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

Report of Annual Meeting, 25 – 27 of October 2016

Uppsala
Hosted by Church of Sweden/ ACT Alliance

Information about the workshop report

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Church of Sweden/ ACT Alliance

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Day 1

Welcome

Anna Garvander (CoS), host of the meeting

After Erik Lysen, International Department of Church of Sweden (CoS) did a welcome speech to the MHPSS group; Anna welcomed the group to Uppsala and gave an introduction about CoS Humanitarian Unit and its role in humanitarian engagements globally. CoS work through ACT Alliance and its member partners at national and local levels. CoS showcases CBPS as a flagship in the humanitarian interventions in humanitarian crisis settings under the guidance of the Humanitarian Imperative.

Nana Wiedeman (IFRC), co-chair of the reference group

IFRC has been elected to lead and represent the IASC MHPSS RG this year. This has coincided with the increased interest in MHPSS from the Director of the Health and Care department at the IFRC. The IFRC Secretariat welcomes the initiative taken by the IFRC Psychosocial Centre to Co-Chair the IASC RG, as they believe that it aids with the visibility of the IFRC and advocacy for MHPSS more broadly within the Red Cross Red Crescent Movement. The Co-Chair position has offered us a bigger voice within our organization. It also has coincided with a close collaboration, support and strategic discussions with Unicef.

Saji Thomas (Unicef), co-chair of the reference group

New (and younger! members are very welcome to the group. There are big milestones to be discussed this meeting such as M&E and Community Based Psychosocial Support.

Hariyati Abdul Majid (Mercy Malaysia)

http://mhpss.net/resource/mercy-malaysia-briefing/

Mercy Malaysia (MM) is 15years old and has been invited to the MHPSS group following its application to be member. MM is non-governmental organization that provides medical and MHPSS interventions in humanitarian assistance, Work areas are emergency response, sustainable health related to development and risk reduction. In each of the responses PSS is integrated.

MM worked in response to the earth quake in Bam, Iran, where a PSS expert was deployed. MM has also been in several other humanitarian responses in different parts of the world. MM is member of ADRR and is deployed in most Asian countries and in others countries such as Philippines, Malaysia, Somalia and Lebanon. MM is adding development as focus area in addition to humanitarian works.

The psychosocial support is not yet a unit but a part in the health unit, where volunteers are deployed in emergencies. The number of volunteers is 30-40, mostly government employees, that are deployed for quick assessments and support soon after a crisis. It is volunteer based work and going through clinical work has shown challenges and we are focusing more on the community based interventions where our work can have a greater impact.

Advocacy- Past, present and future (session facilitated by Ann Wilhoite from CVT)

http://mhpss.net/resource/advocacy-session-rg-annual-meeting/

Women deliver - Nana (IFRC PC Center)

Women deliver is a global meeting about women's rights and women's empowerment that aims to place women and girls at the forefront of the development agenda. There was no attention to MHPSS and it was too late to get it in the agenda. It was extremely disappointing as GBV was included but PSS was not considered knowing that they are closely related. Different organizations are part of it but there is nothing related to MHPSS. Mostly UN Women are involved, Unicef, UNFPA, and Member States. It is held every four years. UNFPA has a focus on PSS and their humanitarian division might be relevant for this.

World Humanitarian Summit - Ananda Galappatti (MHPSS.net)

http://mhpss.net/resource/mhpss-rg-advocacy-at-the-whs/

WHS campaign and participation took place in May 2016. IASC RG meeting was engaged in initial phase and MHPSS was part of the general advocacy group. But the outcome was disappointing. Our main objectives was to increase the general visibility for the field of MHPSS within the humanitarian sector during the WHS; to highlight the priority issues specified by the RG in the symposium 'Growing Up in Conflict'; and try to connect MHPSS with what is being discussed

What we in the end presented was "Voices from the Field" videos with short statements in response to 3-4 key questions. We also pushed out key messages and links, and live tweeting from the sessions highlighted the relevance of MHPSS to specific issues

Post WHS advocacy follow up

IASC Principals meeting Washington DC (June 2016) Advocacy by Mercy Malaysia President

- Acknowledgement that MHPSS did not get good coverage
- No concrete steps moving forward
- We need to have a UN agency to advocate as a champion at this level.
- It is a disappointing outcome from which we can learn a lot

Brazil & Portugal MH & Human Right Statement - Sarah Harrison (IFRC PS Center)

The Governments of Brazil and Portugal initiated the drafting of a statement linking mental health to human rights. This resolution was adopted by the UN Human Rights Council, and was signed by over 70 member states. This is an important initiative as members states will be asked to include reports on how the rights of persons with mental health problems are being held, within their regular submissions to the UN Human Rights Council. The reports from the UN Human Rights Council will thus be a useful advocacy tool and tracking document for MHPSS actors.

Brazil, Portugal and Latin American advocacy initiatives in 2016- Marcio Gagliato, (MHPSS.net)

http://mhpss.net/resource/advocacy-slides-from-brazil-and-portugal-mhpss-initiatives/

What have we learned? Post WHS advocacy:

- Main focus on the role of psychologists and psychiatrists (little on other disciplines)
- Psychology in Emergencies
- Strong Human Rights Based Approach over a needs based approach
    - Liberation psychology
    - Consideration on sociopolitical structure in which a disaster occurs
    - Community based approach and interventions
- Translation of the MHPSS ISAC RG related products (PFA, MHPSS Guidelines, Migration and Refugee GN, 4Ws). PFA and Zika PSS response in Portuguese.
- Workshops and Webinars (Opp 2016 Congress in Porto)
- Launching of the Portuguese IASC, MHPSS M&E framework
- Creation of an MHPSS Lusophone speaking region.

