017.pdf
Leslie Snider is the external consultant for Save the Children for the global centre for child MHPSS, currently a consultative process is conducted. A presentation was given on how this idea came up and why there is a need for it. There was a need identified to fill the gap and take the opportunity to capitalize on emerging research and momentum in MHPSS field, to strengthen the delivery of quality,

contextualized, rights-based MHPSS for children and families in fragile and humanitarian settings. Further information is shared in the powerpoint presentation.

Q&A:
some people emphasized on the importance of measuring the impact, and to know what useful models are that are scalable, easy to use and realistic. Additionally it was questioned if this centre is too global and if it shouldn't be decentralized. A question was posed on how this centre will connect with existing mechanisms and how they provide that support in an interagency setting. Leslie Snider said that these topics were considered and that they connect also with local mechanisms. It will be also a visual hub. Additionally people talked about toxic stress, as it is seen as a catchy and dramatic term and people find it difficult to use the term. It was also mentioned that it's important to further build on each other's pieces rather than individually, it's important to consolidate. Also there was a concern raised on finding the balance between the establishment of another centre and funding staff in frontline humanitarian positions.

PSTIC (Psycho-Social Services and Training Institute in Cairo)
https://app.mhpss.net/?get=325/iasc-reference-group-10-2017-nancy.pdf
PSTIC has set up an urban community based MHPSS center in Cairo. All the staff are refugees working in their own community, they have a protection program that helps the most vulnerable, and they assist with all kind of needs. The situation of refugees in Cairo is profound since there is no hope and no future. PSTIC has developed a new certificated course for urban context, this is a practical course, partly online as well as residential in Cairo. The course is delivered both in English and Arabic. The rationale is that 60% of refugees lives in urban settings and there is still an enormous focus on camps, therefore there was a need identified to develop a course which is specific on issues in urban areas since these issues differ from camp settings. Urban issues are often very much protection issues and this causes mental health problems such as discrimination, harassment, abuse, exploiting etc. People face high risks and have to deal with life and death. There is a need for capacity building for people working in urban areas. The expected outputs of the training are a conference on urban refugees, documents with models of urban interventions, pursue research models on urban interventions and the development of guidance notes.

Q&A:
Many people reacted positively on the new course. Many confirmed the need for capacity building in urban settings, not only in Egypt but worldwide. Many organization would send their staff if the prices are feasible. A question was asked why there are no refugees from PSTIC attending in this meeting, PSTIC had answered that they are not allowed to travel outside Egypt. In addition, as PSTIC is an Observer member of the RG, it is not possible for more participants (such as refugees) to attend the meeting. Some organizations are not able to endorse other courses, but they can support it internally (such as IOM).

Roundtable discussion Save the Children UK
Save the Children will organize a roundtable in January 2018 for 3 days together with DFID. Following up on research and advocating for MHPSS support for children. She will take the comments on toxic stress in consideration for this roundtable.

Working group/ task force updates

Community based MHPSS WG (included IOM manual) (IOM & REPPSI)

This taskforce exists since 2016, as there was a demand from the field. There were many community support related issues. The working group is developing a guidance note on community based MHPSS that will be circulated mid-November, and feedback from the reference group is requested before the end of year 2018. Early 2018, feedback from the wider community and IASC endorsement will be requested. It is a short document (less than 10 pages) which needs to go through a couple of review rounds, plus a review by the community-based MHPSS WG members. (See below for information on the UNICEF community-based operational framework for MHPSS).

Q&A:
Is the community only targeted at level 2 or how do you approach it?
IOM: We are not talking about the second level only but rather on how to develop humanitarian interventions that involve communities across all layers of the pyramid. How do you involve agencies of the community?
IOM: This is very important and therefore the document needs to be endorsed by other agencies

IOM, manual on Community based MHPSS

IOM is in the process of developing a community based MHPSS manual for emergencies, displacement and return situations, which should be ready by June 2018. The manual should be operational and programmatic and will unfold community based PSS programs. There will be a focus on camps, urban settings and transit settings (people on the move). Also, there is a steering committee invited to provide their input (many people from this group), they have a double role: providing research and informing the different chapters & supervising the content. It will be an open resource. Anyone in from the reference group who wants to be part is welcome to participate.

