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Intervention 2008, Volume 6, Number 3/4, Page 338 - 347

After the guidelines; the challenge of implementation

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One year after the official launch of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, initiatives linked to their implementation have been undertaken in over 20 countries ranging from Iran and Nepal to Kenya and Peru. In this article we present an overview of the activities that are currently underway to implement the guidelines. This article provides an overview of different strategies that have been used and presents some of the strengths and challenges of these implementation strategies.

Keywords: Inter-Agency Standing Committee (IASC), guidelines, implementation, challenges, field testing, case studies

In our experience, many practitioners, policy makers and researchers see the effective implementation of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007a) as an important way to strengthen the quality of mental health and psychosocial support (MHPSS) programmes in emergency settings. There appears to be increasing recognition that the content of the guidelines, and the broad based consensus they represent, are crucial for strengthening the work in this field. However, it is less clear how the guidelines can best be used. Many actors committed to the principles of the guidelines continue to struggle and experiment with the most effective way of implementing them. This article aims to contribute to a broader reflection on this question by documenting how the guidelines are currently being used, and some of the challenges and opportunities presented by different approaches.

What do we mean by implementation?

Every year dozens of guidelines, strategies and policy documents are produced, by UN agencies, nongovernmental organizations (NGOs) and donors. In the humanitarian field, the Inter-Agency Standing Committee has issued a range of guidelines and tools that reflect a broad consensus on best practices on various humanitarian issues.[1] Often, these documents are based on a wealth of experience combined with expert conceptual insight resulting in high quality guidance. Once published, the challenge, time and time again, is implementation. The IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings was established with the explicit task to follow up on the implementation of the guidelines elaborated by the 2005-2007 IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings.

Given the range of ways in which the guidelines can be used, implementation can mean many different things to many different people or organizations. This ranges from simply sending out the guidelines to offices around the world, or launching it at high level policy meetings, to developing trainings on the subject, or conducting case studies and identifying best practices linked to them. While some agencies will choose to opt for

'*wide and extensive dissemination*' (i.e. sending it out to as many actors as possible) others will choose an approach based on '*narrow and specialized dissemination*' (i.e. investing in a limited number of actors that will serve as catalysts or advocates). This presents a challenge to those wanting to implement the guidelines on MHPSS; what is the most effective way to use them to improve practice?

Strategies for implementation

The guidelines were officially launched in September 2007. However, they had been already used to some degree to strengthen programming, even as they were being developed. The extensive participation of a broad range of actors in their development (Wessells & van Ommeren, 2008) paved the way for more efficient and effective implementation of the guidelines in two ways: it built ownership of and commitment to them; and strengthened technical understanding and consensus around the content of the guidelines. One year after the official launch, initiatives linked to the implementation have been undertaken in over 20 countries, ranging from Iran and Nepal, to Kenya and Peru. It is, however, too early to evaluate what type of approach has been more successful than others.

We have based this article on a review of available documentation of the use of the guidelines in various settings, including reports produced by external observers of the implementation process in Sri Lanka (IASC, 2007b) and Peru (Macara & Malca, 2008), discussions and correspondence with policymakers practitioners and researchers who have been using them, and our own observations. We begin with the strategies that are more global in nature, and then move to those that are more specific, or targeted. The categories presented below are overlapping, and multiple strategies are often used in the same country, or by one organization.

Printing, translating and disseminating

A first step in using the guidelines is systematically translating, printing, posting on websites and disseminating them.[2] They have, so far, been officially translated into French, Arabic and Spanish and unofficially into Indonesian, Farsi, Tamil, Slovakian, Japanese and Chinese. The translation process has involved checking technical accuracy and also attempts to translate conceptually distinct terms (e.g. '*animateur*' is a concept in French that has no exact equivalent in English). To date, more than 12 000 English copies, 4125 Spanish, 8250 French and 4125 Arabic versions of the guidelines have been printed and sent out to numerous organisations upon their request. In large scale natural disasters, such as in the recent cyclone in Myanmar and the earthquake in China, Reference Group members disseminated the guidelines and promoted their use by their own organizations, as well as national partners. At the global level, the Reference Group is also producing a summary (and illustrated) version of them (IASC, 2008), as well as developing standard PowerPoint presentations.

