IASC Inter-Agency Standing Committee

Handbook

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT COORDINATION

IASC MHPSS Reference Group

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HANDBOOK

OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) COORDINATION

IASC Inter-Agency Standing Committee

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TRANSLATIONS

The Reference Group itself will coordinate translations into Arabic, Chinese, French, Russian and Spanish. Contact the IASC Reference Group for Mental Health and Psychosocial Support (MHPSS) (mhpss.refgroup@gmail.com) for coordination of translations in other languages. All completed translations will be posted on the IASC Reference Group for MHPSS website. If you create a translation or an adaptation of this work, kindly note that:

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HOW WAS THIS HANDBOOK DEVELOPED?

Beginning in November 2020

Desk review of existing coordination handbooks
11 handbooks reviewed: e.g. protection, child protection, WASH, Shelter, Gender-Based Violence

Key informant interviews with MHPSS experts

Iterative consultations with MHPSS TWG co-chairs and IASC MHPSS RG experts
February 2021
May 2021
October 2021

Full document review, feedback and revision
Two "targeted" reviews by experts on specific topics
Two full reviews by IASC MHPSS RG, clusters and international actors

Four dedicated review dicussions with MHPSS Technical Working Groups
Myanmar, North-East Nigeria, Ukraine and Trinidad and Tobago TWGs

Ongoing consultations on specific aspects of the handbook
E.g. key actions for MHPSS in public health emergencies

TABLE OF CONTENTS

ABBREVIATIONS

AoR	Area of Responsibility
CBO	Community-based organization
CCCM	Camp coordination and camp management
CP	Child protection
CSO	Civil society organization
DRR	Disaster risk reduction
GBV	Gender-based violence
HNO	Humanitarian needs overview
HPC	Humanitarian programme cycle
HRP	Humanitarian Response Plan
IASC	Inter-Agency standing committee
ICCG	Inter-Cluster coordination group
IEC	Information, education and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International non-governmental organization
M&E	Monitoring and evaluation
MH	Mental health
MHPSS	Mental health and psychosocial support
MNS	Mental, neurological and substance use
MoV	Means of verification
MSP	Minimum Service Package
NGO	Non-governmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
PFA	Psychological first aid
SOPs	Standard operating procedures
SPRP	Strategic Preparedness and Response Plan
TWG	Technical working group
UN	United Nations
WASH	Water, sanitation and hygiene
WHO	World Health Organization

HANDBOOK OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) COORDINATION

Chapter 1

INTRODUCTION

During and after an emergency, many local, national and sometimes international actors respond to support those in need. In many cases, this aid is crucial and can save lives, reduce suffering and maintain dignity. However, when it is poorly planned, un-coordinated and designed without the participation of local communities,, aid can also lead to harmful outcomes. Therefore, it is essential that the different actors, each responding to the same crisis with their own mandates, missions, interests and working languages, organize their efforts. This **coordination is of critical importance** because it prevents confusion and conflict, reduces duplication and harmful gaps and supports the efficient use of scarce resources. In short, it can truly save lives. Therefore, **coordination is not a goal. Instead, it is a process** of collaboration to improve the quality and accountability of a humanitarian response.

Why is coordination important?

All over the world, people are affected by crises – public health emergencies, socio-environmental hazards, conflicts, large-scale accidents. There are differences in how people and communities react to these experiences, as well as differences in their need for support.

Mental health and psychosocial support (MHPSS)

Historically, "mental health" was often overseen by the health sector while "psychosocial support" was often overseen by protection actors. Considerable advocacy has been essential in redefining MHPSS as a cross-sectoral area of work for all humanitarian sectors.

The 2007 IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings were key to enabling this advocacy by establishing the consensus-based composite term "mental health and psychosocial support". The global humanitarian system now uses this term to unite a broad range of actors to provide appropriate support in both mental health and psychosocial support and to demonstrate how these approaches complement one another.

The inclusion of MHPSS as a cross-cutting area in the most recent iteration of the Sphere Handbook (2018) further highlights the need for diverse approaches across sectors.

MHPSS
is a term used to describe "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental health condition" (IASC, 2007).

Defining common terminology: MHPSS Technical Working Groups and Co-Chairs

Throughout this handbook, the term MHPSS Technical Working Group (TWG)[1] is used to represent the diversity of MHPSS coordination structures, while the term "co-chair" is used to refer to the persons facilitating the work of these groups.

There are multiple ways in which MHPSS coordination structures have been established and named, including MHPSS (Technical) Working Group, Coordination Group, Advocacy Group, Task Force, Coordination Forum, and MHPSS Network or Network Group. Similarly, there are various terms used to refer to the actors facilitating these groups, including MHPSS TWG facilitators, leads, stewards or coordinators.

In complex humanitarian settings, aligning language is key to promoting collaboration.

In fact, where relations among different agencies or among agencies and government are sensitive, The naming and description of these mechanisms can be essential to easing tension, or can sometimes intensify disagreement. For example, the label "MHPSS Technical Working Group" can evoke an intended sense of partnership and collaboration, rather than one of competition or power dynamics. The same is also true of the label given to the person or people facilitating these groups: "coordinator" may imply a sense of unintended hierarchy while "co-chair" may be more likely to indicate the intended role of the person as a facilitator of the group, one among equals.

"Co" is included because it is recommended that the role be shared among two or more persons (i.e. co-chairs), and possibly rotated at regular intervals.

Thus, while in many contexts a single person is tasked with the role, the term co-chair is used in this handbook to reflect this recommendation.

Please note:
An appropriate translation of these terms based on their intention, rather than an exact translation, is strongly encouraged. It is important to ensure that this is a participatory process and that the terminology accurately reflects this intention in the local context.

Overall goal:
to reduce suffering and improve mental health and psychosocial well-being

Humanitarian MHPSS coordination at its best:

- brings together diverse actors, with local humanitarian leadership and knowledge at the centre
- ensures a coherent, principled and sustainable response.

It results in:

- greater predictability, comprehensiveness and success of the response
- identification and filling of gaps in the response
- accountability to affected persons and communities
- equitable and effective collaboration to meet their needs.

Many factors can be a barrier to coordination and can lead to ineffective, inefficient, duplicative and potentially harmful outcomes, including

- limited funding
- differing agendas and time constraints
- structural challenges that lead to division and competition
- narrowly defined sectors and the risk of some being forgotten or ignored entirely
- the existence of separate coordination groups for mental health and psychosocial support
- linking MHPSS to only one sector or cluster.

1 The term "MHPSS TWG" was identified as the agreed term for MHPSS coordination platforms during a high-level meeting among humanitarian actors in London (2017). *"In settings where clusters are activated, these groups are often referred to as "working groups", for example as described in IASC. (2021). Leadership in Humanitarian Action: Handbook for the Resident and Humanitarian Coordinator, while "Technical Working Groups" are otherwise defined as small, task oriented, time limited and created on a needs-basis (e.g., agreeing to minimum standards) and should be dissolved once they have completed their tasks. In these settings, the term "Working Group" may be more appropriate to describe the MHPSS Coordination structures."*

Ensuring MHPSS Coordination: recommendations from the humanitarian system

A number of calls have been made to establish MHPSS TWGs to facilitate coordination.

- **IASC (2021). Leadership in Humanitarian Action:** Handbook for the Resident and Humanitarian Coordinator
- **UN General Assembly Economic and Social Council (2021).** Strengthening of the coordination of emergency humanitarian assistance of the United Nations: Report of the Secretary-General, 2021 (A/76/74-E/2021/54)
- **IASC (2020).** Joint Inter-agency Call for Action on MHPSS
- **IASC Principals** Meeting, 5 December 2019
- Rebuilding Lives – Addressing Needs, Scaling Up and Increasing Long-term Structural MHPSS Interventions in Protracted and Post-Conflict Settings: **Expert Meeting, Berlin, 2018**
- **WHO, UNICEF, UNHCR and UNFPA. Minimum Services Package for MHPSS (MHPSS MSP)**
- **The IASC (2007)** Guidelines on MHPSS in Emergency Settings.

What is the purpose of this handbook?

There is growing consensus around the need for appropriate MHPSS coordination and there are many strong examples of effective MHPSS coordination in emergency settings around the world.

This handbook outlines consensus-based guidance for members and facilitators of MHPSS TWGs and actors working at country level. It identifies the ingredients for effective coordination by building on good practices from past emergencies and provides tools and useful resources.

It contains:
- a description of common coordination structures
- an outline of foundational skills and characteristics
- a set of core actions for MHPSS TWGs across settings.

It assumes that the reader is beginning with a basic knowledge of the IASC MHPSS Guidelines (2007). **It also emphasizes the central role of local actors and affected people, who must be actively identified and engaged** (see box below). While the handbook is specifically targeted towards country-level actors, it may also be useful at the regional or headquarters level for organizations supporting or facilitating MHPSS TWGs in countries where they operate. It can also be useful in supporting advocacy by highlighting gaps in a response and providing avenues to demonstrate the impact of coordination activities.

THE PRINCIPLE OF LOCAL AGENCY

For mental health and well-being, the involvement of affected persons is as important as the services and supports provided.

This handbook emphasizes community-based approaches to MHPSS,[1] including in MHPSS coordination. It recognizes that local communities can and should be leaders in their own recovery. Too often, local actors are excluded from decision-making processes in favour of large, well-funded international humanitarian organizations. When external actors are involved, they must understand and respect this principle and work to support and build on what already exists locally.

This includes relying on the strengths of local actors, including those not affiliated with formal organizations or regularly active in humanitarian response (e.g. local religious institutions, village committees, informal community groups).

1 For more information, please see: IASC Reference Group on MHPSS (2019). Community-based approaches to MHPSS Programmes: A Guidance Note. https://reliefweb.int/report/world/community-based-approaches-mhpss-programmes-guidance-note

How should this handbook be used?

Because of the variation across and within humanitarian settings, this handbook is not intended to be read "cover to cover". Instead, it may be navigated based on the reader's experience, setting, needs and priorities. Keep in mind that it is intended to be descriptive rather than prescriptive, and that adaptation is crucial. Additionally, the handbook is linked with, but does not replace, existing MHPSS guidance, tools and resources. Where relevant, links to these resources are provided.