Q&A
CBM: It is important to add persons with disabilities (e.g., service user group's representation). Particularly is important to have their participation, to give them a role.
IOM: There will be a pilot testing for the manual. We will involve the partners from the field, should we also involve governments? Think about which partners you want to involve?
How isthis manual complementary to the already existing manual from UNICEF? IOM said that this manual is not child focused, its displacement focused, it's more operational and will links resources with tools. It is meant for managers who start working in the field on what to do in the process.

Monitoring and evaluation WG (IRC)

https://app.mhpss.net/?get=325/iasc-mhpss-me-wg-update-prez-an.pdf
An M&E framework was developed by this group and lately released in March 2017. UNICEF had hired a consultant to compile a list of Means of Verifications (MoV) for each impact level indicator. They have found over 100 MoVs and they made a selection through the following inclusion criteria: time of administration, languages, amount of time used in LMICs/ humanitarian setting and psychometric criteria (e.g. established validity, reliability etc.). The objective was to have a limited list of tools that meet all these criteria. There is an introduction guidance needed on how to pick the right MoV, how to adapt it and how to translate. It should be discussed on what the best way is to disseminate it on MHPSS.net and elsewhere.

Q&A:
It was mentioned that this document is a good foundation however there is a need to understand better all the different MoVs and how to use these tools to get a better balanced overview. There was also some feedback and remarks such as, it could be complicated to follow these guidelines as it's also depending on the donor's requests, there is a need for more impact indicators/measurements so that there is more prove that what we are doing has an impact. Also the group asked if this document is going to come as a suggestion or as a recommendation from the reference group since if it's recommended then the group validates the document and that is challenging with all the different approaches in psychology.

Also it was noted that local communities should be more involved in the development of indicators and it shouldn't be only coming from the humanitarian agencies. For example IMC has a tool for communities to generate their own indicators. Also in South Sudan they try to combine the different tools and locals are trained to understand their own indicators and the context. Researchers, including ethnographic research should be involved in this process as well. Additionally it was mentioned that the document should not induce that everyone needs to use these indicators, as people should have their own indicators per project according to the needs of the communities.

➔ How to move forward:
WHO has said that they could follow-up on this with other colleagues, as it is very important to be accountable on what MHPSS sector is doing. War Trauma Foundation also has an extensive spreadsheet that they can share with the group.

Disaster Risk Reduction + flooding guidelines (MHPSS.net, WHO & IFRC PS centre)
Disaster risk reduction (DRR) WG is just established and there are 3 main topics on the agenda, which are sharing information about the activities, to connect with the agencies working on this area and conceptualize the DRR framework. The working group tried to connect the world with DRR, as they aimed to hold a side event on the Global platform. However, they had difficulties to contact the event organizers as they didn't responds until the deadline was closed so they missed this opportunity. They decided not to attend as observers.

The current reality is that this working group doesn't have a network and status yet, everything is still very unclear. The involvement from other group members is limited. There is a growing awareness of the important linkage with MHPSS and DRR. 8 people said that they have DRR in their agency and around 5 said that they also actively speak with their colleagues. There is a need to start getting involved with colleagues who work in DRR.. There are events coming up in 2018 such as the Asian DRR conference in Mongolia (April 2018). These are important events where connections can be made. It is also highly important to start thinking of the added value of MHPSS to the DRR community. It should be considered to include someone from DRR in the reference group to collaborate with us.

WHO was approached to get involved in DRR in India, and now have a contract to try to move forward with DRR and MHPSS in Asia. UNDP is funding NIMHANS (they do DRR MHPSS preparedness in India). WHO is part of the advising group, and they can document and disseminate lessons learned. For example, WHO could start drafting something on what MHPSS could mean in DRR. At the same time WHO will gather some more practical experience which can help in the development of a framework, which will be a 3 year long project. Currently the program is incorporated in India in 6 regions. WHO will conduct a mission to India to visit the DRR project. WHO would like to reach out to agencies within

RG implementing DRR to contribute as advisory board members for the project in India. Possibly this could lead to IASC RG guidance on the topic.

IFRC PS Centre has developed a Crisis Resilience in Urban Areas (flooding emergency focus) manual. This is DRR related, it gives suggestions on practical key actions in PSS in preparedness, response and recovery. It focused on building resilience, empowerment and is very practical. It integrates PSS considerations in flooding situations. This guidance received good feedback from the field.

Disability guidelines + CBM HHOT tool for people with disabilities (Healthnet TPO) & (CBM)

Disability guidelines

The group is developing the IASC guidelines on inclusion of persons with disabilities in Humanitarian action. Since 2013 they have realized on a global level; linked urgent need for guidelines, decided on vocabulary, established a task team (with 90 individuals), realizing the presence of disability organizations and they have conducted a desk review. The following questions were asked to the reference group:
1. Are we ready to change ideas on how to see disability?
2. Ready to adopt the Guidelines?