WB-WHO meeting - Sarah (IFRC PS center)

In April 2016 WHO and the World Bank (WB) organized an event on Mental Health. The IASC RG Coordinator (Sarah) was a panel speaker, along with some other RG member agencies and WHO/ PAHO, all of whom were pushing for the mental health in the WB work. The important thing is that WB has been a member of the IASC Working Group and has now allocated a focal person to work specifically with the IASC MHPSS RG. This person is Patricio V. Marquez who was also the WB organizer of the April meeting. The WB is considering to increase their work on mental health by development of guidance note to inform for financing of mental health in humanitarian emergencies in low and middle income countries.

There was a concept note on how WB could engage with mental health and this could become substantial. The IOM, CVT together with WB developed livelihood and psychosocial support manual that includes how to integrate psychosocial support interventions into livelihood programmes. It is an open source document.

US Senate Appropriations – Ann Willhoite (CVT)

The US based MHPSS actors (CVT, IMC and IRC) were able to include mental health within the Senate Appropriations bill related to humanitarian support for the Syria crisis. This bill ensures that US

humanitarian and development aid includes specific provisions for MHPSS for the Syria crisis. Whilst the bill and financing is geographically limited it is an important advocacy milestone.

Mental Health and the SDGs #mentalhealthnow) – Inka Weissbecker (IMC)

Mental health is taken as part of SDG, there were several speakers from many countries. Clinton Global Initiative and others were present in this big event to facilitate people to talk and increase relevance of MHPSS within the UN. It was successful as a visibility event. The SDG guideline that is being circulating shows how important mental health has become. The Clinton Global Initiative will address 30 cities, with basis needs. IMC will work in these 30 cities. Mental health is one the main advocacy focuses, engaging the private sector more is also taking place. World Mental Health Day next year will be on depression.

Relating to the agenda SDA 2030, there is a forthcoming book linking the SDG agenda with MHPSS. Gulli (IOM) has contributed a chapter to this book.

Discussion/ Conclusions - Advocacy

Ongoing advocacy work
Dutch government has approved that mental health and psychosocial support is part of their focus.

Important strategic targets

- WB it is important to link up with their events; there is no structured meeting after the WHO-WB April 2016 meeting. We are learning about the WB, how they operate and how to better engage with them.
- Next World Health Day (WHD) on April 7 focuses on depression. WHO has developed materials for the public and is coordinating the effort for this next WHD event. Materials have already been released on the WHO website.
- Upcoming Guideline development, disability in humanitarian action. This is another opportunity to include MHPSS in the disability agenda.
- Areas for advocacy moving forward Liaising with the UN High Commission for Human Rights, could offer something in relation to paradigms, of disability, human rights and mental health.
- MHPSS in the Urban Context conference in Cairo, in collaboration with the American University in Cairo.
- Need MHPSS Champions within UN agencies and the humanitarian system.
- Next refugee and migrant summit in 2 years – possibility for engagement now that the first 'political' meeting is out of the way.
- SPHERE Standards revision

MHPSS & Disability

IASC Disability Guidelines in Humanitarian Action- Task Team and IASC MHPSS RG engagement - Sarah (IFRC PS Center)

The Task team consist of Unicef, Handicap International, International Disability Alliance & the wider Disability Community.The primary objective of the Task Team is the creation and endorsement of IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action. The development of guidelines would entail the following specific tasks, spread over a 2-3 year period:

- Data collection, mapping and research
- Development and review of initial guidelines, including testing and validation
- Final review, validation and production of the Guidelines together with the IASC Working Group, and endorsement by IASC members and a broad cross-section of stake-holders.
- Initial development of roll-out plan

UNHCR Disability & MHPSS guidance note- Peter Ventevogel (UNHCR)

UNHCR are working on aligning the various terminologies used in MHPSS, Disability and Protection e.g., psychosocial disabilities vs. MHPSS. The brief guidance document can be shared with the RG members once finalized.

Discussion

- Handicap International (HI) is leading the response through MHPSS and Disability. There is a strong resistance from the field to mainstream another area (e.g., "disability") in addition to protection, GBV, MHPSS< accountability, gender and age. There is significant mainstreaming fatigue, it is confusing partners at the country level and decouples all of these initiatives from 'good humanitarian programming'.
- There is confusion as to how disability is defined, whether it is mental and physical or if psychosocial disability is in the framework. HI has made guides for mental health and psychosocial support in emergency settings. Within HI there is a group that uses MHPSS, the terminologies are different but they are doing it.
- UNHCR would like to be engaged but some of the information on this is unclear. A colleague in UNHCR is heavily involved and actively contributing, but would not take the lead. UNHCR will definitely continue to take part in this.
- Unicef is one of the agencies. For other agencies working in child protection it should not be voluntary, everyone should take up this.
- The meeting schedule to develop the guideline is going to be in 2017 and the guideline will be released in 2019. This is a long term commitment!
- It is important to have clarity whether it will be about mainstreaming MHPSS in emergencies for people with disabilities. It is also good to know if there are psychosocial interventions for these groups of people.

- Save the Children feels it's important to consider children with disability. It is equally important to promote and get more agencies involved with MHPSS aspects of disability and work with challenges to try to tackle them.
- The MHPSS guideline is about ten years and may be updated and improved. It is time to work with the MHPSS in the disability framework with fresh eyes to be more literate on issues of disability.
- Agree to place the IASC reference group as a formal task team member and see if individual agencies could do internal advocacy and have real impact for the inclusion of MHPSS in disabilities. Unicef, UNHCR and HI are members of this group while CBM are involved closely without being a formal member as they do not work in emergency settings. It is better that the agencies that work with child protection are engaged to share some workload otherwise it is going to be heavy for the rest of us.