WHAT THIS HANDBOOK IS...	WHAT THIS HANDBOOK IS NOT!
✓ A descriptive guide, based on lessons learned	✗ A set of prescriptive rules on how a TWG and its members (e.g. co-chairs) should be established across settings
✓ A brief, easy-to-read handbook	✗ An exhaustive resource on how to address all challenges in the humanitarian system or within the MHPSS field
✓ A handbook informed by existing guidance	✗ A replacement for existing guidance
✓ An explanation of what factors facilitate effective MHPSS coordination, including possible steps to take to achieve this	✗ A "step-by-step" guide for MHPSS programming or coordination in every setting
✓ A resource for MHPSS coordination at country or local level	✗ A guide to coordination across regions or at the global level

The need for contextualization and cultural adaptation

Throughout this handbook, multiple actions are recommended to promote better coordination. While the handbook was written to describe these actions based on possible steps, **it must be understood that each setting is different in terms of needs, resources, capacities and stakeholders.** As a result, while the standards and principles described in this handbook are applicable across many settings, certain actions may be relevant in some settings but less relevant in others. **Therefore, the guidance outlined in this handbook must be considered with context in mind and must be adapted accordingly. Any adaptation should be done in collaboration with affected community members and relying on national and local expertise.**

WHAT ABOUT THE READER?

Working in humanitarian settings can be extremely stressful. Promoting staff and volunteer care, including through MHPSS TWG activities, is crucial. Though this handbook does not specifically address how to implement approaches to staff and volunteer care,[1] it does attempt to recognize the role of MHPSS coordination structures in doing this. Also included throughout the handbook are illustrations of simple strategies to promote self-care for the reader.[2] These reminders may be useful in managing stress among those working to promote better coordination and using this handbook.

1 For guidance on implementing strategies for staff and volunteer care, please see: (forthcoming). Guidance note on mental health and psychosocial care for national staff and volunteers in humanitarian settings.

2 Additional simple strategies for self-care can be found in: Plan International. Self-Care: Manual for humanitarian aid & development workers. https://plan-international.org/publications/self-care-manual-humanitarian-aid-development-workers

Chapter 2

OVERVIEW OF MHPSS IN THE HUMANITARIAN SYSTEM

What are the common humanitarian coordination structures?

A key initial step in ensuring that MHPSS responses are well coordinated, integrated and prioritized is to identify and link with active coordination structures in a given setting. Although there are many approaches to coordination, five common examples are highlighted below. For a more detailed overview of the most common coordination structures and their components, please see Annex 1.

How do I know what structures are active in my setting?

National coordination
National or governmental coordination structures can vary greatly from country to country.
Identifying national approaches will require discussion with government officials and other actors.

Cluster coordination[1]
Clusters are formally activated, in consultation with national governments.[2]
To identify if a cluster is active in a country, please visit OCHA's operations webpage.

Refugee coordination[3]
The United Nations High Commissioner for Refugees (UNHCR) facilitates coordination in refugee settings.
For a list of settings where UNHCR is currently active, please visit the UNHCR webpage.

Public health emergencies
The World Health Organization (WHO) tracks global public health events, communicates early warning of risks and activates incident management systems to coordinate response efforts when necessary.
To track global public health events, please visit WHO's global surveillance system.

Area-based coordination[4]
Area-based coordination has been implemented in many settings but varies by country and context.
To engage with area-based coordination, identify the local systems and engage with local leaders.

1 For more on the cluster approach, please visit: https://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach
2 For more information on cluster activation, please visit: https://www.humanitarianresponse.info/en/coordination/clusters/activation-and-deactivation-clusters
3 For more on refugee and mixed coordination, please visit: https://emergency.unhcr.org/entry/38270/refugee-coordination-model-rcm
4 For more information on area-based coordination, please visit: https://reliefweb.int/sites/reliefweb.int/files/resources/inclusive-coordination-konyndyk-saez-worden.pdf

MHPSS IN PHE RESPONSE

During public health emergencies (PHEs), MHPSS is relevant across several pillars of response (see Annex 2) and in some cases it may also be viewed as a specific pillar in its own right, while linked to others as being cross-cutting.

The value of MHPSS within PHE response has been increasingly recognized, particularly during the COVID-19 pandemic.

During the Seventy-fourth World Health Assembly, held in May 2021, governments emphasized the need to develop and strengthen MHPSS services as part of strengthening preparedness, response and resilience to COVID-19 and future PHEs. Within the COVID-19 'Strategic Preparedness and Response Plan (SPRP), MHPSS is integrated in several pillars, including case management, infection control measures, risk communication and community engagement, safe and dignified funeral rites, and maintaining safe and accessible essential health services.

This key role of MHPSS has been emphasized with the creation of an indicator measuring the "percentage of countries with multi-sectoral MHPSS TWGs".

Where does MHPSS "fit" and what is the purpose of MHPSS TWGs?

Because MHPSS is cross-sectoral, the challenge is to ensure that it is emphasized within sectors while also ensuring coordination across them. This can be particularly difficult because each sector may have its own technical approach to MHPSS (see Annex 3 for guidance on MHPSS in different sectors). To meet this challenge, MHPSS TWGs are thus ideally forums that work together to unite approaches (see the humanitarian programme cycle on page 7).

Generic MHPSS coordination structure within the humanitarian cluster system at country level

Humanitarian coordination / government leader

Inter-cluster Coordination Group

Health cluster

Protection cluster (with Child Protection, Gender-Based Violence (GBV) and Mine Action)

Education, Nutrition, Camp Coordination and Camp Management, and many other clusters

MHPSS Technical Working Groups
(with focal points in each of the clusters and with accountability in clusters, MHPSS activities to appear as relevant within Appeal chapters, rather than in a separate stand-alone Appeal chapter)

Reproduced from Harrison et al., 2021.

THE HUMANITARIAN PROGRAMME CYCLE (HPC):[1]
COORDINATION OF RESPONSE IN CLUSTER SETTINGS

The HPC is a series of coordinated actions:
1. needs assessment and analysis
2. strategic response planning
3. resource mobilization
4. implementation and monitoring
5. review and evaluation.

It is used to producethe **humanitarian needs overview (HNO)**, a key output of needs assessments in the country.

It is used to develop the **Humanitarian Response Plan (HRP):** an overview of response objectives and priorities by cluster in the country. Each cluster or AoR formulates its own section.

All HNOs and HRPs feed into the **global humanitarian needs overviews and response plans (GHNOs, GHRPs)** produced by OCHA. These are crucial products for ensuring thatMHPSS is comprehensively provided in cluster settings.

History and purpose of the IASC MHPSS Guidelines and Reference Group

In 2007, the IASC Guidelines on MHPSS in Emergency Settings were published. **They were a cornerstone of the MHPSS field and a major step forward in consensus-building.**[2]

What are the IASC MHPSS Guidelines?
An inter-agency consensus-based resource to help to plan, establish and coordinate a set of minimum multi-sectoral MHPSS responses.

They also include a set of foundational principles, including a consensus-based definition for MHPSS (see page 2), dos and don'ts, a clear articulation of how mental health and psychosocial support practices complement rather than contradict one another and a comprehensive set of guidelines from which a series of accompanying tools and guidance have been developed.

Who was involved?
Developed through an inclusive process, with input from UN agencies and NGOs across sectors of humanitarian action.

Later, the IASC MHPSS RG was formed to disseminate the IASC MHPSS Guidelines to develop further guidance on various aspects of MHPSS.[3]

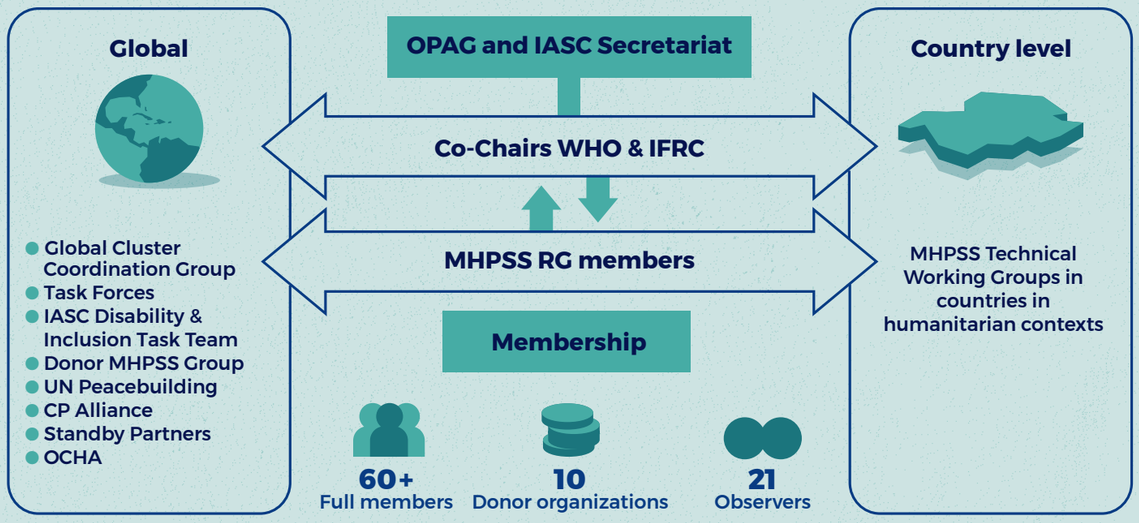
What is the IASC MHPSS RG?
A unique collaboration of 60 + members, including. UN agencies, NGOs, the International Red Cross and Red Crescent Movement, academic partners and other international agencies working with clusters and with the IASC Secretariat and Operational Policy and Advocacy Group (OPAG) to integrate MHPSS across sectors and to advocate with donors and the humanitarian system.

The IASC MHPSS RG also supports MHPSS Technical Working Groups at country level through technical support calls and missions, surge support and guidance for specific emergencies or on specific thematic areas of MHPSS (for examples of COVID-19 resoucres, see page 9).

1 For information on the humanitarian programme cycle, please visit: https://www.humanitarianresponse.info/en/programme-cycle/space

2 For more information on the IASC Guidelines on MHPSS, please visit: https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings-0/documents-public/iasc-guidelines-mental

3 To see a full list of IASC MHPSS RG tools and guidance, please visit: https://interagencystandingcommittee.org/iasc-reference-group-on-mental-health-and-psychosocial-support-in-emergency-settings



Structure and numbers as per December 2022.