Q&A:
The terminology 'psychosocial disability' raised many questions and doubts, people asked what the exact meaning is, when this word should be used and in what context and if this terminology should be mainstreamed. Also some prefer to speak about a condition rather than a disability and it was mentioned that psychosocial disability is contradictory, a positionagainst the legal framework. Disability includes mental and intellectual disabilities; psychosocial is not included (Article 11: inclusion, Humanitarian services not leaving people behind with disabilities). Many said that there is a need to have a clear idea in terms of what is used in different settings and then compare what are the differences and similarities since everyone comes from a different background. Others had already adapted this word. There are also difficulties with the translation of this term therefore in Lebanon they had decided to say person in a disabling situation.
Answer: PSS disability includes access of right, we have to discuss this more and agree. Participants were invited to contact Healthworks and CBM to continue this important discussion.

CBM HHOT tool for people with disabilities

CBM introduced a tool on how to make sure that people with disabilities are included. A video of the tool was showed. HHOT is an app, and there is no need to use internet. It's meant to be a resource for all agencies and different clusters and it aims to give guidelines on what is relevant during an emergency for people with a disability. The need came from the field, there was a request for practical tips for humanitarian implementation. The idea is to implement general frameworks in more practical ways and to use what is already developed. The tool can be used for response, relief, recovery and reconstruction phases. The pilot version is ready and it needs further improvements after the field test and peer review conducted.

Q&A:
What is included for people with mental illness?
Answer: it aims to advocate for people with disabilities that they can have access to all services, so it is not specific to MH illness but it includes it.

Mental health-new developments

Mental Health integration toolkit IMC

https://app.mhpss.net/?get=325/imc-2017-global-mh-integration-toolkit.pdf

This is an online toolkit on integrating mental health in general health care in humanitarian settings. The toolkit is aimed at implementing organizations (also donors and governments). Various actors are involved to ensure that the toolkit is reviewed, piloted, shared and widely disseminated (e.g. WHO, UNHCR, IASC RG co-chair). The process is as follows: 1. Expert Consultation Meeting, 2. Online Consultation meetings and 3. Update IASC MHPSS RG Members & Global Health Cluster as it is important to hear what they are doing and what their needs are.

IMC reviewed 41 tools and came with a list of criteria for the toolkit. IMC also reviewed various MHPSS materials related to MH PHC integration. The toolkit includes the components of preliminary design, assessment & planning, building capacity in general health care workers, strengthening mental health services, advocate & coordinate and sustainability. The next step is to pilot the toolkit between November-February, they already identified 12 organizations for pilot testing in the field, but they encourage other organizations also to pilot test the new toolkit. Organizations can also pilot the toolkit if they already started with a program, it doesn't need to be tested from the beginning until the end. The objective is to have a simple and basic toolkit so that everyone can understand and use it.

Q&A:
Mental Health integration toolkit of IMC, is developed to help implementing organizations understand and plan for the key steps and components of integrated programming and it is developed for humanitarian settings.

MH Gap HIG in refugee settings (War trauma foundation) & (UNHCR)

https://app.mhpss.net/?get=28/unhcr-wtf-mhgap-roll-out-1.pdf

UNHCR:

MH Gap HIG:

Basic evidence-based interventions for the identification and management of mental disorders in humanitarian settings which can be delivered by non-specialized health workers. It is a capacity building tool for general health practitioners. UNHCR wants to know how they can help organizations use this guide.

War Trauma Foundation:

This is the third year of implementation, and it is always based on country needs. There are 2 parallel trainings; group 1: Facility based health workers and group 2: Community-based workers. The main challenge is the lack of follow up as they aim to do supervision with people who have been trained such as with 2 Psychiatrist from Nairobi. They have learned that it is still a robust tool and there is a need to include more local idioms and more cultural adaptation such as distress is not used in many languages. The first results shows better capacity in health issues, the service delivery has been improved, other actors have a better view and collaboration seems to be improved between different levels of care

Minimum Initial Service Package mental health (MH-MSIP) (WHO and UNHCR)

MISP: Building on the success of MISP for Reproductive Health. The name is likely to change at later

stage. Concept note is available. Still in scoping phase, interviewing experts including reproductive health experts. Would be an operationalization and costed tool.

