Who is Where, When, doing What: mapping services for mental health and psychosocial support in emergencies

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Mental health and psychosocial support (MHPSS) practitioners have, like other humanitarian aid providers, grappled with issues of coordination and associated problems, such as duplication of services, gaps in delivery and unmet needs. To combat this, a mapping tool has been developed to address the issues particular to MHPSS programming, both during and following an emergency. 'Who is Where, When, doing What' (4Ws) is a practical tool to assist the mapping of MHPSS interventions. This article provides a brief historical background and describes how the tool has been piloted in Jordan, Haiti, Nepal and Syria. Finally, the authors comment on two field reports on recent experiences with 4Ws mapping in Jordan and Libya, in this issue of Intervention.

Keywords: 4Ws mapping, emergencies, inter-agency coordination, mental health and psychosocial support services

Introduction

The launch of the *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings* (Inter-Agency Standing Committee (IASC), 2007) significantly contributed to a growing consensus on what actions are required to prevent and treat mental disorders, and to promote and preserve psychosocial wellbeing in populations impacted by natural disaster, or violent conflict (Wessells & van Ommeren, 2008). Despite this emerging consensus, considerable gaps remain between what should be done, and what is actually realised (Tol et al., 2011). Another major challenge in the chaotic aftermath of an emergency is the lack of coordination between stakeholders (Melville & Rakotomalala, 2008). For example, following the Tsunami in 2004, a large number of organisations rushed in to provide support, using significant amounts of funds raised from a shocked, and sympathetic public. The influx of humanitarian assistance was difficult to monitor given the complexity of logistics, poor coordination, competition among organisations, overlapping of projects, gaps in services, and individual initiatives. With similar concerns in mind, the development of an initial tool to assess MHPSS programmes on the ground was created by the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), in the aftermath of the Gaza crisis in 2009. In the case of Gaza, immediately after the crisis, many organisations were providing MHPSS support, the majority of whom used different terminology to describe what they were doing, as well as different approaches. There was no standardised way to map what different

MHPSS actors were doing. Existing mapping tools used in humanitarian emergencies did not have the scope nor language to accurately reflect these interventions. Moreover, MHPSS activities may simply be one aspect of broader programmes for health, child protection or education, and therefore do not fall under only one cluster in the humanitarian system. In response, the World Health Organization (WHO) and the United Nations High Commissioner for Refugees (UNHCR) initiated the development of a standardised tool to map MHPSS services in emergencies. The IASC MHPSS Reference Group endorsed the idea, and consulted their members during this process.

Drafting the 4Ws tool

The tool aims to document who is implementing what MHPSS activities, where the activities are taking place, and for what duration of time in the aftermath of a humanitarian emergency. In short: who is where, when, doing what. The specific activities are categorised within the framework of the *IASC Guidelines for MHPSS in Emergency Settings* (IASC, 2007). It enables actors to identify and respond to gaps in services and foster collaboration, coordination, referral and accountability. The mapping additionally provides the possibility for reflecting on patterns of practice and for learning lessons for future response. The results can also inform national plans for emergency preparedness, identify gaps in services, geographic and target group coverage, and the human resources and technical expertise necessary for effective programming. The tool is part of the new '*toolkit for assessing mental health and psychosocial needs and resources: toolkit for major humanitarian crises*' (WHO & UNHCR, in press), parts of which have been adapted by the IASC mental health and psychosocial support reference group in 2012. The tool uses a data spreadsheet to capture the collected data and facilitate analysis.

During the process of drafting the tool, several challenges emerged, including whether to map only '*good practices*', or also practices outside the range of international consensus. For example, in emergencies, the practice of '*single session debriefing*' is not recommended (IASC, 2007), but it does remain popular. Although there is a risk that mapping all practices may inadvertently provide credibility to discredited practices, the consensus among the consulted experts was that it was essential to map what is actually done without prior value judgements.

Experiences with 4Ws mapping: challenges and changes

The 4Ws tool was initially pilot tested in Jordan in 2009, and then subsequently also tested (and adapted) in Nepal (2009), Haiti (2010) and Syria (2011). Throughout this process, the tool was continuously revised and adjusted, and was ultimately transformed into a more useful tool in comparison to its original form. Below, we present case studies from each of the locations in which the tool was tested, and discuss lessons learned during the adaptation process.