MHPSS Surge Support

Surge support mechanisms can increase MHPSS capacity at country level by deploying MHPSS experts. For example, the Dutch Surge Support (DSS) rapid deployment mechanism[1] maintains a global roster of MHPSS experts who are often deployed in short-term roles to facilitate the establishment (or boost the capacity) of MHPSS TWGs and overall MHPSS coordination. The DSS mechanism is implemented in collaboration with the IASC MHPSS RG. Contact: mhpss@rvo.nl

IASC MHPSS RESOURCES FOR COVID-19

During the COVID-19 pandemic, the IASC MHPSS RG has released many MHPSS resources to support the response. Many of these resources have been adapted in accessible formats, including Braille and Easy-to-Read.

- Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak
- Basic Psychosocial Skills: A Guide for COVID-19 Responders
- Living with the Times: An MHPSS Toolkit for Older Adults During the COVID-19 Pandemic
- My Hero is You. How kids can fight COVID-19!
- Operational Considerations for Multisectoral MHPSS Programmes during the COVID-19 Pandemic
- Actions for Heroes: A guide for heart-to-heart chats with children to accompany reading of My Hero is You!
- A webinar on the Basic Psychosocial Support Guide and skills part 1, part 2, part 3.
- Accessible Word files for these documents are available upon request: mhpss.refgroup@gmail.com

1 For more information on DSS, please visit: https://english.rvo.nl/subsidies-programmes/mental-health-and-psychosocial-support-humanitarian-emergencies-dss-mhpss

Chapter 3

FOUNDATIONAL ELEMENTS OF MHPSS COORDINATION

What are the foundational principles for MHPSS?[1]

All MHPSS activities, and their coordination, should be grounded in a set of core principles established by the IASC (2007) Guidelines on MHPSS in Emergency Settings. These are:

1. **Human rights and equity** should be promoted for all affected persons, and those at heightened risk of human rights violations should be protected.

2. **Participation** of local affected populations, national authorities and other local actors in all aspects of humanitarian response should be fully promoted.

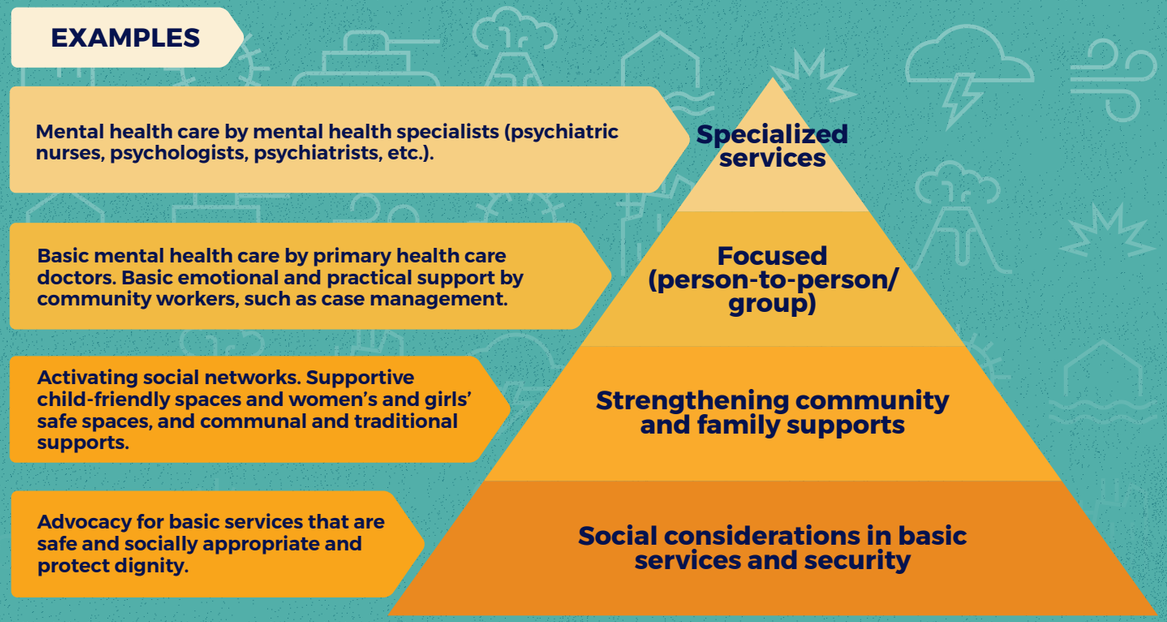
3. **Do no harm** to affected persons through the support provided.[2]

4. **Build on available resources and capacities** by engaging and working with local groups, supporting self-help and autonomy and building on existing resources.

5. **Integrate support systems** so that MHPSS is not a stand-alone programme operating outside other programming. Integrated services reach more people, are more sustainable and carry less stigma.

6. **Multi-layered supports** are crucial and acknowledge that people affected by crises respond in different ways and require different kinds of support (demonstrated in the pyramid below).

EXAMPLES



1 It is important to also consider foundational humanitarian principles, such as the Core Humanitarian Standard, Protection Mainstreaming Principles and others, through MHPSS coordination.

2 Several resources exist for assessing risk for harm, for example please see: CDA Collaborative Learning Projects (CDA) (2004) The "Do No Harm" Framework for Analysing the Impact of Assistance on Conflict: A Handbook. https://www.cdacollaborative.org/publication/the-do-no-harm-framework-for-analyzing-the-impact-of-assistance-on-conflict-a-handbook/

What are the foundations of an effective MHPSS TWG?

MHPSS TWG members and co-chairs have identified several key qualities that lead to better coordination between members

CO-CHAIRING THE TWG: KEY FACTORS FOR SUCCESS

- **Allocated time:** Co-chairing a TWG is a full-time position. Those appointed to the role should be prepared to fully allocate their time to the position.

- **Accountable to the TWG:** While co-chairs may be contracted by an agency, they should be accountable to the TWG.

- **Competency and experience:** Co-chairing requires a wide range of knowledge and competence in MHPSS. Past experience in MHPSS activities is also key for promoting buy-in from the group.

- **Operational in nature:** While TWGs are ideally broadly inclusive groups, they should be co-chaired by agencies with an operational nature and focus.

- **Sharing the role:** Optimally, **TWGs are facilitated** by two co-chairs with equal roles, responsibilities and influence.

- **Localization:** Ideally, at least one TWG co-chair is a local staff member.

- **Linked with the IASC MHPSS RG:** TWG co-chairs can seek support from and also contribute to the IASC MHPSS RG and its co-chairs.

Do's for an effective MHPSS TWG	Don'ts
✓ Promote an open and collaborative environment	✗ Dictate or dominate the agenda or act alone
✓ Be transparent in communications and actions	✗ Mislead or misrepresent information or actions
✓ Keep tasks and expectations reasonable	✗ Commit to unrealistic expectations
✓ Promote local and national participation and ownership through power sharing and inclusivity	✗ Exclude or bypass national authorities or actors, or foster dependency on international aid
✓ Emphasize and benefit from the capacity of the group	✗ Emphasize a single agency or individual agencies
✓ Consult local actors and emphasize community views	✗ Assume that one knows it all
✓ Actively engage in cultural awareness and adaptation	✗ Assume that global guidance doesn't require adaptation
✓ Remain impartial and focus on collective success	✗ Serve the interests of only a single agency or person
✓ Plan for the group's long-term sustainability	✗ Focus only on the immediate or assume sustainability
✓ Be respectful of time and purpose	✗ Waste time or "meet just to meet"
✓ Ensure good practices and disseminate guidance	✗ Assume that all humanitarian aid is helpful
✓ Attend to, correct and learn from practices that inadvertently cause harm	✗ Overlook potentially harmful practices
✓ Promote self-care and well-being of staff	✗ Assume that burnout will not be a factor
✓ Allocate adequate time and resources to TWG functions	✗ Assume TWG responsibilities without reducing workloads (e.g. co-chairs struggling to "double-hat")
✓ Be creative and willing to try new approaches (informed by evidence and in line with foundational principles)	✗ Fail to adapt or innovate in response to new needs or challenges

Collaborative leadership:[1] bringing different perspectives together to develop a shared approach

In MHPSS TWGs, facilitating collaborative leadership among TWG members is key. This is particularly supportive in settings where co-chairs are expected to fill multiple roles and responsibilities (i.e. double-hatting). However, this is not a simple process and requires ongoing attention and effort from all stakeholders.

1 For more information on effective leadership, please see: Knox Clarke, P. (2013). Who's in charge here? A literature review on approaches to leadership in humanitarian operations. ALNAP/ODI: London. https://www.alnap.org/help-library/whos-in-charge-here-a-literature-review-of-approaches-to-leadership-in-humanitarian

Tips and strategies for building collaborative leadership

- **Build relationships among group members:** What are their strengths? What about preferences for learning and working? Remember that all collaboration is facilitated through relationships.
- **Develop clear roles and responsibilities:** Are expectations clear? To whom are the group and its members accountable? Ensuring clarity in roles and responsibilities promotes collaboration.
- **Attend to group dynamics and power relations:** Why do organizations join the group? What are the benefits? Understanding these motivations will help identify group dynamics and motivations.
- **Be sensitive to group norms:** What does the group expect to happen? What are the implied rules? Group norms can greatly affect the functioning of the group.
- **Understand pressures on individuals to conform:** Are group members expected to agree or think similarly? Conformity can be helpful or problematic, depending on the situation.
- **Harness group cohesiveness:** What factors help the group work well together? Emphasize how group members benefit from working toward shared goals, including agreed terms of reference (ToRs), workplans or other strategic tasks.
- **Be clear and transparent about decision-making processes:** Do all members understand how decisions are made? Is information equally accessible to all? Transparency can strengthen trust in group processes and outcomes.
- **Share decision-making:** Do group members feel a sense of collective ownership over decisions? Collaboration is promoted when decision-making power is shared from the beginning.
- **Instil a focus on the overall response:** Do members prioritize the overall response, or the agenda of their own organization? Multiple or divergent agendas can be a major barrier to collaboration.
- **Seek input from each stakeholder:** Do any members seem excluded, including relevant actors not yet at the table? Does a certain agency dominate? Be sensitive to those who feel overshadowed and encourage participation.