Advocating on a global level, within organizations and with clusters

The guidelines were launched in Geneva, New York and Washington D.C. in late 2007 to government representatives, donors, the media, UN agencies, other inter governmental organizations and NGOs. Policy level launches often suffer from criticism in terms of money spent and lack of impact. However, given the historically highly divided nature of the field (Ager, 1997; Weiss et al., 2003) and the lack of understanding of the issue itself, the IASC MHPSS Reference Group felt that these launches would be important opportunities to strengthen decision makers' understanding of, and commitment

to, MHPSS. Anecdotal evidence from members of the Reference Group suggest that these launches did help to achieve this goal; some donors now make their funding conditional on organizations' adherence to the guidelines.[3]

Many members of the IASC, as well as other organizations, have been working to integrate the guidelines into their work on MHPSS, as well as their other sectoral areas of work. The Inter-Agency Network on Education in Emergencies (INEE) integrate the relevant sections of the guidelines into their trainings on education,[4] and organizations such as the South African based Regional Psychosocial Support Initiative (REPSSI) and Terre des hommes (Tdh) have been reviewing their own guidelines to incorporate these guidelines. In addition, training material such as the *Inter-agency self-learning CD-Rom Introduction to Child Protection in Emergencies* as well as *Action for the Rights of the Child (ARC)* draw heavily on the guidelines.

Another use, has been to integrate them into the work of the global IASC Clusters, linked to humanitarian reform. This has included making presentations on the guidelines to various clusters (protection, nutrition, and health), revising documents produced by the clusters, developing specific guidance for the clusters on MHPSS, and liaising with field level clusters to ensure integration of MHPSS.

Advocacy and integration of the guidelines into donor, government and organizational policies and practices is a time consuming and potentially unending task. However, it is crucial to ensure sustainability and to introduce lasting change in practices.

Adapting the guidelines for local policies, coordination and planning

At the field level, the guidelines have also been adapted into local contexts and have informed local policy development on MHPSS. In Iran (UNICEF Iran, 2007) and Nepal,[5] the first step of implementation has been to work with local actors to review and revise them to reflect the local context. Some organisations, such as the International Organization for Migration (IOM) and UNICEF in Kenya, Save the Children in Jordan and International Federation of the Red Cross (IFRC) in Bangladesh (Dash & Christensen, 2008) have used the guidelines as the key policy document on which to base their national policies for MHPSS in emergencies.

Another important use of the guidelines has been as a coordination tool. The government of the Philippines has used them as a framework for emergency preparation and planning for MHPSS[6]. Similarly, in the rapid onset of emergencies, such as natural disasters, the guidelines can be used as a checklist for MHPSS coordination groups to identify gaps and verify that the different activities are being carried out by the appropriate actors. An interesting coordination exercise in Kenya was to show the pyramid and the 11 core areas of the guidelines on a blackboard. Practitioners from different agencies then spoke for 1 minute, and the facilitators located their contributions on the pyramid and core areas. It soon became apparent where there were gaps, leading to a concerted discussion, including by the national Director of Mental Health, about the need to develop a more comprehensive approach. It can be also used in emergency preparations to strengthen MHPSS planning and intersectoral coordination, as was highlighted by a participant in the trainings of school counsellors on the guidelines in Iran.

> *'The IASC [guidelines] clarify what each sector such as the health and education sectors must do before, during and after an emergency.*

It clearly outlines the minimum amount of action that is required for collaboration, assessment and evaluation, providing support to field workers, health services and various other required tasks during an emergency. It serves as an organising tool for various humanitarian workers and organizations.'