Conclusion/Plan
The IASC Disability task team should come up with a workplan, which will be shared with everyone, so that RG members can plan ahead.

The task moving forward is that Sarah remains on the mailing list of the task team and shares items with the rest of the group members. Sarah will circulate the final ToR and workplan.

Cluster interaction and updates – taking stock

Each of the following clusters: health, CCCM, education, nutrition and protection/CP/GBV presented their ongoing works and their interactions and in relation to MHPSS.

Health - Mark van Ommeren, WHO

The Global Health Cluster in its meetings generally does not focus on specific technical areas or sub-topics; the focus is generally more on overall coordination and other core cluster functionsand as well as disease outbreaks of international concern (eg yellow fever, Ebola) .

CCCM – Gulli Schinina, IOM

There was new cluster manual for CCCM actors last year. CCCM kept PSS mainstreamed among different sectors. Now they came up with request that the actors found out that the manual is ok but it must be conceptualized with MHPSS. Working on this now, working on the integration of MHPSS in CCCM through mobile teams and trainings. There is an article in the forthcoming edition of the Intervention Journal on MHPSS and CCCM in the context of northern Nigeria.

PRM is financing IOM as the Co-Chair of the CCCM Global Cluster to integrate MHPSS activities. This is more of a policy for us on best practice.

CCCM is working to mainstream MHPSS in SGBV in all its activities it undertakes. There is new CCM manual and psychosocial support is part of all activities, but now PSS is being part of the manual, dedicated a chapter.

Education – Saji, Unicef

In the symposium in The Hague, a section was dedicated to psychosocial support in the school system. It is immensely contextual field, and there is a very under-utilized or under-performing. There is a discussion underway between Unicef and INEE of having annual meeting. They initiated two related processes with Unicef funding. One is to understand what it is means, and develop a concept paper that shows the PSS and social emotional learning SEL. This background paper was produced over the summer by a Consultant hired by the INEE-PSS Taskforce. Many RG member agencies also peer reviewed the document. We are waiting for the final version to be released before circulating it to all RG members. The second phase is funded by Unicef and is to develop a global guidance on psychosocial support and school systems. It is going to be very operational and field friendly. By the end of this year we could have the paper ready.

Nutrition – Cecile Bizouerne, ACF

Advocating for technical factors, there is an on-going interest on mental health and PSS and to combine interventions with MHPSS. In terms of advocacy, we are trying out technical document on integrating PSS in nutrition, social behaviors change is being taken up as something new in the last five years. PSS work in social change and behavior change and we continue to promote this. Social change/behavior change is seen by nutrition experts as an important part of nutrition and to integrate the MHPSS components. For Ebola response, WASH was pushed together with PSS. Strong push is for treatment of acute malnutrition and mental health and PSS issues.

Protection/CP/GBV – Sarah Harrison (IFRC PS Centre), Alison Schaefer (WVI) & Maria Bray (TdH)

- PSS task force on PSS for care givers and parents (TdH, WVI, War child International)
- Community Based Protection Mechanism: cross-sectorial learning on community based programming: child protection in emergency, PSS is mainly CFS, this can be linked with capacity building
- There is a guideline on Case management. The idea is now to pilot the use and develop application and tools. One of the objectives will be use of PSS in child protection.
- Improved methodologies for child protection in assessment, monitoring and development. PSS included in the parts.
- Strategies to protect violence against children ex. aiming to provide a clinical therapeutic tool that would aim to reduce violence against children.
- Split on the area of responsibility and alliance: the child protection working group was based on thematic discussions and global support group to provide technical support as part of the cluster system. The problem was that the group became too big, at global level you are working with guidelines and long term issues. Because of this we have child protection alliance that will work on policy development guideline, more technical work, and the child protection area of responsibility (CP AoR) will continue to support the child protection sub-clusters in various clusterised emergency settings.
- Capacity building M&E on 'hard to measure' child protection issues.

Country level MHPSS Coordination Groups/ emergencies

Overview of requests- Sarah

http://mhpss.net/resource/overview-of-requests-handled-by-rg-coordinator/

Presentation of overview of requests between March and October 2016. Requests from country level, 18-19 active groups, led by different agencies. Majority requests on coordination/ who to link up to in-country, Iraq- country with highest nr of requests, mostly about coordination. UNHCR- agency with highest nr of requests, requests mostly related to refugee context

Ukraine- IASC capacity building project- Anna Goloktionova (IMC)

http://mhpss.net/resource/iasc-guidelines-on-mhpss-implementation-case-in-ukraine/

Presentation of an Implementation case of IASC MHPSS in Emergency Settings Guidelines.
Community based support. PSS support banned. Focus on IDPs, through INGOs, uneven distribution of assistance. Lack of coordination. Competition over resources. Need to mainstream- cross-sectorial. Development of Capacity Assessment Tool. Translation and awareness rising. Requests on how to imbed the guidelines in the implementation. Pyramid multilayered support mapping. Importance of contextualization for relevance and "buy-in". Lack of link to health sector. Need to be community based. INGOs prone to support activities rather than organizational capacity building. MHPSS sub-group on operational level. Tendency to focus on "trauma". Challenge of sustainability of this work.

Syria crisis- Jordan, Lebanon, Iraq, Syria, Turkey – Inka Weissbecker (IMC)

IMC coordination groups throughout the Middle East. Assist on needs assessment in Northern Iraq. UNHCR (Pieter) supported an MHPSS mapping and strategy workshop with Erbil based MHPSS partners. The Erbil and Dohuk MHPSS WG requested a support mission from the IASC RG Coordinator. Due to the ongoing Mosul military offensive, this will most likely take place in January or February 2017. IOM (Gulli) will be visiting Iraq in November/ December 2016.