BUILDING CONSENSUS[1]

Understanding when it is important to build consensus around a decision is key to facilitating an effective MHPSS TWG. Consensus brings collective ownership and leads to more active engagement. However, reaching a consensus is complicated and time-consuming and can be difficult when there is a serious conflict. **The IASC Guidelines (2007) can be a starting point for consensus, given their wide inter-agency endorsement.** However, in many situations, further consideration will be needed and, in some cases, it may be necessary to proceed without consensus. However, this has the potential to affect cooperation and relationships.

Consensus is ideal when:	Consensus may not be necessary when:
There are conflicting views, but unity is required **Example:** Agencies disagree about the workplan	**Inter-agency standards are compromised by consensus** **Example:** A harmful practice is popular among actors
Collective buy-in is needed **Example:** Designing a shared workplan	**The problem is clear and solutions obvious** **Example:** A TWG meeting needs to be cancelled because several agencies cannot attend
The way forward is unclear **Example:** Confronting a unique challenge	**Solutions are very limited** **Example:** Funding is available only for a specific activity
Solutions require collaboration and participation **Example:** Completing a mapping exercise	**There is not enough time to reach consensus** **Example:** The situation requires action now
The group is small and members understand one another **Example:** The group is cohesive and functions well	**Another decision-making process is more effective** **Example:** Views are so split that consensus is impossible

POSSIBLE STEPS TO BUILDING CONSENSUS

Possible Steps	Details	Role of MHPSS TWG co-chair
1 Agree on the objective(s)	All parties must agree on the goal(s).	• Facilitate the development of shared goals. • Identify shared interests that may underlie differing perspectives.
2 Define the problem	Identify the barriers that stand in the way.	• Take a flexible, problem-solving approach. • Facilitate the identification of problems.
3 Brainstorm solutions	Brainstorming involves creating a list of possible solutions.	• Facilitate the creation of a list of solutions. • Remain open-minded and focus on areas or "zones" of agreement.
4 Discuss pros and cons, narrow the list	Evaluate the potential solutions and reduce the list to realistic options.	• Facilitate the identification of pros and cons. • Be transparent. **TIP:** If power dynamics or excessive attention to individual agency mandates are a clear barrier, it can be useful to invite colleagues to "take off their agency hats" for a short time to problem-solve.
5 Adjust and compromise	Compromise will be needed to reach a result that the group can accept. Sometimes, consensus may not be possible when a group is sharply divided, and it may be necessary to temporarily "let go" of trying for consensus.	• Remain impartial, use active listening skills. • Test for agreement by summarizing ideas and asking for a vote. **TIP:** Groups can waste time talking "around" ideas they mostly agree on. Check levels of disagreement (i.e. "I cannot agree to this" vs "I don't like this, but I can go along with it"). **TIP:** While consensus is important, co-chairs should recognize when groups are clearly divided and accept that consensus may emerge later.
6 Decide	Decision-making should be a shared process and should not be dictated. It can follow a standard agreed process (e.g. majority vote).	• Facilitate a shared decision-making process. • Discuss the implications. **TIP:** In cases where views differ but there is potential for consensus, it can be useful to extend the decision-making process over multiple meetings. Additional time allows ideas to settle and tempers to cool, while also enabling one-on-one discussions.
7 Act	MHPSS is recognized as a cross-cutting priority for action.	• Event reports. • Pre-post surveys. • Stakeholder plans/budgets.
8 Monitor & evaluate	Always assess the decision's impact and effectivenes.	• Facilitate monitoring and evaluation (M&E). • Revisit the decision, if necessary.

1 Adapted from The The Global Nutrition Cluster (2013). Nutrition Cluster Handbook: A practical guide for country-level action. https://reliefweb.int/report/world/nutrition-cluster-handbook-practical-guide-country-level-action

Addressing common challenges

Despite the variation across and within emergency settings, multiple challenges are common across settings. Potential solutions have been identified in consultation with MHPSS TWG members.

CHALLENGES AND POTENTIAL SOLUTIONS

Challenge	Potential solution
MHPSS is not being prioritized	• Clarify and streamline advocacy messages, based on identified needs. • Engage TWG members to advocate for MHPSS in their networks of influence. • Invite focal persons from other areas of work or coordination groups (e.g. health, education, protection) to join the TWG, and vice versa. • Organize a donor or partner briefing or orientation workshop.
Multiple MHPSS TWGs exist, without coordination	• Try to understand why there are multiple groups and address these factors where possible (e.g. lack of awareness, lack of political will, differences in approach). • Develop a steering committee with equal representation from different working groups to coordinate collective efforts.
The number of members limits productivity	• Establish sub-working groups to focus on specific issues and recommend actions to the larger MHPSS TWG. • Differentiate between the MHPSS TWG and larger networks of MHPSS actors. • Request that agencies delegate a single representative to the TWG.
Mental health and psychosocial support are viewed as being separate	• Use the complementary nature of MHPSS to emphasize the need for a single, unified TWG to better coordinate across the layers of MHPSS intervention (see the mental health intervention pyramid on page 9). • Work to mainstream the IASC Guidelines and the complementary nature of different MHPSS activities (e.g. the MHPSS intervention pyramid). • Identify and engage champions respected by all parties to build unity. • Develop sub-working groups focused on improving integration.
Expectations do not match reality	• Develop ways of working that are tied to practical concrete actions and resources. • Assign tasks to specific members, with timelines included.
Members are not engaged	• Collaborate with partners and invite them to present or lead on preferred subjects. • Share responsibility; rotate meeting chairs, venues or the focus of agendas. • Discuss lack of engagement openly to identify solutions.
Decision-makers are not attending meetings	• Clearly indicate when decisions will need to be made to promote attendance. • Set deadlines for decisions to be taken. • Require representatives to have the capacity to make decisions for agencies to be represented in the TWG.
Difficulty collecting information from TWG members	• Engage one-on-one and build relationships. • Make the working group an open space to informally discuss challenges and successes. • Where relevant, work across the cluster system with different information management units.
Funding is limited or narrowly earmarked	• Identify a set of common goals to inform resource mobilization. • Advocate for agencies to include budget lines to support MHPSS TWG activities.
No local agency is willing to co-chair	• Ask a local organization to "shadow" the co-chair, and demonstrate the benefit of doing this. • Develop a plan to support capacity development and the transfer of responsibilities.

Challenge	Potential solution
There is competition rather than collaboration	• Develop clear roles and responsibilities for agencies that focus on the overall effectiveness of the collective response. • When necessary, seek support in negotiation from high-level decision-makers. • Request technical support and guidance (e.g. from the IASC MHPSS RG).
Global guidance requires contextualization	• Hold workshops to adapt global guidance to the local context. • Budget and plan for adaptation needs.
MHPSS co-chair role is not budgeted as full-time	• Advocate for inter-agency funding to support the role and promote neutrality. • Identify challenges involved in serving in dual roles and advocate with line managers.
The group is less cohesive than ideally it could be	• Involve stakeholders from the beginning in developing or reshaping the group. • Take a collaborative leadership approach: rotate the chairing role, venues or topics.
Languages used exclude certain groups	• Alternate the languages used for meetings. • Budget for translation and interpretation. • Develop agendas with space for interpretation and the clarification of terminology.
There is a disconnect between national authorities and the MHPSS TWG	• Organize TWG meetings together with representatives from relevant ministry offices (e.g. the ministry of health (MoH)) to build buy-in. Try to alternate the venue if multiple ministries are involved (depending on local customs). • Engage in bilateral discussions with authorities, particularly on sensitive issues, in advance of raising such issues with larger groups.
Agencies do not see the benefit of the TWG	• Organize participatory evaluations, including stakeholders who do not attend TWG meetings, to find out how the TWG can improve. • Establish a clear plan with agreed and concrete objectives; re-examine if needed. • Sometimes, members do not actually benefit (e.g. from funding, from sharing data). It is essential to ensure that members do see returns from their contributions by ensuring that activities are mutually beneficial. • Organize quarterly presentations of MHPSS TWG achievements to highlight benefits.
High turnover among TWG representaties	• Develop a resource centre (see Core Action 2) that includes "mini-briefings" to orient new members. • Encourage agencies to delegate national staff members to the MHPSS TWG and advocate for delegates be appointed to fully represent the agency and make decisions.

Negotiation and conflict management

Sometimes consensus cannot be reached, and conflict occurs. However, if it is approached properly, managing conflict can lead to better coordination.

POSSIBLE STEPS TO NEGOTIATION AND CONFLICT MANAGEMENT[1]

	Possible steps	Details	Role of MHPSS co-lead/co-chair
1	**Recognize conflict**	Conflict is natural and can be constructive. However, conflict can also be destructive (e.g. name calling, reprisal). Sometimes, it can be obvious (e.g. yelling) and sometimes less clear (passivity, non-attendance).	• Monitor for signs of conflict and identify when management is needed.
2	**Engage stakeholders**	Certain members, or their host agencies, may be central to the conflict. **TIP:** Understanding participants can be a valuable first step. For example, understanding if a person tends to react to disagreement with anger can be key.	• Facilitate the bringing together of parties. **TIP:** Consider the timing of negotiations problem-solving is not ideal when people are extremely tired, stressed or under pressure.
3	**Focus on core issues and needs**	Conflict can lead to a focus on past issues. Focusing on the issue at hand is essential.	• Identify the central issues. • Redirect towards a productive focus.
4	**Draw out and consider each perspective**	It is important to ensure that each person's view is heard and valued.	• Facilitate the conversation. • Encourage the sharing of all viewpoints.
5	**Draw out suggestions for a path forward**	Encourage participants to share realistic solutions.	• Invite suggestions. • Avoid argument or criticism.
6	**Check for agreement or acceptance**	Sometimes not everyone will agree, but they may be willing to accept a solution.	• Check with participants on their levels of agreement, disagreement or acceptance.
	If agreement cannot be reached:		
7	**Refocus on the goals of the group and on points of consensus (e.g. the IASC Guidelines)**	Disagreement can lead to real and negative outcomes for people in need.	• Identify consequences of disagreement. • Invite participants to review their goals.
8	**Review areas where there is agreement**	Identifying "zones" of agreement can lead to compromise. It can help to identify underlying values that motivate positions, and such discussions may clarify that there is more agreement than originally thought.	• Check if there is room for agreement on smaller issues. • Build on consensus. **TIP:** Consider meeting in small groups or meeting individually to identify what would be needed for a solution to be accepted.
9	**Hold a majority vote**	A majority can be used to move forward.	• Facilitate the vote. • Remain impartial and express appreciation of willingness to speak.
10	**Act and evaluate**	Once a decision is made, evaluate it and revisit negotiations, if needed.	• Facilitate implementation. • Monitor for continued conflict.