Individual organizations and practitioners have also used the guidelines as a framework to plan, reflect and review their programming. In Myanmar, organizations such as Action Contre la Faim (ACF)[7] have used them as a basis to guide their national staff working in this field. In Jordan, they were used as a backdrop to assess the situation of MHPSS for displaced Iraqis in Jordan (Ventevogel, 2008). As stated by a male colleague:

'An important tool to strengthen the working frame. The guidelines proposes what to do by axis (. . .) one reviews each one of those axis and can take out concrete ideas to see what can be done with concrete activities. In fact, based on what you are doing, you turn to it as you need it, to see some examples, look for other kinds of actions. What I wanted to consult, I have found.'

Building capacity

For non-specialist audiences, such as government decision makers and heads of organizations short orientations or presentations of the guidelines have been conducted in many countries around the world. In Sri Lanka, a key lesson was the importance of preceding longer orientations with short orientation sessions for heads of agencies to enable buy-in, and to open the door for staff participation in longer workshops and implementation efforts.

In depth capacity building with the guidelines for specialists working on MHPSS has been conducted in many countries in a variety of ways. Professional organisations such as the World Federation for Mental Health[8] and the US Disaster Mental Health Institute[9] organized international conferences to promote knowledge and understanding of the guidelines among their members. Several courses for training of mental health professionals in emergency settings have used them as a reference for different modules.[10,11,12]

In Iran, UNICEF trained 150 school counsellors from around the country on the guidelines. In Haiti, Action Aid and UNICEF organized a 2 day workshop on Psychosocial Support that included more than half a day orientation to build understanding of the guidelines. In East and Southern Africa, TPO Uganda, Christian Children's Fund (CCF) and UNICEF organized a training of trainer's workshop to build regional capacity and strengthen the use of the guidelines (Wheaton, et al., 2008). Building on this experience, a global capacity building workshop is planned for Reference Group members in September 2008 in Geneva. As stated by a participant at the training in East and Southern Africa:

'Before this training I thought that only mental health professionals could handle mental health problems in emergencies, but I now understand that others may need to, and can, handle these problems as well.'

While taking a variety of different forms, these capacity building initiatives all provide the opportunity to present the guidelines, action sheet by action sheet, to discuss them in depth and to reflect on their possible application in the relevant country. Feedback from these initiatives suggest that such capacity building initiatives are more effective when they focus on using the guidelines to address practical challenges faced by organizations.

Operationalization at the community level

The final and possibly most effective form of implementation is operationalizing the guidelines at the community level. This involves engaging with communities (and not only service providers) to use the guidelines as a framework to identify their specific MHPSS needs, and to develop tailored responses using them as a framework. This type of implementation, carried out in only a limited number of countries to date, requires more intensive resources and is often done in collaboration with local NGOs or community based organizations (CBOs) working within communities. Agencies may develop material, such as posters and picture versions, as well as organize focus group discussions and meetings with children, parents and community leaders. They may also work to mobilize the community in addressing MHPSS and broader humanitarian response issues. In Latin America, and in Asia, the Red Cross and Red Crescent Societies have developed a series of visual materials around the guidelines that can be used as tools to work with communities (Prewitt Diaz & Dayal de Prewitt, 2008) In Peru, the NGO Medecins du Monde (MdM) engaged in this type of work following the earthquake (Rivera et al., 2008), and in the Mano River region in West Africa, the NGO CCF lead an interagency psychosocial project in which international NGOs engaged the community in the implementation of particular action sheets from the guidelines. It is this community mobilization aspect that is arguably the most transformative component of the guidelines, and therefore among the most challenging.

Challenges and opportunities in implementation

Below are highlighted a number of challenges and opportunities for implementation.