New products in mhGAP forum (WHO)
The WHO mhGAP aims at scaling up services for mental, neurological and substance use disorders for countries especially with low and middle income countries. News: there is a release of training materials for mhGAP IG 2.0, this will be available for field testing soon. MhGAP HIG training materials and facilitator guide will also be released at the forum,

MhGAP operations manual is meant for district health managers and the focus lies on system level changes to implement various mhGAP products.

E-mhGAP: is a clinical decision-making tool, used on mobiles. This is also a field test version

Q&A:
MhGAP and HIG are compatible. The content of HIG is less, however it has in comparison with mhGAP more background information on depression and PTSD.

Scalable psychological interventions-new developments

Updates WHO
There are currently 5 interventions. The 6th intervention, which will be an App, will focus on older adolescents with emotional problems.
The next steps are developing guidance on quality and implementation and making small operational guides on what are the basics to do in health, education and protection sector, lastly develop capacity building projects.

Implementation manual for routine implementation of psychological interventions (WHO)
https://app.mhpss.net/?get=59/workforce-development-and-implementation-manual-iasc.pdf
WHO is currently drafting a psychological implementation manual as many people don't know how to implement the interventions. This guide complements the tools that are already available, and it will refer to other documents that are available in order to minimize overlap with other documents. It will become a very practical document suppported by GIZ's Regional Program "Psychosocial Support for Syrian/Iraqi Refugees and IDP". It will be available in March 2018 for field tests.

Q&A: Isn't there already a general operational manual for mhGAP?
→This guide is specifically for the psychological interventions not for the MHgap.
Comments on the psychological interventions were that manuals need a certain level of intellect and experience and it is difficult to use for people without program experience. Also the question arose who will conduct the trainings as a certain level of experience is required.

Workforce development for psychological interventions (WHO)
→ See same PowerPoint as for the implementation manual.
This project is funded by USAID. iIt will encompass all competencies that needs to be used to deliver PSS interventions such as therapeutic competencies, home delivered competencies and there will be different competencies depending on the level. The aim is to improve mental health, wellbeing and functioning of people through the publication of an evidence based, expert informed and consensus

based framework and toolkit. It is a 3 year project and firstly WHO will develop a framework, then engage many stakeholders and will look for academic partners and for other collaborations.

Q&A:
As for the workforce development, people were wondering what the level of ambition is and if there will be an accreditation or acknowledgement of this training. Also people wanted to know more on how the training covers the wide range of personnel and multidisciplinary teams. WHO answered that it's their ambition to make something useful & relevant and they welcome feedback to develop the workforce, there is an aim to engage from bottom up and top-down.

Early adolescents skills for emotions (EASE) Lebanon and Tanzania (War Child) and (IRC)

EASE is developed by WHO for children of 10-14 year. Currently there are 2 RCTs in Lebanon & Tanzania.

War Child care package, Lebanon:

- Multilevel care
- Tested in 3 sectors where Warchild works
- Following 5 phase model WHO
- An adaptation workshop was held in Lebanon in September

EASE Tanzania IRC:

- Research will be done in 3 camps
- WHO and John Hopkins
- Oak foundation is funding
- They are in the first phase and they just hired a project coordinator

Q&A:
It was mentioned that IRC has in collaboration with UNICEF an Adolescents toolkit, and they wondered how they fit together and if there is a communication with each other. IRC said that they work with GBV teams to make sure not duplicating efforts. EASE curriculum focus on experiencing depression, anxiety and is not focusing on prevention. War child program, children can be referred and then will receive more support

Psychosocial support-new developments

PSS evidence based review (John Hopkins University)
https://app.mhpss.net/?get=325/jhu-ofda-presentation_04oct17.pdf

The focus of the study is to conduct more research on interventions that look promising but are lacking evidence. The aim is to develop further evidence for humanitarian settings. It is a multiyear project with the following steps: 1. Systematic literature review, 2. Discussions and meetings with stakeholders, 3. Webinars and 4. Two regional meetings.