1 Adapted from The Global Nutrition Cluster (2013). Nutrition Cluster Handbook: A practical guide for country-level action. https://www.nutritioncluster.net/resources/gnc-handbook-final-gnc-january-2013

Notes

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CORE ACTIONS OF MHPSS TWGs

There are seven core actions described in this handbook.
They are considered to be generally applicable and to be a high priority across many settings, based on existing guidelines, available evidence and consultation with current and past MHPSS TWG members and co-chairs.[1]

Each core action is split into four key sections:

- **Background:** Why is this important?
- **Possible steps:** What are possible steps?
- **Outcomes and indicators:** How can this be measured?
- **Case studies:** Practical stories from MHPSS actors

Annex 4 presents a list of indicators for each core action and **Annex 5** a checklist of potential core action deliverables.

Navigating the core actions

The core actions outlined in this section, and the possible steps within them, may not necessarily be implemented in a linear order by every MHPSS TWG or in every situation. Instead, core actions can be prioritized depending on the phase of the emergency, existing needs and capacities and the status of coordination among actors.

1 Each Core action is aligned with the coordination section of the forthcoming MHPSS Minimum Service Package (MHPSS MSP), which outlines a set of costed activities that are considered to be of the highest priority in meeting the needs of emergency-affected populations, based on existing guidelines, available evidence and expert consensus «Annex 6 for MHPSS MSP Actions arranged by Core Actions).

Core Action 1

(RE)ESTABLISHING AND MAINTAINING A TECHNICAL WORKING GROUP

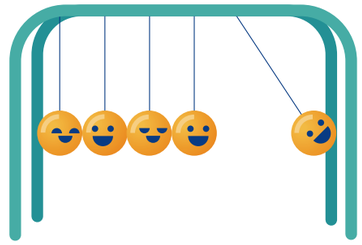
Mental Health and Psychosocial Support

WHY IS THIS FUNCTION IMPORTANT?

Having multiple disconnected coordination groups focused on MHPSS leads to miscommunication, duplication, inefficient use of resources and problematic gaps.

Instead, it is recommended that a single MHPSS TWG that unites MHPSS actors across sectors (e.g. health, protection, education) be established early in any emergency response to facilitate coordination. Wherever possible, it is recommended that national authorities, and potentially one or more national organization(s) or actor(s) knowledgeable in MHPSS, co-chair the MHPSS TWG and are supported by international organizations, if necessary.[1,2]

The added value of the group depends on the buy-in of its membership and the functioning of collaborative structures. From the outset, it is important that roles and responsibilities, coordination mechanisms and a shared vision for the group are developed and collectively owned. The MHPSS TWG must also be inclusive of the wide range of local, national and international MHPSS actors active in the response (see below and Core Action 3). As discussed in Chapter 2, some countries may already have functioning coordination systems. These structures naturally take on different forms and focuses, depending on context. In some settings, such forums may be sufficient for facilitating MHPSS coordination. In others, new structures may be necessary. Annex 7 outlines key questions to ask when assessing existing coordination structures and determining their potential for hosting an MHPSS TWG.



TIPS FOR EMPHASIZING LOCAL PARTICIPATION IN TWGs[3]

As previously mentioned, this handbook emphasizes community-based approaches to MHPSS, including in MHPSS coordination. This includes working with local actors and seeking their active engagement in MHPSS TWGs. However, in settings where many international organizations are active, or the emergency is large in scale, this can be challenging, particularly when there is conflict between national authorities and local groups. To promote local participation, the following tips may be useful for MHPSS TWGs.

Be aware of community dynamics and power structures and avoid reinforcing power imbalances.

Use local, national and international expertise to identify local coordination systems and priorities for the MHPSS TWG.

Build on local resources, including individual skills and expertise, social supports and systems and cultural, religious or spiritual resources.

Identify and engage with existing informal structures at the community level that may facilitate coordination.

Hold TWG meetings in local languages, with interpretation made available for agencies or members who do not speak the language.

Hold meetings close to operations or provide logistical support, if needed, to ensure access for members who may be less able to travel certain distances or to certain locations.

Where possible, **use existing communication mechanisms** to share information (e.g. remote/tele options, visual or audio if literacy rates are low).

Avoid unnecessary jargon, acronyms or terminology in meetings and allow space for questions and clarification to mitigate lack of understanding.

Pay attention to security or other local conditions that could prevent participation (e.g. cultural limits on acceptability of women's movements).

1 Sphere Project. (2018). Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. https://spherestandards.org/handbook-2018/

2 Meeting of the IASC Principals 5 December 2019: Summary Record and Action Points. https://interagencystandingcommittee.org/inter-agency-standing-committee/summary-record-iasc-principals-meeting-5-december-2019

3 For further guidance related to the IASC system, please see: IASC. (2021). Strengthening Participation, Representation and Leadership of Local and National Actors in IASC Humanitarian Coordination Mechanisms

WHAT ARE POSSIBLE STEPS?

BUILD ON EXISTING COORDINATION STRUCTURES

where they exist and function, rather than developing parallel systems.

CO-CHAIRS' ROLE
Identify and link with coordination structures or platforms that already exist and could facilitate MHPSS coordination (see Annex 7).

IDENTIFY AND ENGAGE WITH MHPSS ACTORS

Engage with a wide range of stakeholders to facilitate coordination (see Annex 8 for a list of potential stakeholder roles and responsibilities).

CO-CHAIRS' ROLE
Advocate for the added value of an MHPSS TWG, or for joining in MHPSS coordination.

CONVENE AN INITIAL MEETING

Introduce key stakeholders and create a shared vision for the group. Identify actors not involved and invite them to join.

CO-CHAIRS' ROLE
Facilitate an open dialogue among members and promote collaboration.

TIP
Engage in informal and interactive exercises to build relationships.

DEVELOP A CONSENSUS-BASED WAY OF WORKING

Whatever form it takes, it is important to agree on a structure and purpose for the TWG to facilitate understanding of roles, accountabilities, objectives and timelines.

CO-CHAIRS' ROLE
Facilitate development and regular review of consensus-based ways of working, such as terms of reference (ToRs) and workplans (see Annex 9 for tips).

TIPS
- If developed, ToRs must be a tool for coordination and not an objective.
- Community participation, including by people with lived experience MUST be actively emphasized in coordination activities, including workplan development.
- Ensure that responsibility for tasks is assigned early on. If not, unallocated tasks may fall to co-chairs or be forgotten.

DEVELOP PROCESSES FOR ROUTINE COORDINATION

Develop procedures and mechanisms for meeting, sharing information and coordinating services from the national to the local level.

CO-CHAIRS' ROLE
- Agree on meeting times and prepare agendas.
- Set up and maintain a mailing list and shared drive of resources.
- Identify and address needs (e.g. accessibility, gender considerations, family responsibilities) in order to support participation.
- Facilitate regular discussions about service coordination across members.

LINK WITH NATIONAL STRATEGIES AND PLANS

Align with national plans or strategies to promote sustainability. Where plans do not exist or are outdated, advocate for their development (see Core Action 7).

CO-CHAIRS' ROLE
- Review relevant national plans and strategies, including national mental health, education, social welfare and other relevant plans.
- Organize MHPSS TWG discussions to orient members and align programming.

MOBILIZE RESOURCES

Identify resources (e.g. human, financial, technical) among TWG members to support the group's work. Where possible, agencies may also include coordination activities in joint funding proposals.

CO-CHAIRS' ROLE
- Engage agencies to identify availabe resources available to support the TWG.
- List collective resource mobilization as a regular agenda item.

TIP
Wherever possible, funding for the group should be discussed transparently so that all members are aware of how funds are raised and how they will be spent.

REDUCE POWER DIFFERENCES AND FACILITATE PARTICIPATION

Work to reduce competition for resources among TWG members and instead promote equitable participation.

CO-CHAIRS' ROLE
Monitor for power imbalances and negotiate solutions.

TIP
Inviting organizations to present on topics of their choice, rotating venues and sharing the co-chairing roles can all promote participation.

HOW CAN THIS FUNCTION BE MEASURED?

OUTCOME
A functional MHPSS TWG is established and facilitates better coordination

INDICATORS
- **Existence of a functional workplan developed in collaboration with local actors and affected persons**
- **% of workplan objectives achieved in specific period (e.g. one year)**
- **% of MHPSS TWG members who are local or national actors.**

MEANS OF VERIFICATION
- **Workplan review**
- **Meeting minutes.**

CASE STUDY 1

In Yemen, MHPSS coordination has been challenging due to issues with access to certain areas and the barriers these present for effectively organizing the response.

An MHPSS TWG had previously been established in Aden, but due to practical and logistical challenges it became inactive for some time after its creation. In 2020, an MHPSS expert with prior experience of facilitating MHPSS TWGs was deployed to reestablish the group. In the initial days and weeks of re-engaging with partners, it became clear that the previous workplan and ToRs, though expertly written and developed, were too ambitious and had become impractical in dealing with the evolving situation on the ground. The members of the newly reformed MHPSS TWG set about revising the documents to emphasize more practical, and concrete and more simplified objectives and to clearly define roles and responsibilities. The group held a one-day brainstorming workshop where members identified needs, resources and priorities, all of which facilitated the development of a workplan and revision of the ToRs. Since this time, the MHPSS TWG has remained active through regular coordination meetings and has begun to carry out its workplan, facilitated by a clear sense of roles among members and a direction set out by these foundational efforts.

Resources **For additional resources to support implementation of this core action, please see Annex 14.**

Core Action 2

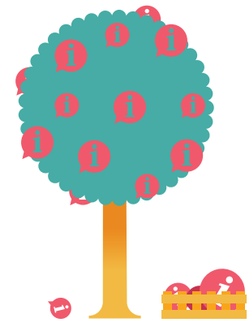
INFORMATION MANAGEMENT

Mental Health and Psychosocial Support

WHY IS THIS FUNCTION IMPORTANT?

Information management (IM) includes the collection, analysis and dissemination of information to guide decisions. IM supports MHPSS actors in developing a shared understanding of the situation and what is needed in response. MHPSS IM does not simply mean performing an activity, such as producing a 4Ws mapping or assessment report. Rather, it is an ongoing process to inform priority setting.