Support versus resistance

Many stakeholders, from grassroots practitioners to policy makers, have commented that they find the content and principles of the guidelines helpful and important. In fact, in these authors' experience, some of the most vocal support for the guidelines have come from field-based practitioners who stress the important validating role that the guidelines provide for the community based approach they have been using, and promoting, for some time. In addition, the members of the Reference Group have repeatedly stated the importance of the guidelines in building consensus, common understanding, language and approaches. The range of activities over the past year also attests to the perceived usefulness of the guidelines.[13]

On the other hand, resistance has also been identified:

- disagreement with the basic premise that MHPSS is an essential element of humanitarian response. This has been a common response among humanitarian decision makers, some of whom perceive this area as a secondary priority;
- substantial disagreements over the content of the guidelines – for example, some actors think that the guidelines should not have omitted population based mental health surveys as a minimum response (Lopes Cardozo, 2008); others like Yule (2008) believe the guidelines should have given more attention to trauma focused clinical psychological interventions, especially cognitive behaviour therapy[14];
- disagreements based on misunderstandings or misinterpretations of the guidelines; some experts had perceived that the guidelines warn against using existing, western, evidence based approaches for mental disorders. Yet, care for severe mental disorder (including care for severe

posttraumatic stress disorder (PTSD) and potential use of medications for a range of disorders) is part of minimum response as described in the guidelines;

- in quite a few cases, organisations claim to be working in a manner consistent with the guidelines, but then persist in using strategies inconsistent with them: for instance, conducting individualized therapeutic support after a natural disaster without first considering minimum responses, such facilitating community selfhelp and social support built upon community structures;
- resistance to the guidelines because of the threat they pose to well established approaches: e.g. widespread *'trauma counselling'* and psychological debriefing in Kenya;
- in other cases, local mental health professionals trained in western approaches have been extremely sceptical concerning the recommendations in the guidelines to explore engaging with traditional healers, for instance in Iran:

> *'A preliminary list of traditional healing practices were gathered from the 150 IASC trainees and are now open for discussion and cataloguing. Naturally we will not endorse those that have potential to do harm, or go against the guidelines, or risk harming children. But we have said that traditional healing can not be thrown out outright in view of claims that they are 'unscientific' . . . Yet, here many mental health professionals have a particularly strong attachment to Western clinical models. Overall traditional healing is a very important subject and must be further explored'.*
> *(Maziar Taleshi, UNICEF staff, Iran)'.*

Sustainable change

Due to the complexity of the field, and therefore the guidelines, it is important that the implementation is seen as a gradual, ongoing process. One of the lessons learnt from the Sri Lankan experience is that many actors find the guidelines overwhelming, and therefore, in many contexts it is important to begin with a summarized version and focus on using them as a framework and resource to address the challenges of MHPSS in a given situation. To address this issue, the Reference Group is working on the development of an illustrated field version of maximum twenty-five pages. (IASC, 2008). This publication will hopefully allow people to get a quick understanding of the main issues and possible interventions. The Reference Group is also working on compiling information on effective ways to use, train and orientate actors in the guidelines.

Some of the most promising uses of the guidelines are through an inter-agency, open and multi-stage process aimed at stimulating dialogue and shared reflection. In Peru, Iran and Nepal (process still underway) agencies have taken the time (up to 12 months) to implement the guidelines through adaptation to the local context, awareness raising with decision makers, capacity building of key agencies and operationalization.

Promoting ownership

A key challenge identified in many implementation initiatives is how to build ownership of the guidelines. The importance of building government ownership has been highlighted in many contexts (e.g. Colombia, Iran, Kenya, Philippines, and Sri Lanka). In addition, the importance of building ownership of them among communities and civil society is equally important, and has been highlighted in some implementation efforts (e.g. Peru). Strategies to strengthen ownership that have been used, or recommended, include seeking official government endorsement, using the guidelines to affect national

MHPSS policy, identifying and supporting local champions of the guidelines, or avoiding using the name IASC (as recommended in Peru). A one-year anniversary event is planned in New York to advocate for engagement of governments with them.

One of the most important ways to build ownership adopted by the Reference Group is to support a diverse range of locally lead initiatives on the guidelines. At the beginning, the Task Force had envisaged conducting 3-5 highly structured field based case studies using similar implementation methodologies, as well as supporting more informal initiatives. However, based on the problems involved in using a structured case study in Sri Lanka, and the practical difficulties of identifying other '*case studies*,' it was decided to adopt a more flexible approach. This involved identifying local champions and supporting them to design and manage locally led processes of implementation. This has resulted in the large number of diverse field based initiatives described above. While this has presented a challenge in coordination and quality control, it has arguably led to a greater number of sustained locally relevant initiatives on the guidelines. There is now a need to collate, learn from, and distil the lessons learnt in using the guidelines that promotes both local ownership, while ensuring cross fertilisation between different initiatives and avoiding common problems.