The researchers get input from the field and the prioritization is not only done by researchers but needed input from webinars and steering committee. The conceptual framework is also created together with steering committee. During the regional meeting there was more focus on stakeholders and what has been found in literature review. They hope that the review will be useful for everyone in

different context for children and adolescents. The idea is to set up a webinar and engage other people through mhpss.net

Faith sensitive MHPSS guidelines (Church of Sweden, World Vision, The Lutheran World Foundation)
https://app.mhpss.net/?get=325/geneva-fspsp-update-presentation_october-2017-1.pdf
https://app.mhpss.net/?get=325/draft-guidelines-for-faith-sensitive-psychosocial-programming_for-pilot-testing.pdf

Led by Lutheran World Federation, Church of Sweden, and Islamic Relief, various organisations (faith-based and non-faith based) are working on guidelines for Faith sensitive MHPSS programming.

The reasons why they came up with the manual is to encourage people to go back to traditions, it is peoples human right to practice their religious faith practices, also it is proven that people who have the ability to practice their faith have a faster recovery and better resilience, faith actors are under-utilized while they know their community best and to enhance PSS through work with faith communities.

So far they have done an extensive survey, looked at experiences in programming and linked regular engagement with the IASC guidelines. They also conducted a desk review which was revealing as actually many people work with faith sensitive practices but NGO's are not really engaged. Therefore the question was raised what role faith based actors can play.

The guideline project is in 2nd phase, the draft version is shared and currently planning and orientation workshops are conducted. The guidelines will be field tested in 5 countries between October and December 2017. It will also be included in the Sphere Handbook.

An interesting note is that faith communities are not aware that there is an interest in their role and they were excited to hear that they can participate. Let's bring them on board.

➔ Action: Request for everyone to peer review the draft guidelines which is due mid- December

Q&A:
People wondered what was included in faith sensitive practices and if cultural practices were also integrated, additionally if the guidelines also include the dos and don'ts.

Answers were that the guidelines were drafted following the IASC guidelines and structure and the do no harm is already an important part of this. There are many spiritual practices in place, these are practices that you can do to help people

PFA material and CFS Guidelines update (IFRC PS centre & World Vision International)
World Vision International, IFRC PS centre and Colombia University are working on the development of guidelines on CFSs. The evidence on CFSs is quite mixed, the Higher the quality of the CFSs the better the outcome, however getting high qualified people in CFSs is easier said than done. It is recommended to build from the learnings and research and WVI aims to enhance the quality of child friendly spaces. Different documents are produced such as an Activity Catalogue with psychosocial activities for a 12-week programme that can be done either in sequence or independently and also for different age groups and children with disabilities. In addition, operational guidance will be developed

on how to set up a CFS according to quality standards, recruitment of facilitators, monitoring CFS, quality standards and training curriculum etc.

Q&A: People suggested to start with reflecting on what is the goal of CFS, as the goals and objectives are not clear, we shouldn't start with activities. Also people asked if there will come a recommendation for a structure, such as what are stress related aspects, what activities are better in the morning, how to manage from one group to another etc.
Answers were that there is a big problem with CFSs since people claim to do art therapy but they only do some drawing and painting without any therapeutic element and the idea that trauma can be solved after one activity. We're starting with activities as it is requested by the field, but we intend to have a full picture by the end.

UNICEF Community-based MHPSS operational framework (UNICEF)

https://app.mhpss.net/?get=325/20171004-unicef-cb-mhpss-presentation-iasc-mhpss-rg-annual-meeting-zh.pdf

UNICEF has developed a community-based operational MHPSS framework to provide clear guidance and tools for UNICEF and partners to strengthen community-based MHPSS approaches together with children, their caregivers and community leaders. This new approach for MHPSS programming is part of a holistic child protection response. This is an update on the upcoming launch of the guide (this was presented in last years' meeting and the community-based working group has given input). This is the field testing version and will go through a consultation process and testing in 2018. The work is closely aligned with work of the CP AoR/the Alliance to reduce risks and strengthen protective factors that reinforce child and family resilience. It's developed for UNICEF field office staff and partners that are implementing MHPSS programming – but received wide review of IASC MHPSS RG members and can be a broader resource for the field. The framework is based on the Social Ecological Model and 9 Circles of Support. It is accompanied by a Compendium of Resources on community-based resources for MHPSS.

The frameworks is now ready for field tests, please provide your input to UNICEF if you have any suggestions for a location.

PFA retrospective update Church of Sweden (Church of Sweden& Leslie)

PFA has undergone a rapid development, it's now available in 22 languages and there has been lots of capacity building in various regions of the world. However, there is also misuse and misunderstanding. Church of Sweden (with World Vision International as advisor) is funding a retrospective study on PFA. A desk review and select interviews have been conducted and a survey has been sent out to gather information and feedback from the field. Preliminary survey and interview results where shared, and participants invited to submit case studies and to take the survey.