Requests from Iraq related to Mosul crises; assessment. Challenges on coordination in Damascus- role for MHPSS RG to play in this, in a neutral capacity. UNHCR- -IMC-RG Coordinator to follow up.

Greece/ Mediterranean/Migration – Inka (IMC), Gulli (IOM) & Peter (UNHCR)

IMC, IOM, Babel (local actor): coordination group, referrals, assessment, some regions with no access to MHPSS. Translation of guidelines and tools in Greek. Challenge of translation and language. Longer term solutions, linking with local NGOs, volunteers and health sector. Challenge of varied level of quality of volunteers, vast amount of actors. 52 camps. CBPS

South Sudan – Gulli (IOM)

Coordinator of MHPSS-group recruited. Waiting for security situation to stabilize before the Coordinator can return to the country in order to step up on MHPSS activities. WHO will be conducting a field support mission in November as a follow up to Sarah's trip report and recommendations. Pieter (UNHCR) is also due to visit South Sudan within the next 6 months to roll out mhGAP-HIG in refugee camp settings.

Tanzania –Ashley Nemiro (IRC)

Two working groups, for logistical reasons. Partner with Plan, UNHCR, Tanzanian Red Cross & MSF. 4Ws-mapping has just begun and they are looking into referral systems.

South & Central America- Zika virus disease – Marcio/Ananda (MHPSS.net)

http://mhpss.net/resource/mhpss-zika-virus-response-briefing/

A lot of children born with development disorders- long term challenges and needs of many aspects; "social emergency".

Focus on preventing and managing medical complications caused by Zika virus infection. Four main objectives to support national governments and communities in preventing and managing the complications of Zika virus and mitigating the socioeconomic consequences: Detection, Prevention, Care & Support, Research. The IASC RG was instrumental is directing the Zika Strategic Response Plan away from mosquitos (vector control) to place human beings at the centre. We significantly contributed to the Care and Support Objective.

Developed:

- PSS for Pregnant women and families with microcephaly and other neurological complications in the context of Zika virus (WHO)
- Zika virus infection: step by step guide on Risk communication and community engagements

South Korea – Gulli (IOM)

Translation of the IASC MHPSS Guidelines, Checklist for Field Use and the MHPSS-CCCM booklet into the Korean language. The translations were made possible through the financial support of OFDA/ USAID.

MHPSS & Reconciliation

Peacebuilding review - Marian Tankink (WTF)

The Institute for Justice and Reconciliation (South Africa) and WTF (Netherlands) have for a while been working on understanding the interconnectedness between mental health and peacebuilding. In 2015 we jointly hosted an international conference to explore this topic further and to engage with relevant stakeholders from both fields on where and how further efforts should be concentrated. It was found that further research was necessary to make for a case that the two fields should be integrated in order to generate sustainable outcomes.

They are now inviting interested academics and practitioners from both fields to submit articles to a special issue of the journal Intervention on the topic of linking mental health and psychosocial support to peacebuilding. This special issue of Intervention seeks to focus on how to create a nexus between the two fields of MHPSS and peacebuilding, and how to prevent their continued isolation from one another. What projects and practices already exist which attempt to bring the two fields closer and what theoretical models might underpin a successful confluence of the two fields? These and other issues need to be explored further, and thus we welcome contributions on this topic for this upcoming Special issue of the journal in 2017.

Engaging with reconciliation, conflict transformation and peacebuilding actors (terminology) - Gulli (IOM)

Discussion

- Look for more literature (input from RG, e.g., reports from Liberia and DDR)
- Ashley Nemiro/IRC: Shares example of a MHPSS/peace building initiative in post-ebola Liberia. As ebola brought up community divisions so it was important for communities to come up with joint projects. The IRC project was framed as a joint MHPSS /peace building project.
- Martha Bragin: Flagging up Medical anthropology publications on practices for reconciliation (Institute for Mental Health and Human Rights)
- Pieter (UNHCR) Points out how far we are from a solid desk review of resources and suggests a more modest approach: The “peace building movement” is not familiar with what we do.
- Kathy Angi recommended reaching out to faith based NGOs and their local church partners who do a lot of work on peacebuilding and reconciliation. It would be worth checking with ACT Alliance, Caritas and the Ecumenical Centre in Geneva.

Conclusion/plan

- ☐ MHPSS RG to produce a short 4 page MHPSS – what do actors in peace building need to know?
- ☐ MHPSS RG to ask for a similar short guidance note on the basics of peace building initiatives.

Day 2

New tools 1: IASC Common M&E Framework for MHPSS in Emergencies programs – field testing

In March this year a draft of the document was sent to an M&E Specialist, before it was sent out to the MHPSS RG group. The comments and proposed changes from RG members were reviewed by the Task Force members. Thus, they are incorporated in the draft presented today. This document arrived last Friday from Unicef and the Graphic Designer but is still not finalized. We hope to have the final document ready by the end of the year. Nevertheless, the document has been presented at three conferences in October as part of the Common M&E Framework dissemination:

Brazil & Sri Lanka workshop - Marcio & Ananda (MPSS.net):

http://mhpss.net/resource/me-workshop-brazil-and-sri-lanka/

: The M&E framework was launched together with a M&E workshop at a Conference of DRR. This was an opportunity to launch the document to the big group that has a crucial role in the MHPSS role in Brazil. 25 actors were present (Academics, MSF, Red Cross, WV, Plan International; Fiocruz, Psychological Federation Association), and had more than 1000 views on the online FB, with possibility to ask questions.

The preliminary results/conclusions:

- 75% had no or little previous knowledge of the MHPSS guidelines
- The framework / structure is helpful for different approaches
- Great opportunity to insert the MH file into DRR Brazilian mechanisms.
- The workshop was a powerful way of introducing the M&E framework.