A wide range of methods can be used for effective and systematic MHPSS IM. Deciding the scope, what tools to use and how frequently activities are performed will depend upon contextual needs and resources. Ideally, MHPSS TWGs should have the resources and capacity for a dedicated MHPSS IM officer or team with the requisite skill set. However, in reality is that MHPSS TWGs do not often have dedicated IM officers and tend to rely on member agencies or on overburdened and under-resourced co-chairs for IM. Therefore, it is crucial that only essential information is collected and managed. Information should also be assessed for quality, rather than assumed to be useful. MHPSS.net is a key resource for MHPSS IM, and regularly publishes emergency briefings in an effort to help fill the information gap.



"I recall my rapid deployment to Gaza in 2014. There was little time to make decisions and needs were all around. Immediately, I tried to identify MHPSS information from the previous crises, given it was the third in seven years. Before arriving, I spoke with many colleagues. When arriving, I spent initial days meeting stakeholders to understand immediate needs and past lessons. To my dismay, there was little information – no reports, no documentation. Only oral memories remained, useful stories from local stakeholders, but very little was concrete. I spent a lot of time collecting basic information. Eventually, I became the one 'briefing' others who were arriving with the same questions. It was shocking to see how information can be so needed and yet so hard to find. Yet I also realize how simple it is to have a basic resource centre. I would have been SO grateful to have this, and therefore I say this is a vital function in MHPSS coordination."
MHPSS expert deployed in Gaza emergency response

FOUR COMMON STRATEGIES FOR MHPSS IM

Conducting a gap analysis and mapping activities and agencies provides an understanding of who is where in the field, what they are doing and when. This provides information on resources, referral pathways and gaps in response and can help to identify potential MHPSS TWG members.

Coordinating MHPSS needs and resource assessments ensures that MHPSS assessments are not duplicated, maximizes resources and informs collective response. This includes integrating MHPSS in (multi-)sectoral needs assessment and response planning (such as HNOs and HRPs; see Annex 12 for tips).

Cultural information, adaptations and desk reviews can help identify literature on pre-existing information relevant to MHPSS. The MHPSS TWG can gather this information in a number of ways, including desk reviews and through in-depth assessments.

Compiling and maintaining an MHPSS resource centre or database allows for a "memory" of MHPSS information to be stored and transferred across emergencies and actors. Information can be stored in many formats but is ideally maintained by an MHPSS TWG.

1 See the https://mhpssmsp.org/en MHPSS MSP Gap Analysis Tool
2 The MHPSS.net emergency toolkit includes a section on MHPSS cultural adaptations and desk reviews. For more information, please visit: https://www.mhpss.net/toolkits/emergency-toolkit
3 MHPSS.net houses several groups for country-level MHPSS TWG and is a useful centre to compile information.

WHAT ARE POSSIBLE STEPS?

STEP 1.
DEFINE THE SCOPE OF IM NEEDS

The information needs and the scope depend on the phase of emergency and the capacities of the group. If possible, it can be helpful for TWGs to designate an agency to lead on IM for the group.

CO-CHAIRS' ROLE

- Facilitate discussion to build consensus on the scope of IM needs.
- Facilitate identification of an MHPSS IM focal point within the TWG. In ideal situations, the TWG should have a dedicated IM officer to liaise with other IM teams.

STEP 2.
IDENTIFY EXISTING INFORMATION

This includes desk reviews and data collected by other sectors. Information on cultural factors is essential at this stage.

CO-CHAIRS' ROLE

- Liaise with stakeholders to identify existing information.
- Review, or support reviewing, the existing sources of data.

STEP 3.
DEVELOP AND MAINTAIN A RESOURCE CENTRE

Whatever the format, the resource centre should be easily accessed and regularly updated, and should include key operation information (e.g. cultural and contextual information).

CO-CHAIRS' ROLE

- Support the collation, sharing and regular updating of information held by the resource centre.
- In some cases, it may be useful to identify an MHPSS TWG agency that would be willing to manage the resource centre.

STEP 4.
COORDINATE MAPPING AND ANALYSIS OF GAPS

The IASC MHPSS RG has produced guidance on 4ws mapping.[1] The MHPSS Minimum Service Package (MSP) also includes a gap analysis tool. However, the scale of the mapping will depend on the situation and on needs. In all cases, these activities must be used to inform and improve service delivery.

CO-CHAIRS' ROLE

- Facilitate the identification of roles and responsibilities and the carrying out of the exercise (or supporting the lead agency that conducts it).
- Use mapping/gap analysis results to inform service coordination meetings.

TIP

- Keep it simple: introduce mapping to showcase work, create referral pathways and inform service delivery, not as a bureaucratic exercise.
- Data collection requires time. Consider organizing mapping and gap analysis workshops to collect data. In cluster settings, build on cluster IM systems.
- Consider the purpose (e.g. referral pathways, identifying gaps, advocacy) from the outset, to avoid collecting data that is not used.
- Always explain the purpose of the exercise and inform providers that the data will be made public (unless there is a reason of sensitivity or safety for not doing so) to promote transparency and obtain consent.

STEP 5.
COORDINATE NEEDS ASSESSMENTS

Incorporating MHPSS considerations into single or multi-sectoral assessments is key to informing the response and promoting the cross-cutting nature of MHPSS. The WHO/UNHCR MHPSS Assessment Toolkit[2] can be used to identify key MHPSS questions (see Annex 10 for further guidance).

CO-CHAIRS' ROLE

- Advocate for the inclusion of MHPSS in multi-sectoral needs assessments and work planning.
- Support the development of relevant questions for multi-sector needs assessments.
- Use needs assessments to inform the coordination of service delivery.

TIP

- Avoid asking too many questions: less is always more.
- MHPSS assessment tools will need to be adapted prior to use in any emergency (see Annex 11 for guidance in the context of PHEs).

STEP 6.
DISSEMINATE INFORMATION AND LESSONS LEARNED

This can be in the form of a formal report, a spreadsheet, a website or an online platform, such as through OCHA. Plans should be made to regularly update mapping exercises.

CO-CHAIRS' ROLE

- Disseminate results to inform the response and advocate for the inclusion of MHPSS.

TIP

- 4Ws mapping can create large but unused reports if not disseminated well. Use easily accessible formats (e.g. dashboards) and ideally introduce them from the start.[3]
- Include mapping/gap analyses as a regular agenda item in TWG meetings.

STEP 7.
REGULARLY DISCUSS INFORMATION GATHERING

Making information needs and plans for information gathering a standing item for discussion can support effective IM.

CO-CHAIRS' ROLE

- Facilitate regular discussion of information needs and gathering.
- Use this discussion to update the resource centre and coordinate IM.

HOW CAN THIS FUNCTION BE MEASURED?

OUTCOME

The size and nature of the MHPSS response is known and needs and gaps are identified and addressed.

INDICATORS

- **# of gaps addressed following mapping/gap analysis**
- **% of needs assessments or workplans integrating MHPSS.**

MEANS OF VERIFICATION

- **Mapping and gaps analysis report**
- **Meeting minutes**
- **Assessment or workplan reviews.**

CASE STUDY 2
MAPPING AGENCIES AND ACTORS IN SOUTH SUDAN

In June 2016, an MHPSS coordination structure was formed in South Sudan.

However, the group initially struggled to engage many key stakeholders. To facilitate mapping, a four-day workshop was organized in Juba to bring together MHPSS stakeholders. On day one, all member organizations of the health cluster, protection cluster, education cluster, child protection sub-cluster and GBV sub-cluster were invited to a refresher training on MHPSS basic principles and on the 4Ws mapping process. Thereafter, each cluster and its member agencies were invited to a half-day session to complete a 4Ws Excel sheet. Five people who had received in-depth training on mapping were present to assist participants, as well as two computer technicians, and computers were made available for all. In addition, the MHPSS TWG co-chair worked with IM officers within each cluster to incorporate MHPSS data that had previously been reported to the cluster. Partners who were not cluster members but who were crucial to the MHPSS system in the country were also engaged. After data were compiled and analysed, a one-page brief was presented to MHPSS TWG members and clusters with a set of practical key recommendations. The MHPSS TWG co-chair also presented the results of the exercise at the Inter-Cluster Working Group to facilitate inclusion in the HNO and HRP for South Sudan during that cycle. A larger report was also compiled and published in an online resource centre.

1 For more information about IASC's Who is Where, When, doing What in MHPSS: 4Ws Tool, please visit: https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings/documents-public/iasc-who-where-when-doing

2 For more information, please visit: https://www.unhcr.org/en-us/protection/health/509bb3229/assessing-mental-health-psychosocial-needs-resources.html

3 For example, see mapping dashboards from the MHPSS TWG in Ukraine: https://www.humanitarianresponse.info/en/operations/ukraine/mental-health-and-psychosocial-support

Resources **For additional resources to support implementation of this core action, please see Annex 14.**

Core Action 3

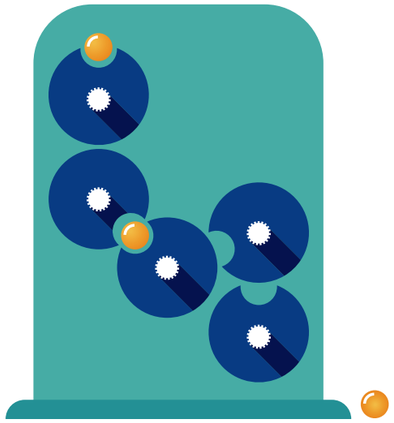
ESTABLISHING LINKS BETWEEN STAKEHOLDERS

Mental Health and Psychosocial Support

WHY IS THIS FUNCTION IMPORTANT?

A key role of an MHPSS TWG is to facilitate the coordination of integrated MHPSS activities among local actors (including those not affiliated with a formal group or humanitarian agency), national actors (e.g. community-based organizations (CBOs), government ministries) and international actors (e.g. INGOs, UN agencies) and across and within sectors.

Depending on the context, establishing links across sectors and with other stakeholders can be facilitated within the humanitarian programme cycle, within needs assessments, through indicators for reporting and monitoring or via joint activities (e.g. trainings, awareness-raising events). Whatever the approach, establishing these links is vital to ensuring that MHPSS does not "fall through the cracks" between different sectors of humanitarian action.