When talking on how to deal with GBV survivors in camp settings, especially for non-specialists, PFA comes often up. GBV working group is developing guidelines and we would like to have someone from this WG to be involved. Please contact Jennifer Chase: chase@unfpa.org at the GBV AoR if you are interested.

Day 3

Intervention journal (War Trauma Foundation)

A summary was given on the development of the Intervention Journal that exists now for 15 years. There will be a special edition on MHPSS and peacebuilding in November. War Trauma Foundation and the editorial board would like to continue with the Intervention Journal but aim to reach more people and make it more accessible for everyone (field workers, academics etc.), currently articles are only available for free after one year and official downloads are quite expensive especially for people from LMIC. There is a need for a new publishing house as it doesn't fit in the business model of the current publisher which is Wolter Kluwer Health. Medknow is an online low cost publish house based in India and it has an open access website which is very active. Also, War Trauma Foundation is currently the only project manager and an involvement from other agencies is desired.

Input for a discussion, from War Trauma Foundation:

- Is it possible to make a difference for authors from HIC and LMIC?
- How to create a sustainable model? And also have free access to download?
- How to increase referrals? Should it be all open on MHPSS net? Now it's only after one year?
- The more submissions received, the stricter the requirements for editing

There is an important need for a contribution from the RG members or if the organization is not able to support in funding a contribution with a guest editor is also welcome. Bear in mind that the peer review process will remain and that articles will not be automatically published if an organization has contributed. It's about helping colleagues in LIMC.

Q&A:
Organizations shared the importance of this journal, and said this is a unique platform for sharing with other people in the field and many have the intention to help. The importance to hear voices from people who are not able to express themselves is highlighted and therefore editorial assistance is required. However, War Trauma foundation said that the peer review process takes lots of time and very challenging since it difficult to get peer reviewers.

An idea was suggested that Save the Children could co-host or fund the journal in the MHPSS global centre that is currently developed as this centre aimed at disseminating knowledge and experience on MHPSS. However, it should be a shared responsibilities and not only from Save the Children. Others suggested to look at the missions and visions of each organization to see who has knowledge dissemination included. As a reaction to the question if organizations could contribute, IFRC and Terres des Hommes said they could possibly contribute 2,500 USD. Also UNHCR and WHO could probably contribute 5000 USD. IMC wondered if this budget is restricted or unrestricted since IMCs budget is depending on the donors and if it is in a specific country it would be easier to add it to the budget. USAID doesn't fund journals, but if it is in the budget line of certain projects that they fund (e.g., under knowledge dissemination or lessons learned), then a part can be dedicated to this journal. GIZ colleagues will talk to head of GIZ Regional Program "Psychosocial Support for Syrian/Iraqi Refugees and IDP" to see if they can support, and UNICEF will also look into ways to support.

Also some challenges were mentioned, for example organizations said that it would difficult to sell to their management that they have to pay for the journal and additionally have to pay. Also TPO Uganda highlighted the important to review the added value of the journal and what changes need to be made to compete with other journals.

➔ Action: War Trauma Foundation has sent a formal request to donors to ask to come back ASAP before November 1st how they could support.

MHPSS & Peacebuilding report & way forward ((War Trauma Foundation) & (IOM)

https://app.mhpss.net/?get=325/pspb-guidelines_september-2017_-consultation-phase-i.pdf
A webinar will take place in October, organized by Ananda from MHPSS.net. The focus will be on discussing the guidelines for both MHPSS and peacebuilding practitioners. They will circulate all the information beforehand, such as mapping exercise and the draft guidelines on peacebuilding and PSS.

IOM: War Trauma Foundation did a research with all humanitarian and peacebuilding actors on what they think of these linkages. Many organizations are working on this connection between MHPSS & Peacebuilding. Now they are going to look for more engagement from other agencies by creating a subgroup within the RG, also with other organizations to link MHPSS and peacebuilding, finalizing and endorsing the guidelines. It was mentioned that the institute for Justice and reconciliation developed guidelines that are still in a draft version.

IOM has started a program for Masters in PSS and community reconciliation. They work on 3 pillars: PSS, conflict mediation and use of culture and creativity in these context. Last experience was in Ankara, for Syrian and Turkish PSS professionals. IMC and other agencies were there as well. Every second weekend people met so that people were able to continue working. IOM highlights the importance to work together with local universities. The November edition of the Intervention journal will be focused on PSS and Peacebuilding, therefore the best work of this program will be selected and published.
IOM asked if there is an interest to make the program more mainstreamed in interagency in and develop a short master program (6 months) so that it could be implemented in the work where peacebuilding is very important. The down side is that this is under the same portfolio of security and counter violence extremisms. And IOM raises the question if MHPSS want to be involved in that sensitive topic?