Coordination

One of the continuing challenges in implementation has been coordination among actors on the ground. Challenges have included: ensuring genuine partnership with local and international organizations; building consensus among key UN and NGOs working in particular countries to support the implementation of the guidelines; and bridging the traditional divide between clinical mental health approaches and those that work more on non clinical psychosocial approaches. Practice has also shown that one to key to success is to have a core group of committed organizations to lead the process together – ideally with people from both the Health and Protection sector (or Cluster) around the table, to integrate both mental health and psychosocial approaches. While this has been extremely difficult to achieve in many emergencies (e.g. Lebanon), in some emergencies this has been achieved. In Myanmar an inter-agency MHPSS group was established bringing together representatives of the protection, education and health clusters (among others) which uses the guidelines as a policy framework. Experience suggests that leadership plays a crucial role. If coordinator(s) of key sectors/clusters are committed, on a long term basis, to getting the right people around the table and open to involve all agencies working in the field of MHPSS, the guidelines appear to be more likely to be correctly understood and implemented at country level.

Sharing information

As noted above, one of the challenges presented by this flexible approach to implementation of the guidelines has been coordination and information sharing. Reference Group members have shared relevant information and tools though both formal (such as meetings, conference calls and group emails) and informal mechanisms (such as emails, and other forms of networking). This approach has limitations, as it is not open to all actors involved in the use of the guidelines, relies heavily on individuals to share information, tends to be very centralized (through the co chairs of the Reference Group) and can lead to duplication and a lack of cross fertilisation between initiatives in different countries. To address some of these limita-

tions, an online platform is being developed that can support this information sharing and networking among those involved in implementation. Case studies on the use of the guidelines have been done in Colombia (Echeverri & Castilla, 2008), Jordan (Horn & Strang, 2008a), Kenya (Horn & Strang, 2008b), Peru (Rivera et al., 2008), and Sri Lanka (IASC, 2007b), which are providing rich and detailed lessons learnt on implementation. The reference group is also planning to develop resource kits on training and orientation of the guidelines, coordination concerning using the guidelines, and institutionalisation of the guidelines within organisations.

Conclusion

The challenges facing the implementation of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* outlined above can only be overcome with ongoing and expanding partnership, effective documentation, sharing implementation strategies, and in particular mobilizing affected communities. The authors hope that this article will contribute to the ongoing reflection and constructive debate about how these guidelines can be most effectively used to improve the mental health and psychosocial wellbeing of people affected by emergencies.

References

Ager, A. (1997). Tensions in the psychosocial discourse: Implications for the planning of interventions with war-affected populations. *Development in Practice, 7*(4), 402-407.

Dash, S. & Christensen, L. (2008). Recent experiences and future challenges with implementation in South Asia: the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Intervention 6*(3): 323-326.

Echeverri, C. & Castilla, J. (2008). A case study in Colombia: Implementation of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Intervention 6*: 284-290.

Horn, R. & Strang, A. (2008a). A Jordanian case study: the implementation of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Intervention 6* (3): 291-293.

Horn, R. & Strang, A. (2008b). A Kenyan case study: the implementation of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Intervention 6* (3): 294-297.

Inter-Agency Standing Committee (IASC) (2007a). IA*SC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: Interagency Standing Committee *http://www.humanitarianinfo.org/iasc/content/products.*

Inter-Agency Standing Committee (IASC) (2007b). Support Lessons from Sri Lanka: Lessons Learned and Recommendations on Orientation Workshops and Field Testing the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva, IASC. Available at: *http://www.humanitarianinfo.org/iasc/mentalhealth.psychosocial.support.*

Inter-Agency Standing Committee (IASC) (2008). *Mental Health and Psychosocial Support: Checklist for Field Use*. Geneva, IASC. Available at: *http://www.humanitarianinfo.org/iasc/content/products.*

Lopes Cardozo, B. (2008). Guidelines need a more evidence-based approach. A commentary to the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Intervention 6* (3): 252-254.