Sri Lanka: The workshop was hold for MHPSS practitioners and for M&E practitioners. 24 participants attended from the Govt, LNGO, UN, INGOs. After an orientation of the MHPSS guidelines, the participants were walked through the M&E manual and could apply the manual to their own project – making it practical. The exercise of applying the framework to their own project was crucial. The more people worked with it, the more they got interested and positive and could see the benefits.

The preliminary results/ conclusions

- Likelihood of use it on current projects & future proposals: 25% Definite likelihood of use, 15% High likelihood of use, 50% Moderate likelihood of use
- Usefulness
    - For me as a professional >85% high or essential
    - For organisation >85% high
    - For field 25% moderate >35% high > 35% essential
- We need to be aware of the need of feedback in the process of grasping the M&E framework. You can not only hand it out
- Quote from a participant: “we often know what we do, and we know what we call it, but it’s hard for us to explain this to our donors. The M&E framework gives us a tool to use the same vocabulary as our donors, and will help us describe our work in a way so donors will understand”

MENA GIZ Regional M&E Conference in Amman – Andreas Loepsinger (GIZ) & Sarah (IFRC PS center)

The conference was held with more than 70 participants from the countries affected by the Syria crisis including: Syria, northern Iraq, Turkey, Lebanon, Jordan and Yemen. Sarah presented both the IFRC M&E Framework for PSS Programmes and the IASC Common M&E Framework for MHPSS Programmes in Emergency Settings. Comparisons were conducted between the two frameworks. On Day 2, there was an interactive group session, whereby agencies were split into their respective countries or operation (or origin for local actors) and encouraged to apply both frameworks to an actual project in that context. Participants were encouraged to select one impact level indicator, one outcome and a corresponding outcome level indicator from the IASC Framework. They were also encouraged to view the Means of Verification (MoVs) and the data collection tools in the IFRC Framework to see if any of them maybe of use to their current or planned projects.

Conclusions

- The frameworks need to be introduced, and workshop setting is a great way of presenting it. It is not feasible to just put the framework on the web and expect people to use and understand it. It requires facilitated dissemination to the country level, where participants apply the framework to their projects and programmes.
- Overall good feedback from the participants on the framework

Group Discussion/conclusions of tool 1:

- Discussion about: how to support in the long-term, country level dissemination.
- We need to remember this is not about us, it's about the rest of the world.. We have no power, only the ability to educate. It is intended to empower organisations
- This is a field test version for the next 3 years. It is not a perfect document, but a god start. It's lacking. Let us test it and see how it's going. We will learn as we go.

Conclusion

- Are we being too prescriptive?
- one hour online course - case analysis
- Online Feedback for projects
- Role of Technical advisors within RG member agencies/ organisations
- Self – study worksheets
- MoVs- Suggestions of tools. – data analysis
- IFCR toolbox-analyze it to see if useful for the IASC M+E framework
- 6 Guidance notes related to 6 impact indicators
- Ukraine MHPSS Subcluster willing to test.

M+E next steps:

1. Technical advisors introduce within your own agency plus with partners / civil society.

2. Online 1 hour introduction course: video library, Webinars
3. Collection of feedback as it is introduced in countries / regions 2-3 years field testing
4. Creation of an M+E Task force to look at the 6 impact indicators.
    - Library of tools / database
    - Guiding questions to choose tools – process documents
    - Not prescriptive
    - Prioritise impact level indicators as written in the Common M&E Framework

New tools 2: IASC MHPSS RG referral from and guidance - Sarah (IFCR PS Center)

Sarah presented the final draft of the IASC referral form and guidance and opened it up for RG endorsement

Discussion/suggestions:

- Would be nice to have something (checklist or a box) about follow up, if the client has given permission to follow up because it makes people more embedded in the process. Also serves as safe mechanism, to make sure that the referral actually worked out.
- Box where can be noted if client have bed screened with a special tools.
- Overall: good tool! Great tool! Some suggestions of changes of the draft.
- Need to urgently translate it to Arabic.
- Specify which tools has been used, in order to avoid screening the beneficiary twice.
- A request to have a proper “fill in the line” electronic document. i.e PDF.
- Specify what kind of information the person who signs the document is giving his/her consent to share. Now it’s unclear.
- Specify the status of children (unaccompanied?)
- Add “check if the child is already in the child protection system?
- How to manage Date of Birth, if it is unknown? A request to change this to put age instead of date of birth was brought up.
- Add the text “make sure that the data is safely stored”. Since it includes sensitive information.

By December 2016, Sarah plans to have it published in English.

Arabic and French translations will be prioritized for early 2017.

Mental Health updates

MHPSS Toolkit (MH into PHC integration) - Inka (IMC)

http://mhpss.net/resource/mental-health-toolkit-presentation/

IMC is in the process of developing a toolkit. Reasons why toolkit is need:

- Increased number of organizations involved in integrated MH/health programming
- High need for integrated MH services in humanitarian settings but often low capacity and technical expertise
- Increasing number of different tools and resources
- The toolkit will have clear steps and associated links to existing global guidelines, tools and resources.
- Target: implementing organizations, donors and governments.

Who will be involved in the process?

- Toolkit advisory group (WHO, IMC, UNHCR; IASC MHPSS RG Coordinator and other key actors)
- Engagement of Key Humanitarian Actors & Consultation Groups (IASC MHPSS RG Members, Global Health Cluster & Key Humanitarian Actors)

Project length is 19 months.

Discussion*:* **Do you think this Toolkit could be useful? What should the Toolkit include? What makes a Toolkit: Effective, Practical and Easy to Use?**

- UNHCR expressed a need to have a tool with different layers. Where we have low resources, we should have guidance to do it well enough. We need guidance on how to do that.
- Need of having a toolkit that might indicate what is relevant / what to expect
- Link this tool with CBPS?
- Include something about staff wellbeing or a small reminder not to forget the staff.