Case Study: Jordan, 2009

In Jordan, the 4Ws tool was piloted by the International Medical Corps, in coordination with WHO and the National Center for Security and Crisis Management. The initial codes for MHPSS activities were revised in order to address inconsistencies, doubly entry, overlapping concepts, etc. It proved challenging to balance comprehensiveness with simplicity: having too many coding categories would decrease the utility of the tool, but on the other hand, the coding categories should be sufficiently specific to capture the essence of the activities. A main

issue here was the lack of common terminology to describe activities: for example, '*counselling*' is used by some organisations to describe long term, individual work with a trained counsellor, while others use it to describe group sessions with women or children facilitated by a social or community worker, and yet other organisations use it to indicate advising clients on psychosocial issues. The coding category for '*counselling*' initially did not include activities such as psycho-education, relaxation techniques, emotional support and problem solving counselling, which can all fall under the same concept. This created confusion, which resulted in double entries for each activity. Therefore a new set of codes was introduced, using two categories: '*psychological/psychiatric support*' and '*social support*', together with a code to capture general activities that impact over all MHPSS interventions. Beneficiary categorisation was also revised during the pilot in Jordan. The initial categorisation of target groups was broad, having an entry for '*general population*' and another for '*women*' and another for '*adults*'. This caused confusion and led to double entry of some target groups. Therefore, it was decided to omit the '*general population*' category and replace it with '*men*' and '*women*', and break down the '*children*' category into three age groups. In Jordan, after a week of data collection, a large workshop was organised for all agencies where the findings were presented for feedback and suggestions. This allowed participating agencies to see what was, and could be, done with the information and also prompted those whom had not responded, to provide information so they could be on the map.

Case Study: Nepal, 2009

In Nepal in 2009, during the piloting of the tool by TPO Nepal, UNICEF and WHO, it was felt that more information was needed on training, qualifications and supervision of service providers due to the presence of many types of counselling training in the country. During the piloting phase, a category to capture this was added. The changes made in the MHPSS codes in Jordan were retained in Nepal. Location codes were also included, in order to enable UNOCHA to enter the information into their larger database, which was also linked to Google maps.

Case Study: Haiti 2010

Following the earthquake in Haiti, UNICEF coordinated a 4Ws exercise. The initial low rate of participation was addressed through follow up visits, and by collecting data during MHPSS coordination meetings. This doubled the volume of information gathered in a three-week period. Another factor introduced early in the process to increase participation, was the production and distribution of a situation analysis for MHPSS, which included a gap analysis based on the *IASC Guidelines for MHPSS*. The resulting document was used for advocacy purposes. The findings of the assessment were perceived as a reliable source of information by other coordinating bodies (not related to MHPSS), which used the results in their own areas of work. In this way, the 4Ws tool was closely related to overall coordination efforts, and developed into a significant tool for a broader coordination of the humanitarian response.

Case Study: Syria, 2011

In Syria, WHO coordinated a 4Ws mapping in the first quarter of 2011, with the aim of collecting data on MHPSS services for displaced Iraqis. The tool was helpful in demonstrating the significant inequities in service delivery across different geographical areas. For example, there were minimal MHPSS services in the north east

of the country as well as limited services for particular groups, such as elderly populations. However, there was an abundance of '*structured recreational and creative activities*' in most areas. In Syria, several limitations of the current version of the 4Ws tool were identified. Firstly, the tool does not show how the various services were functionally linked to each other. For example, the collaboration between organisations, and the referral pathways that were developed among them, were not shown in the tool. Secondly, the introduction of the tool through the formal, larger coordination mechanisms for nongovernmental organisations (NGOs) and UN agencies led to an incomplete picture. This was a result of smaller, local NGOs and charities (often linked to religious institutions) being left out of the formal coordination mechanism in place. In fact, many of these local organisations provide important psychosocial services, particularly for smaller minority groups. However, it is only by the active efforts of the larger organisations that such initiatives could be identified and included in the mapping. Thirdly, it was difficult to collect reliable data on the use of (mental) health services by displaced Iraqis, because health services did not aggregate their data based on nationality.