WHO / David Spitz

WHAT ARE POSSIBLE STEPS?

STEP 1.
IDENTIFY RELEVANT STAKEHOLDERS

It is crucial that this process is inclusive. In many settings, essential local stakeholders are overlooked or excluded.

CO-CHAIRS' ROLE
Consult with local actors to identify key local stakeholders.

TIP
Keep an open mind and cast a wide net.

STEP 2.
ADDRESS BARRIERS PREVENTING PARTICIPATION IN THE TWG

In some settings, local actors may be hesitant about joining coordination efforts because of language barriers, access barriers or other practical challenges.

CO-CHAIRS' ROLE
Identify barriers and brainstorm solutions with all stakeholders.

TIP
Avoid using unnecessary jargon in TWG meetings.

STEP 3.
LINK WITH OTHER COORDINATION PLATFORMS

In order to coordinate with relevant sectors, cluster coordination groups, government actors and civil society organizations (CSOs), MHPSS TWGs should aim for mutual representation, participation and contribution in all coordination meetings.

CO-CHAIRS' ROLE
- Facilitate the identification of focal points within the TWG to engage with other coordination platforms (e.g. clusters or AoRs).
- Invite stakeholders to join the TWG (e.g. relevant ministries).
- Advocate for the inclusion of MHPSS as a regular item on inter-agency agendas (e.g. the Inter-Cluster Coordination Team (ICCT), where relevant).

STEP 4.
HOLD MHPSS ORIENTATION SESSIONS

Holding sessions to introduce stakeholders to each other's work is key to linking initiatives. Holding orientation sessions on MHPSS (e.g. the IASC (2007) Guidelines) for non-MHPSS actors is also useful for mainstreaming MHPSS within and across sectors.

CO-CHAIRS' ROLE
- Advocate for and coordinate MHPSS orientation sessions (e.g. MHPSS in education for education sector colleagues).
- Facilitate regular discussion of the projects of TWG members.

TIP
Regular presentations by members on their programmes encourage engagement and facilitate collective understanding.

STEP 5.
DEVELOP AND IMPLEMENT JOINT REFERRAL PATHWAYS

Joint referral pathways facilitate access to the full range of MHPSS services and additional supports (e.g. protection, health, education, GBV, education, livelihoods).

CO-CHAIRS' ROLE
- List referral pathways as a regular item for discussion.
- Where relevant, discuss the development of standard operating procedures (SOPs) for referral, and disseminate these SOPs.

STEP 6.
SUPPORT SECTOR RESPONSE PLANNING

As sectors begin to integrate MHPSS within response plans, the MHPSS TWG can provide technical support. In cluster settings, the HPC, including the drafting of HNOs and HRPs, can provided important entry points (see Annex 12 for tips on integrating MHPSS into the HPC). Identifying MHPSS indicators (Core Action 5) can also support sectors with the integration of MHPSS and the coordination of service delivery.

CO-CHAIRS' ROLE
- Encourage TWG focal points to advocate for a decision-making role in the response planning of other sectors (e.g. HNO/HRP).
- Ensure regular coordination of service delivery among TWG partner agencies.

STEP 7.
ENGAGE IN JOINT ACTIVITIES

Joint activities build relationships and conserve resources. They may include inter-agency workshops or trainings, advocacy campaigns or other joint response activities. Encourage TWG focal points to advocate for a decision-making role in the response planning of other sectors (e.g. HNO/HRP).

CO-CHAIRS' ROLE
- List joint activities as a regular item for discussion.
- Support focal points in advocating for joint planning with sector leads and with government ministries and national counterparts.

HOW CAN THIS FUNCTION BE MEASURED?

OUTCOME
MHPSS is integrated within the work of relevant stakeholders.

INDICATORS
- **# of joint initiatives, activities or workplans integrating MHPSS**
- **# of sectors, clusters or AoRs represented in the TWG**
- **Establishment of a functioning referral system.**

MEANS OF VERIFICATION
- **Activity reports**
- **Meeting minutes**
- **Referral records.**

CASE STUDY 3
LINKING MHPSS ACROSS AND WITHIN SECTORS IN JORDAN[1]

In response to the Syrian refugee crisis in Jordan, the existing MHPSS TWG developed a system where new actors responding to the crisis were asked to first visit with the TWG and discuss beginning their activities based on clear needs assessments, and not to begin implementation on their own but in consultation with the group.

In 2012, the MHPSS TWG also issued a four-page inter-agency document that represented "consensus among the different actors and provided a coherent framework to organizations wishing to fund, develop or implement activities in the field" (MHPSS Working Group, Jordan 2012). The document highlighted important principles of the group based on the IASC MHPSS Guidelines, defined key terms and outlined the group's approach to MHPSS. It also emphasized the need for coordination and recommended joint assessments, information sharing, mapping and other activities (e.g. joint training and advocacy). These efforts have created strong links across sectors and between partners. For example, joint assessments have been conducted focusing on the role of shelter and site planning, camp management, orientation and access to information, distribution of water and non-food items, and approaches to food and nutrition and MHPSS. These assessments have led to a clear understanding of how the actions taken by the WASH, shelter, nutrition and other sectors may reduce stress, encourage community mobilization and support, and improve psychological well-being.

1 Case study adapted from: IASC (2014). Review of the Implementation of the IASC Guidelines on MHPSS in Emergency Settings: How are we doing? https://interagencystandingcommittee.org/node/9056

Resources **For additional resources to support implementation of this core action, please see Annex 14.**

Core Action 4

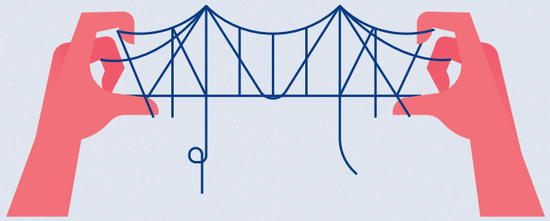
BUILDING CAPACITY, KNOWLEDGE EXCHANGE AND PEER SUPPORT

Mental Health and Psychosocial Support

WHY IS THIS FUNCTION IMPORTANT?

In every humanitarian setting, there are diverse capacities, experiences and professional backgrounds. Some agencies will bring expertise in community-level programming, others with specific groups and others with the delivery of specific services. Likewise, local actors, particularly those who are themselves affected by the emergency, will bring crucial and unique knowledge and expertise.

MHPSS TWGs provide a forum to share all of these experiences, skills and knowledge between members and, importantly, to leverage individual expertise so that it benefits the collective response. As a result, MHPSS TWGs can support agencies working on similar kinds of programming to expand their geographical reach and cross-sectoral integration and increase quality through joint capacity-building and knowledge exchange. Conducting joint trainings or workshops on a specific topic lifts the group's capacities as a whole, rather than selectively improving the performance of a single agency. Likewise, expanding MHPSS training or workshops to include cluster or sector partners helps to build positive working relationships and supports the integration of MHPSS into programming activities, in addition to being more cost-effective.



CASE STUDY 4 CAPACITY-BUILDING FOR PSYCHOSOCIAL WORKERS IN NORTHWEST SYRIA

In northwest Syria, the MHPSS TWG identified the need to build capacity among health workers to provide MHPSS services.

The group developed an approach to standardize the roles and responsibilities of a new cadre of MHPSS paraprofessionals called psychosocial workers (PSWs). This standardization aligned with the creation of an Essential Package of Health Services (EPHS) for northern Syria, which was key to ensuring higher-quality MHPSS services. To support the development of PSWs, the MHPSS TWG created a training handbook and package, which included 14 modules on topics ranging from basic psychosocial support, such as psychological first aid (PFA), to basic mental health care and psychological interventions, all adapted to the local context. The MHPSS TWG began rolling out the training package in 2018 through an initial Training of Trainers (ToT) and series of seven-day trainings. As of June 2021, more than 460 PSWs had completed the curriculum and were providing MHPSS services.

WHAT ARE POSSIBLE STEPS?

STEP 1.
DISCUSS AREAS OF LIMITED CAPACITY

Discussions should include international actors, who must learn about the local cultural aspects of MHPSS, the complexities of the context, indigenous practices and systems and many other topics from local experts.

CO-CHAIRS' ROLE
Include capacity-building as a regular agenda item for MHPSS TWG meetings.

STEP 2.
CONDUCT A TRAINING NEEDS AND CAPACITY ASSESSMENT

The needs assessment should be completed by each member of the MHPSS TWG as well as by partners across sectors.

CO-CHAIRS' ROLE
Identify a focal point to lead the needs and capacity assessment.

TIP
- It is key to assess gaps in capacity in order to address the needs of service users and to link capacity-building to identified gaps.
- A simple survey asking participants to rank priorities for capacity-building, identified through discussion, can be very useful.

STEP 3.
IDENTIFY RESOURCES FOR CAPACITY-BUILDING

Identify resources that MHPSS TWG members or cluster or sector partners can provide (e.g. facilitators, finances, venues).

CO-CHAIRS' ROLE
List an agenda item for TWG meeting(s) asking members to discuss resources to support trainings.

STEP 4.
DEVELOP AND IMPLEMENT A CAPACITY-BUILDING PLAN

It is essential to facilitate trainings based on needs and on available resources in order to maximize impact. A plan that addresses training needs helps to facilitate effective use of resources.

CO-CHAIRS' ROLE
- Facilitate the development of a realistic training or workshop plan with input from MHPSS TWG agencies.
- Implement the plan in partnership with TWG agencies.

TIP
Remote approaches can greatly reduce costs, where these are feasible.

HOW CAN THIS FUNCTION BE MEASURED?

OUTCOME
Humanitarian actors demonstrate increased MHPSS knowledge and capacity.

INDICATORS
- **Existence of an MHPSS capacity-building plan with clear indicators**
- **# of humanitarian actors oriented on MHPSS guidance and on how to avoid harm (for example, on the IASC Guidelines on MHPSS in Emergency Settings, the MHPSS MSP, disaggregated by type of workshop, and by sector/field)**
- **# of identified capacity gaps addressed via capacity-building initiatives.**

MEANS OF VERIFICATION
- **Capacity-building plan**
- **Inter-agency training needs assessment reports**
- **Training or workshop evaluation reports.**

STEP 5.
DISSEMINATE INFORMATION ON TRAINING OR WORKSHOP OPPORTUNITIES

Disseminate information on events organized through the MHPSS TWG or capacity-building offered by different clusters or sectors, national authorities and local resources (e.g. universities).