  Answer to previous comment: focus on the objective, staff well-being is important everywhere and not specific for this case.
- Pilot testing – suggestions to do it in region with low resource countries/ more difficult- if we get it right there, it will be easier in other context to
- Time is an issue
- File keeping – link to data collection tools and databases to collect MH information within PHCs – many agencies struggle with this.

- Focus on other places than the Middle East (except for Northern Iraq). There are other areas that need assistance and the Middle East has resources. If succeeded in Chad etc., it's much easier to implement in the Middle East.

Group counselling manual -Ann (CVT)

http://mhpss.net/resource/group-counselling-manual-presentation/

With 15 years of international group counselling experience CVT now presents: "Restoring hope and dignity: Manual for group Counselling – Center for the Victims of Torture" 2016

It is for use in humanitarian or low-resourced settings. It is a transdiagnostic intervention for people who are experiencing marked distress and reduced daily functioning due to having experienced extreme stress related to war, torture or human rights violations. To be facilitated by trained local counsellors who are receiving ongoing clinical supervision and training. It is a 10-session model, intend to have 10 persons in the group, but it is allowed to remove some sessions if the supervisor and counsellor see that they don't fit the group. It is currently being implemented in Jordan, Kenya, Ethiopia and Uganda.

Future directions:

- Randomized control trial
- Special session in anxiety and depression to replace the traumatic memory processing
- Will soon be on the Website – available for free
- Sarah will disseminate to all RG members through the monthly mailout, once it becomes available.

Community based Psychosocial support

Updates from CB-PSS WG - Maria Bray (TdH) & Martha Bragin (Care Austria)

The WG had a meeting on Monday, this is the group conclusion**.**

Suggested goal: *To improve our capacity to provide qualitative CB-MHPSS in emergency settings, to build the evidence for effectiveness of the approach and to raise status on the relevance of CB-MHPSS in emergency settings among donors and implementers.*

- Clarification of terms, key elements and process to improve capacity to provide quality CB MHPSS
- Producing/collecting evidence base
- Advocacy/ Raising status

Working Plan: Continuation of WG as an official WG of the RG. Everyone is welcomed to join. IOM and REPSSI will take the lead. The end product: Guidance on CB MHPSS within the IASC guidelines (intervention based guidelines?) IASC product / inter-agency product or bilateral org. product?

Proposal: Write a "2 pager": background + ethical standards+ definitions/ key elements CB MHPSS + selected existing evidence –base

Discussion/conclusion

- There is no agreement on how to use the term, creating confusion.
- Confusion about where CBPS is located on the Intervention pyramid. It is across all levels with a special emphasis on level 2.
- Yes, there is a discussion what is CB MHPSS and what is not? Even within the WG there is not a unified view of this. Good to clarify.
- Definition of CB components (difference with community based protection or community-based child protection)
- How the concept (CB-MHPSS) links to other thematic areas/ concepts/ approaches: protection, resilience, etc
- Emphasis on making MHPSS interventions more community-based.

UNICEF operational Guidance on Community-Based MHPSS: Supporting children, families and communities: a three-tiers approach to child wellbeing - Saji, Leslie & Zeinab

http://mhpss.net/resource/presentation-on-unicef-operational-mhpss-framework/

Proposed by UNICEF in IASC MHPSS RG meeting 2015.

Development of first draft: Presented to UNICEF NY HQ stakeholders. Development of second draft in concert with compendium development, and information gathering for four country case studies. Review by UNICEF working group and IASC RG & Community-Based PS working group members. Iterative process of refining based upon these inputs is still in progress. Links in with the M&E document. Field test of guidance.

Why is a Compendium of CB-MHPSS Resources Needed?

- Existing evidence-based resources for the implementation of good-practice CB-MHPSS activities across layers of intervention.
- Supporting documents and applications/adaptations of resources in different settings.

CFS outcomes 'one year on 'project (Plan, Save, WVI) - Alistar Ager (QMU, MHPSS.net)

http://mhpss.net/resource/findings-from-an-inter-agency-initiative-evaluating-the-impact-of-child-friendly-spaces-in-humanitarian-emergencies/

Findings from an inter-agency initiative evaluating the impact of Child Friendly Spaces in humanitarian emergencies. Impact on program on strengthening PS wellbeing in children varied in different contexts/countries (different focus of activities, level of security…). Also, variations in long-term impact. Cannot overestimate the program's effect on longer term but not neglect the positive effect in the short term/alleviate suffering. CFS- not about only offering a space, more qualities needed. Timing of intervention is essential; tend to be based on available funding rather than most crucial time of suffering/needs. Lack of partnership from beginning and local ownership for sustainability. Vulnerability measures on individual/family level not taken into account. Should CFS be more standardized? No, needs to involve Adult engagement, safety, structure and adequate activities. High notion of vulnerability seems to benefit most from CFS (not a selection criteria)

Not great costs of the interventions per head, mainly staff costs. Tendency to include more people in activities for cost cut reasons, should shift back to focus on quality. Children's Right to Play- a gain in itself in CFSs

Psychological First Aid

Child-Child PFA in Japan - Mikuki Akasaka (Save the Children, Japan)

http://mhpss.net/resource/i-support-my-friends/

Child to child psychological first aid "I support my friends". It's a one day training for 9 years old and above, linked to child led DRR and to community resources. The work is building children's self-help and solidarity. It has been pilot tested in Mongolia and Japan. Found challenges are related to confidentiality, linking and capacity of the trainers. The MHPSS RG group invited to be a part of reviewing (by December 2016), in piloting (Jan to June 2017) and contributing to the implementation guideline (Jan to June 2017). A pilot test is planned to take place in a German refugee camp, but there is still openness for other settings.