Common challenges

A major challenge encountered in all four piloting exercises was how to encourage MHPSS actors to complete the mapping. Many organisations felt the exercise was too time consuming, or did not see its importance. In all contexts where the tool was piloted, it became apparent that some agencies completed the mapping tool using information based on what was planned in the proposal, as opposed to what was actually happening when the mapping was undertaken. This may have been in order to satisfy donors, or to appear in a more favourable light. Also, it was found that case managers and service providers preferred that the focus of the data collection be on the activities per location, and contact person for referral. However, for donors, the placement of organisations and their activities vis-à-vis the MHPSS pyramid was of a higher importance, in order to help them in programming and setting their funding priorities. When plotting the different activities in the IASC MHPSS pyramid, some agencies wanted their services reflected one tier higher. Many agencies felt that being higher on the pyramid meant being more '*professional*'. Without a clear guidance on the meaning of categorisation of activities, and training on the principles of the *IASC Guidelines*, some agencies may feel their expertise is being undervalued.

Recent experiences in Jordan and Libya

This issue of *Intervention* contains two field reports on the use of 4Ws tool in Jordan (Baca et al., 2012) and Libya (Fitzgerald, Elkaied & Weissbecker, 2012), illustrating how the tool was used in two very different contexts. In Libya, the tool was used in an acute and rapidly changing emergency situation that was overwhelming for the existing (and partially disintegrated), national services. In Jordan, a relatively stable country with good, basic services, the local population were not directly affected by an emergency situation, but the influx of refugees had led to an added complexity in MHPSS service delivery. In both settings, the tool proves useful in assessing who is where, when and doing what at a specific moment in time. The challenges faced by the mapping teams in Jordan and Libya were broadly similar in nature.

There are some important lessons learned which can be taken into account for future mappings. One particular cause of concern is the high level of human resources support needed to implement the mapping process. Substantial staff training is needed beforehand, and dedicated staff is required to follow up individual agencies and assist them in using the tool. Without this approach, it is doubtful whether the end product will be of acceptable quality. Both field reports also refer to the difficulty in finding reliable information on the amount, and nature, of MHPSS training needed for field staff to implement activities. This information would be useful to plan the resources needed when establishing or scaling up an MHPSS response after an emergency. One of the difficulties identified during the development of the tool, by both field situations mentioned in this edition, is the participating organisations' misconception that they were being *'judged'*. In particular, local organisations may be hesitant to participate out of fear that financial donors will use the data to evaluate the quality of programming, and base decisions in terms of funding on it. Therefore, it is of critical importance to emphasise that the tool is not meant as a means of evaluating programmes, but simply to identify gaps in service provision. Another interesting addition to the tool in Jordan was the inclusion of more detailed child protection questions. This resulted in a broader understanding of what was being provided, and also ensured that a separate mapping would not have to take place. It will be interesting to see if this is something which can be introduced, in future mappings in new emergency settings.

Conclusion

MHPSS coordination in the field has been traditionally challenging, and there is no consensus as to where MHPSS coordination should sit within the humanitarian system. The *IASC Guidelines* advocate for a single coordination body for mental health and psychosocial support, in order to ensure that affected populations receive the support they need (Wessells and van Ommeren, 2008). Whereas the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) does not recommend a separate coordination body. In the context of these challenges, the 4Ws tool can have an important function in documenting MHPSS activities, and facilitating coordination between actors. While there have been challenges in developing and using the tool, it appears to be a useful instrument to encourage collaboration between MHPSS actors, identify gaps and overlap in service delivery, develop a common language of implementation and programming, and strengthen the sense of community among MHPSS practitioners in the field. Ultimately, the mapping tool helps to ensure that communities affected by emergencies have the best chance of receiving the mental health and psychosocial support they need.

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References

Baca, M. J., Fayyad, K., Marini, A., Weissbecker, I. (2012). The development of a comprehensive mapping service for mental health and

psychosocial support in Jordan. *Intervention, 10,* this issue.

Fitzgerald, C., Elkaied, A., Weissbecker, I. (2012). Mapping of mental health and psychosocial support in post conflict Libya. *Intervention, 10,* this issue.

IASC (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: Inter-Agency Standing Committee.

Melville, A. & Rakotomalala, S. (2008). After the guidelines: the challenge of implementation. *Intervention, 6,* 338-347.

Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., Golaz, A. & van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: linking practice and research. *Lancet, 378,* 1581-1591.

Wessells, M. & van Ommeren, M. (2008). Developing inter-agency guidelines on mental health and psychosocial support in emergency settings. *Intervention, 6,* 199-218.

WHO & UNHCR (in press). *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Crises.* Geneva: World Health Organization and United Nations High Commissioner for Refugees.

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