Macara, M. & Malca, C. (2008). Implementation of the IASC Mental Health and Psychosocial

Support Guidelines after the August 15th earthquake emergency in Peru: Evaluation Report. Unpublished report submitted to Columbia University.

Prewitt Diaz, J. O. & Dayal de Prewitt, A. (2008). Words to Action: Pictorial contextualization of the *IASC MHPSS guidelines. Intervention 6* (3): 327-333.

Rivera, R., Pérez-Sales, P., Aparcana, J. L., Bazán, M., Gianella, C. & Lozano, A. (2008). Community mobilization after an earthquake in Peru: Case study of the use of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. *Intervention 6* (3): 275-283.

UNICEF-Iran (2007). Past, Present and Future Activities Related to IASC-MHPSS Guideline Roll-out. Brief Update. Unpublished document.

Ventevogel, P. (2008). Mental health and psychosocial support for displaced Iraqis in Jordan; a brief assessment of needs and services. Report prepared for WHO Jordan.

Weiss, M., Saraceno, B., Saxena, S. & Van Ommeren, M. (2003). Mental health in the aftermath of disasters: consensus and controversy. *J Nerv Ment Dis, 191*, 611-615.

Wessells, M. & van Ommeren, M. (2008). Developing the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. *Intervention 6* (3): 199-218.

Wheaton, W., Alumai, F. & Onyango, G. (2008). Training of trainers on mental health and psychosocial support in emergencies, Africa. *Intervention 6* (3): 298-303.

Yule, W. (2008). IASC Guidelines – generally welcome, but. . . *Intervention 6* (3): 248-251.

[1] See http://www.humanitarianinfo.org/iasc/content/default.asp.

[2] Available on IASC website (www.humanitarianinfo.org) and Humanitarian reform website (www.humanitarianreform.org).

[3] This was one of the key recommendations made in a meeting with donors during the Geneva launch.

[4] http://www.ineesite.org/.

[5] *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Nepal Case Study*, Work Plan 2007.

[6] Stakeholders' Consultative Workshop on Emergency Health Services for Survivors of Typhoons (2007) June Pagaduan Lopez, Portia Fernandez Marcelo, Rose Linda O. Bautista, and Michaela Maniebo.

[7] Personal communication, ACF representative to the IASC MHPSS Reference Group, 15 May 2008.

[8] World Federation for Mental Health. Forum on mental health and psychosocial support in emergency settings. August 28-29, 2008, King's College London.

[9] Disaster Mental Health Institute, 11th Annual Conference on Innovations in Disaster Psychology: IASC guidelines on MHPSS in emergency settings, Vermillion, SD, September 4-6 2008.

[10] Short Course for Mental Health in Complex Emergencies. London School of Hygiene & Tropical Medicine, IMC, HealthNet TPO and the Centre for International Health and Cooperation (CIHC), London, September 1-6 2008.

[11] Practice Oriented Course in Mental Health and Psychosocial Support in Post Conflict Settings. HealthNet TPO, War Trauma Foundation and Cogis. Soesterberg, the Netherlands, Oct 20-29th 2008.

[12] Training of Trainers (TOT) for Psychosocial and Mental Health Initiatives in Countries

Affected by War, Violence and Natural Disasters, January 11 – February 1, 2009, Arua, Uganda. Global Psycho-Social Initiatives (GSPI) of Kenya and Egypt, International Trauma Studies Program (ITSP), TPO Uganda.

[13] Insufficient information was available regarding community members perceptions of the usefulness of the guidelines.

[14] Cognitive behavioural therapy is a complex psychotherapeutic intervention that has a large evidence basis in high-income countries and a limited, yet slowly increasing, evidence basis in low income and and middle -income countries.

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