Discussion

Several voices were raised on the interesting step of taking the PFA from the emergency setting, unwrapping it and linking it with DRR. Based on that the project is directed to children, a discussion followed on the challenges raised: how do we deal with confidentiality and children? How do we deal with linking? Where should children link to? How do we deal with issues about age, is 9 a good age?

PFA review - Maria & Leslie Snider (CoS/ACT)

http://mhpss.net/resource/pfa-retrospective-presentation/

It is five years since PFA was launched. The discussions at last year's MHPSS RG meeting highlighted some confusion, leading up to the initiative to look at PFA in retrospective. PFA was rolled out in various humanitarian emergencies by governmental entities, UN and NGO actors. Various organizations have also used it in capacity building for their own staff. With the use has followed a risk of misuse: Capacity building has extended to a wide variety of helpers – from health and mental health professionals, to school counsellors, firemen and staff in other sectors. There is a danger of its widespread use and acceptance: misunderstanding its place within the spectrum of MHPSS supports, that it can be implemented in isolation of other supports. A retrospective review can help to:

- Elucidate the potential applications of PFA
- Provide practical lessons learned for applications in future emergencies and by various stakeholders
- Clarify the place of PFA within the larger frame of MHPSS in emergencies

The purpose is to look back at the journey of the PFA Guide's development and application in various contexts since its launch to draw lessons learned about: Translation and adaptation processes; Application in different types of crisis contexts, including misunderstandings of its use; Use by

different types of helpers; Place in the overall scheme of MHPSS in emergencies; Recommendations for the future. The plan is a work process over 6-month period, leading to the end product of a publication from CoS/ ACT Alliance, in collaboration with Peace practice and WVI.

Discussion/conclusion

The discussion confirmed the wide range of issues of confusion, and the positive work of trying to clarify them. There is confusion about where PFA belongs in the pyramid. There is confusion about if PFA is a level 3 intervention. There is insecurity about how to deal with actors that claim to have finished a psychosocial intervention just by implementing PFA. Several positively voices was raised about PFA being a great tool with the simple, accessible framework and the additional pictures. A suggestion raised was to include in the manual something about how to train trainers. It was also suggested a need to add something about what to think about after PFA, what comes next? Need to place PFA within the broader spectrum of care. Possibility to look at having an online course?

Day 3

Faith sensitive PSS programming initiative - Alistair Ager (QMU), Atallah Fitzgibbon (IRW) Wendy Ager, & Michael French (LWF/ATC)

http://mhpss.net/resource/developing-guidelines-for-faith-sensitive-psychosocial-programming/

Presentation of Developing of guidelines for faith-sensitive psychosocial programming. Why doing this? Faith is overlooked by HUM agencies though majority of refugees and displaced persons are persons of faith. Local faith communities are complex and dynamic. Faith leaders are important and nature of leadership that of youth and women is vital to understand. Faith language is very useful, and western view of religion is embedded in faith as a non-neutral term. The term Guide is chosen to avoid repetitive use of guidelines that are somehow restrictive.

Key Insights from Guidelines and Desk Review

The basis for sensitivity to faith:

- It is indicated by the IASC Guidelines
- It is required by humanitarian law and principles,
- Religion is an active and effective source of coping in many contexts
- The 'comparative advantage' of local faith actors in humanitarian settings
- Coherence with emerging policy and practice

The challenges of engaging with faith:

1. Religion used as a basis for maladaptive coping
    - Religion as a fermenter of conflict
    - Religion as undermining of agency. However, the power of Imams'' wives has important role in humanitarian responses in Sierra Leone.
2. Religious engagement being seen to compromise impartiality
3. Practices being poorly documented, disseminated and developed

    Learning from the field experiences will be looked at to reverse the learning pattern.
    - Being neutral
    - Religious consortium
    - The way of truth and love always won

Planed activities

- Structured Survey Of Programme Experience
- Individual Reflections On Engaging With Faith
- Thematic Analysis and Joint Workshop

- Fieldwork connected to Islamic Relief Worldwide (IRW) and Lutheran World Federation (LWF) country teams in Jordan, Nepal and Kenya. 110 surveys and 57 individual reflections have been completed across three country settings

Discussion

Issues and questions? Status /endorsement so as to be useful to the wider humanitarian community? Interest in developing/piloting guidelines?

- Dialogue with religious leaders has not been done, will be a discussion whether we will work together or not. CARE continues to use documentation in terms of evidence based for child protection programs in child development, what has been done in the past, what is lost now and what can be done in the future, in SGBV, the role of religious leaders and healers. There is a growing body of document: ex. Healing and getting back to society in Uganda.
- PROCUMURA: role of religious groups in Africa. Helping people have access to what they do within their faith. It will be important to have guidance on that.
- Question is if there is guidance reinforcing tolerance between people with different religions, on peace building and building bridges.
- There are no guidelines.
- I want to be sensitive to cultures but how do I deal with harmful practices.
- There is a Unicef programme with religious leaders in Cairo. It is about mobilizing communities and they take it on using their resources. Identifying local faith groups is what is done.
- Working with faith leaders in Brazil and lately in Iraq has been done, and there is a process to develop tools to use to show the role of religious leaders in humanitarian responses.
- Literature on faith and culture is included in all the Desk Reviews for the large-scale level 3 emergencies including – Haiti, Nepal, Ecuador, Guinea and Syria. All desk reviews can be found on MHPSS.net.

Scalable psychological interventions – Mark (WHO)

Mark presents WHO studies on low resource intensity (scalable) psychological interventions for people with prolonged disabling distress. A reason for looking into this is to stay updated on the evidence base. There is a growing evidence base for psychological interventions from an increasing range of contexts. Psychological interventions can be effectively delivered by non-specialists, using less scarce resources. Simple scalable interventions are also effective.