Q&A:
People shared their opinions on these matters and some said that the MHPSS group needs to make a statement as there is a public responsibility and a need to have a collective voice to stand up for situations that damage the mental health wellbeing. Also people said it is stated in the IASC guidelines. An example from the field was shared from Latin America in the 80s where PSS was seen as part of the peacebuilding process to get different groups that were fighting on the same table to start a dialogue. PSS workers played a significant role in this process.

Other people said that it is a very sensitive topic and that the MHPSS group should pay attention to make sure that the services are well received and to not get involved in politics (which could lead to tensions). Therefore there is a need identified to have clear guidance and a ToR on how to approach this area of support and people from different background should be involved in this process. Also

people see it as a popular topic and warn that it's important to first do research on the efficiency and best practices before implementing programs.

➔ Next steps: War Trauma Foundation and IOM will send out a work plan.

IASC RG MHPSS surge support discussion (MHPSS –CAP) and PSS RRT with CP AoR (IFRC PS Centre, WVI & CP AoR)

IFRC Co-Chari, talked about how to provide better surge support in countries that need support on coordination and to enhance the quality of the programs. Last year it was intensively discussed at the global level after the results of the scoping document.
The protection cluster has ProCap: a senior level person can be employed to provide support or to raise the protection profile in order to help actors and the coordination team to deal with protection related issues. This is an expensive but longstanding mechanism.
GenCap, is another mechanism, in order to deploy in high level emergencies and agencies can work better to include gender. Both mechanism are inter-agencies and work across the humanitarian cluster architecture.
Lot of UNICEF led clusters, 5 clusters, RRT that can go out after 3 months deployment. Funded by the lead cluster and also by other agencies.

MHPSS Inter-agency surge support mechanism has failed so far as nothing has been decided yet. The sector has looked at by-stand partners (not INGOs and UN, but for example Governments) to have standby agreements (such as Swiss, Swedish). However, it is not possible to receive help from standby partners as the reference group is not a legal entity and thus the group cannot sign any MoU with agencies nor receive funds. All support needs to be directed through an agency which is a reference group member. Therefore, there is a need to think out of the box.

UNICEF CP AoR:
Child protection, standby partnership with DRC, Swiss development, NRC, UNICEF and Child Fund Alliance. Child protection have made a policy decision that a stand by partner cannot be paid. As this undermines the ability of some organizations such as NRC to get funding. They have a steering committee mechanism and based on field request, from the coordination group they decide who needs support. Standby partners provide support for more than 3 years. They don't get paid but the benefit is to bring the learning back in their own organization. There is link between practice and guidance. Over the last year, the issue of coordination MHPSS have come up as a priority. The CP AoR is interested to improve the coherence of the coordination efforts between child protection and MHPSS. Seeking deployable capacity focusing on MHPSS is on the CP AoR work plan for 2018 - 2019 period. Coordination with MHPSS is also included. We need people in the field. Remote support is valuable, when there is difficult politics we need people on the ground.

Q&A:
World Vision International: has indicated that it is difficult to contribute to this topic with the high workload already. There is a need for more agencies to look into this and resources that already exist should be used. Also World Vision suggest to learn while trying.

Action Contre La Faim (ACF) requested more clarification on how the RRT teams and standby partners are financed. UNICEF explained that Child protection has helped with fundraising but most standby

partners have their own funds. RRT are more stable, in financial sense, as it's not depending on funding as the standby partners such as Canada have their own funding, for example Canada has a focus on child protection, and requested DFID for financial support. Action Contre la Faim also mentioned the need for equity in salary scaled for RRT as the salaries among UN and INGO's differ.

MHPSS.net tried to help with the coordination on this and will also continue to contribute to knowledge exchange around relationship management and information management. Which means to help to bring actors together such as online 4W's and help people to provide information on key documents as often time and resources are limited in emergencies and this can be done remotely.

IFRC Co-Chair: asked people how easy it is for agencies to find someone for a coordination function.

IOM normally includes coordination in the overall job description. However lately a separate coordination role (mapping and content gathering) has been deployed in big crises (projects bigger than 1 million USD), as neutrality in this role is important as well. Most other organizations mentioned that coordination is tagged on the job description and not a separate function due to funding difficulties. IMC mentioned that it's only possible when there is local capacity.

➔ Conclusion & action
Information gathering and disseminating can be done through MHPSS.net. A draft ToR for the MHPSS RRT position will be circulated to working group members and it will be placed on the MHPSS RG work plan for 2018 & 2019.

A note: UNHCR is looking for a standby MHPSS partners, deployed in UNHCR refugee based responses. UNHCR doesn't have any money but would like to partner with interested agencies.

Development of 2018 & 2019 work plan, Consolidation of action points from previous sessions (IFRC PS centre & WHO)

Interagency training courses:
Listed in the work plan on behalf of this group as these courses are field focused, including:

1. Summer school: psychosocial interventions in migration, emergency and displacement from IOM and Sant'Anna University, 4-17 July 2018 in Pisa, Italy

2. The Mental Health in Complex Emergencies (MHCE) course from Fordham University, UNHCR & IMC will take place in Uganda in 2018

3. Urban MHPSS Intervention Course, from PSTIC. There were some questions when and how courses can be endorsed by the reference group.

➔ Action point: the Co-Chairs will work with PSTIC to clarify narrative and help advertise her urban course in Cairo.

Work plan discussions:

IFRC PS Centre is requesting more clearance on the purpose and deliverables of each working group as sometimes nothing happens. WHO, Co-Chair emphasises on the importance for each group to have

TOR and deliverables as this is important for the ongoing review process. The group lead, should create within 2 months ToR and deliverables. Also Terres des Hommes wonders what the key objectives are or the group in terms of priority. There is a risk that there are series of working groups and no-one knows what they signed up for.

Child protection: we have 2 things on the agenda: working together with governments & local language networks. We should link this and we have to remind ourselves

Action Contre la Faim, initiated to talk about methodology and how to support the field on the ground, they believe this should put as a priority. Also there should be a focus on how to support countries where there is no working group. Lastly, ACF mentioned that there is a tendency that MHPSS narrow the scope, e.g. is there a willingness to open discussions on other issues such as stigma under cholera. IFRC co-chair replied that the work plan will be circulated and each agency can sign up to help to drive that group and come with TOR. The work plan needs to be finalized by the end of this year.

WHO initiated an idea to create a new tradition to set up a call every 2 months with a focus on one of the crises receiving less attention e.g. Yemen. But the topics can vary we can also choose a topic to discuss things that go very well. It could be organized with a local organization body in the country, preferably where agencies are asking for it. Many reacted positively and said it should be in the local language since there is a need to connect with the people in place. MHPSS.net can offer their webinar platform to make it available in multiple languages.

Lebanon National Mental Health Programme always sends out a google questionnaire to the group members to ask what the priorities are, then a clear action plan is developed including responsibilities. They also questioned if task force groups have an annual work plan. IFRC Co-Chair replied by saying that this is up to the group, some have a work plan and some not as every group has different way to disseminate their resources and materials. Then Lebanon National MH Programme suggested to have a short know-how letter or video, on how do you set up the group.

IFRC Co-Chair, asked the group if an additional country call is required or a need to include the reference group in other cluster calls. WHO Co-Chair, is trying to convene a TC with different countries, every 2 months a new country.

The group wanted to go over the different groups now and therefore the Co-Chairs decided to use flip charts now and agencies can also sign up later. Each working group has to start drafting TOR and decide on deliverables to know for other agencies if they want to join. Agencies are also allowed to nominate other people from their agencies.

Review and finalization of the work plan-WG leads- 2018 meeting location (IFRC PS centre & WHO)

Location and hosting agency next year:

People suggested to align the next meeting with the Child protection meeting which will probably be held in Istanbul next year. However many other people mentioned that this would be very hard to combine.

As for the time, should it be again in October, November, December or a different time. For people in the field the October and November is not possible, as this is the busiest time of the year. December will be difficult with Christmas and busy for headquarter staff in general.

What is involved in hosting (previous meetings, may be different moving forward):

- Meeting room
- Meeting space
- Having reporter, minute taker
- Printer of copies agenda etc.
- Organizing tea/coffee
- Participants can also bear the costs of the hotel if needed
- There is funding for a room etc.

➔ Action: co-chairs will send out a doodle planner to decide what the best time is for most agencies and look into best options for the location.

Closing the meeting
Thank you by WHO