The current objectives are to publish a range of different scalable psychological interventions with a focus on increasing access to effective care. Approaches towards WHO published interventions:

- Adopting existing evidence-based manuals
- Developing and testing new interventions

Use a five phase model for new interventions. Current project involved are:

- Adult Problem Management Plus: individual (Pakistan & Kenya) and group (Pakistan & Nepal)
- Self-Help Plus (SH+, multi-media package) (Uganda)
- Young Adolescent PM+ (Lebanon)
- E-Mental Health (Lebanon)

IASC RG MHPSS Capacity, building strategy - Sarah (IFRC PS Center)

During the past several RG annual meetings there have been discussions on becoming more operational and providing more direct support to the field in the form of deployments of technical MHPSS professionals. At the 2015 annual meeting, the RG requested that the research be undertaken on the various mechanisms to provide international deployments in emergencies. Sarah presented the draft research, focusing on summarizing the differences in deployment modalities involving a CAP or at RRT, (see page 7 for the MHPSS-CAP research paper).

Sarah's suggestion is a strategic vision: to have an international roster of MHPSS that can be deployed. This requires the following components: a steering committee, an administrative secretariat, and an international roster. If it is to move forward from here, there is implication and there is a lot of management involved. We need to discuss if we want to take this forward and if so-how?

Discussion/conclusion

Several voices were raised on the difficulty of seeing the advantages and disadvantages with CAP or RRT deployment. Therefore, the question was directed back to Sarah, as being the most informed on the topic. Sarah made a clear suggestion to go with the CAP, because it fits best with how the MHPSS wants to work. It takes time to set up clusters and get things going. Three months are not adequate to do all this and build relationships. Pulling out capacity after 3 months as per the RRT approach is a disadvantage because we have seen that it is after three months that we usually need to inject additional capacity, not pull out. It is better to work from this and go until early recovery. It does not make sense to deploy a RRT, because then we would do just what others do. However, the need remains to have someone quickly in the beginning.

Several voices were raised, agreeing on the argumentation. The discussion therefore continued in the exploration conditions for such a step.

- Have an international roster? Should it be P5, P4, P3? P3 is easier to deploy. Should these be people who work for our agencies? Are they independent consultants? We don't know how many are in Pro-CAP.
- Surge have very good protection roster, they do very good protection on the ground for early recovery as well they are thinking having roster as well.
- If they are rostered, what are they doing in between? The challenge would be people who qualify as many are already employed.
- We are assuming OCHA wants MHPSS deployment. Is this the only option? The best option?

- IRC model, using people with coordination role – surge is one Pro-Cap is a second type. We should not use RRT, short term deployment is not the best option. May be it is better to have a third option, since we are not bound to these two (Cap and RRT). Perhaps doing it in groups, is it realistic to explore this or is it better to go the official route?
- We still need somebody to write for funds and someone to manage this. From this point of view the CAP is easier to explore. Can OCHA have budget for this?
- Donors could be asked, and are probably willing to engage more than we think. Especially if we can show that this is needed to insure quality.
- Perhaps easier to think of two persons in deployment, someone who goes in and sets initial coordination, and someone to take on and stay up to nine months.
- This can be game changer and is super important for the RG to take forward.

Decision

An, 'exploration task force' is formed with participants from MHPSS.net, ACF, IRC, WHO, UNHCR, IOM, Save the children & TdH. Sarah will call on the group and start the work in 2-3 months. RG members are requested to please discuss with your agencies, internally, and get back to Sarah with further thoughts on the MHPSS Capacity building project.

Practicalities & decision, making processes – Saji (Unicef) & Nana (IFRC PC Center)

Last year it was decided that IFRC should be one of the co-chairs. There was some Skype communication, and it was a transparent communication. Today's discussion is about the transition from Unicef, who has been co-chairing for ten years, to the next co-chair. WHO is interested to take on the position form Unicef, however WHO don't have the funding confirmed to start 1 of January 2017. Transition plan is therefore: Unicef continue until mid of 2017, and then transition to WHO if everything has worked out. Mark can confirm on 1st March 2017. If the funding's doesn't work out, there is still time for someone else to take on. Saji and Nana both express support on this transition. Until now no other agency has shown interest in the position, but if there is anyone, they are asked to come forward as soon as possible.

Discussion/ Conclusion

- The group is getting more operational, do we need to change structure? Need of a clearer structure on when to elect and for how long time? The group is growing, and together with this more responsibility is put on the coordinator. Option on a steering group?
- Wouldn't be better to have a clear structure for election? Everyone is elected for two years? And having the election one year before the co-chair should start? This would make it easier to look for funding.
- We are growing, and If we grow bigger or take on the international roster, we need additional capacity and perhaps another more organized network.
- It is important to have a complaint mechanism.
- It is not sure what differences are between a steering group and a working group.

- If someone can develop ToR for the steering group, so people have a clearer idea to say yes or no. If people don't like we continue as a working group. It doesn't have to one without the other - one can be for decision making, and the other for operations.

Decision

ACF (Cecile) and TdH (Maria Bray) will share the steering group ToRs from the other clusters (e.g., nutrition) and CP AoR. This ToR will be adapted to the IASC RG and circulated to RG members to see if they wish to adopt this approach or not.

Meeting next year

Mark invites next MHPSS RG meeting to Geneva 2017. He will try have it in connection with the mhGAP forum. Dates for your diaries are:

- 2-3, Oct 2017 practitioner + RG member's workshops on scalable psychological interventions
- 4,5 & 6, Oct 2017 IASC MHPSS RG annual meeting
- 9-10 Oct mhGAP forum.

Development of workplan 2017-2018 – Group work