CO-CHAIRS' ROLE
Share information on training or workshop opportunities via the TWG mailing list or monthly newsletters.

STEP 6.
ARRANGE FOR APPROPRIATE SUPERVISION AND FOLLOW-UP

Capacity-building initiatives are not sustainable without on-the-job training, mentoring and supervision to trainees. One-off trainings are not recommended.

CO-CHAIRS' ROLE
Advocate for agencies to include on-the-job training, mentoring and supervision approaches for all capacity-building initiatives.

STEP 7.
DEVELOP A REPOSITORY OF TRAINING MATERIALS AND/OR TRAINERS

Create a shared drive containing training materials and a list of trainers as part of the resource centre (Core Action 2).

CO-CHAIRS' ROLE
- Collate training materials and a roster of trainers.
- Encourage TWG members to share their training materials with one another.

STEP 8. (OPTIONAL).
CREATE A STANDARD INTER-AGENCY COMPETENCY FRAMEWORK OF MHPSS POSITIONS[1]

In protracted emergency settings, some MHPSS TWGs have developed an inter-agency competence framework for MHPSS workers in that context, which lists MHPSS worker profiles (e.g. community health workers, social workers, activity facilitators, doctors, case managers, etc.), minimum qualifications required, the skills and knowledge (competencies) needed and the training packages recommended to build such competencies.

CO-CHAIRS ROLE
- Organize a workshop with MHPSS TWG members (ideally facilitated by an impartial consultant) to populate the competency framework, based on agency standards and national guidelines.
- Advocate for agencies and donors to use the framework.

TIP
Keep the requirements realistic and aligned with national laws or policies (e.g. labour laws) and with the local context and mandate.

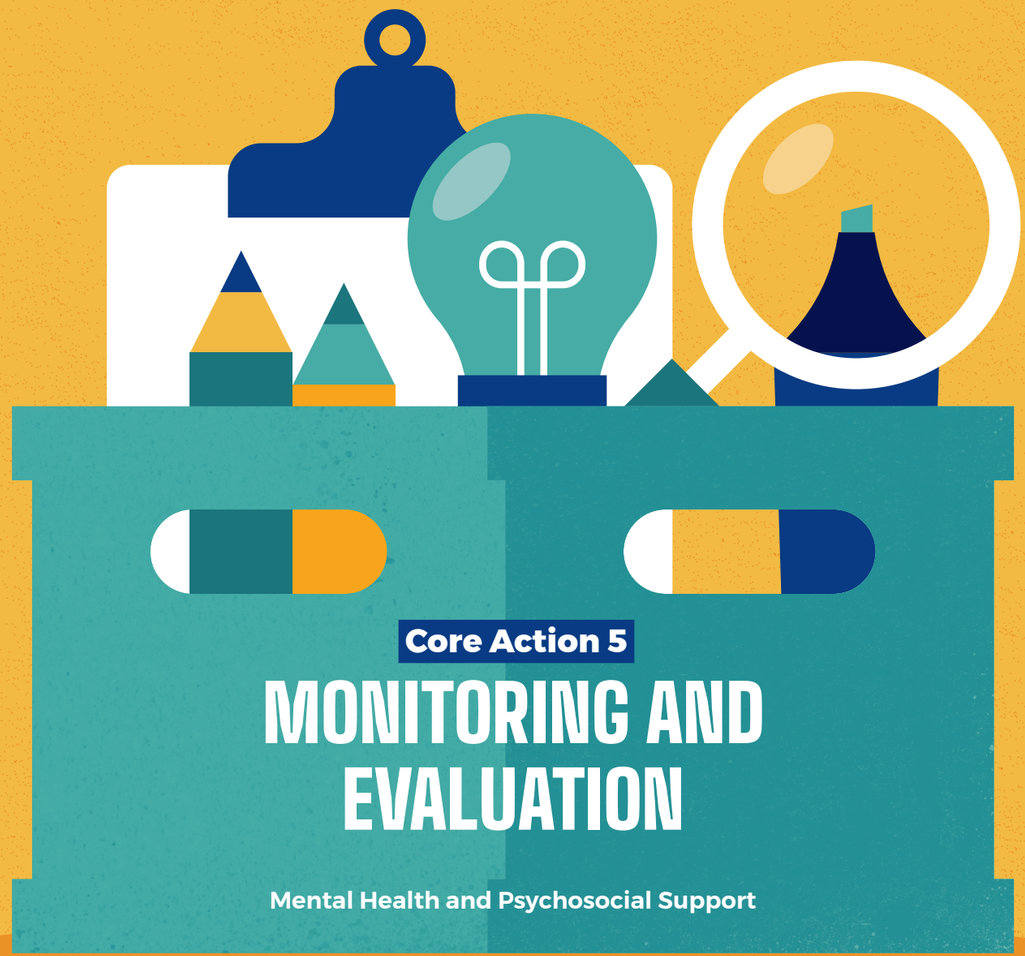
CASE STUDY 5
CAPACITY-BUILDING AMONG MEMBERS OF THE AFGHANISTAN MHPSS TWG

In Afghanistan, the MHPSS TWG is chaired by a national staff member who facilitates the group in a funded full-time role.

Crucially, the donor also supports the TWG by funding a series of inter-agency MHPSS-related trainings that are open to MHPSS TWG members and actors from clusters or sectors. To facilitate these trainings, the MHPSS TWG developed an inter-agency capacity-building plan based on an inter-agency training needs assessment and prioritization exercise. Topics identified in the needs assessment were included in a successful funding proposal in 2019. Thereafter, a series of face-to-face trainings were held throughout 2020 and 2021, freely open to MHPSS TWG members and other agencies. Topics included life skills for children and youth, basic and advanced counselling for adults, the IASC MHPSS Guidelines, MHPSS assessments, M&E of MHPSS programmes, MHPSS referrals, and early childhood development and mental health care practices for caregivers of infants. Trainings and workshops were facilitated by agencies with a specialization in the identified topic and through a DSS MHPSS expert deployment. The project also included peer learning across organizations, whereby agencies (including the Mental Health Directorate of the Ministry of Health) visit MHPSS TWG member projects and complete knowledge exchange peer visits. These visits are organized through, and are reported back to, the MHPSS TWG at monthly meetings. The visits support the oversight responsibility of the Mental Health Directorate and help agencies to link up to broader initiatives, such as the National Mental Health Strategy and the "Strategy to support Women, Children, Disabled Persons and Martyrs from the Conflict".

1 The WHO-UNICEF Ensuring Quality in Psychological Support (EQUIP) platform can be a useful tool for MHPSS workforce development. It includes competency assessment tools, guidance and resources for trainers, e-Learning modules, implementation guidance and other components. https://equipcompetency.org/en-gb

Resources **For additional resources to support implementation of this core action, please see Annex 14.**



Core Action 5

MONITORING AND EVALUATION

Mental Health and Psychosocial Support

WHY IS THIS FUNCTION IMPORTANT?

The field of MHPSS is advancing rapidly, with MHPSS activities now forming part of many humanitarian responses.

However, there is often wide variation in the quality and consistency of these activities. Additionally, many agencies struggle to document their work, which can lead to difficulties in demonstrating the value of MHPSS activities and ensuring accountability to affected populations. Monitoring and evaluation (M&E) is part of good humanitarian practice and addresses these issues by demonstrating collective impact and promoting enhanced quality. Therefore, a key role of MHPSS TWGs is to ensure the M&E of MHPSS activities and the response as a whole.

THE IASC COMMON MONITORING AND EVALUATION FRAMEWORK FOR MHPSS PROGRAMMES IN EMERGENCY SETTINGS[1]

An M&E framework for MHPSS programming should be developed as part of the initial programme design. Where MHPSS is being incorporated into existing programme activities, M&E plans should be updated to include MHPSS components. The IASC Common Monitoring and Evaluation Framework for MHPSS Programmes in Emergency Settings: With means of verification (Version 2.0) is a useful resource that can guide individual agencies in the M&E of their MHPSS programmes, including the selection of agreed goals, outcomes, outputs, indicators and means of verification (MoV). It can also be used at an inter-agency level between MHPSS TWG members providing similar types of programming. By carrying out quality M&E, MHPSS TWG members can contribute to the global evidence base for MHPSS approaches in different contexts while also establishing mechanisms to inform and listen to affected communities, address their feedback and take corrective action so that MHPSS actors remain accountable to the affected people they intend to support.

WHO / Sean Hawkey

1 IASC (2021). IASC Common Monitoring and Evaluation Framework for MHPSS Programmes in Emergency Settings: With means of verification (Version 2.0). https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergencysettings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency

WHAT ARE POSSIBLE STEPS?

STEP 1.
ORIENT AGENCIES ON THE IASC COMMON M&E FRAMEWORK FOR MHPSS

Jointly funded or organized orientation workshops on the IASC Common M&E Framework can support agencies in designing M&E plans and promoting a collective approach to assessing the response.

CO-CHAIRS' ROLE
Advocate with donors and MHPSS TWG members for funding for inter-agency orientation workshops.

TIP
Workshop facilitators may be available from the surge support mechanisms, if there is limited in-country expertise.

STEP 2.
ALIGN AND IMPLEMENT M&E APPROACHES

Aligning M&E approaches for similar areas of work (e.g. case management services, children's clubs, mental health in primary care) can improve quality, support collaboration and build evidence.

TIP
Be sure to partner with affected persons (e.g. people living with disabilities, people living with mental health conditions) in developing M&E approaches to ensure that they are culturally relevant, inclusive and accessible.

CO-CHAIRS ROLE
Facilitate the process of developing agreed approaches to M&E among TWG members, where possible.

TIP
- This could happen in an annual one-day workshop or during regular MHPSS TWG meetings under an M&E theme.
- Because actors have varying reporting requirements, advocacy to align M&E requirements by donors is also essential.

STEP 3.
IDENTIFY MHPSS INDICATORS AND MOV FOR EACH SECTOR

Developing a list of this sort can support sectors to integrate MHPSS into response planning and ultimately into their response activities.

CO-CHAIRS' ROLE
- Collaborate with sector focal points to identify 2–3 suggested indicators and MoVs for each sector.
- Support focal points to advocate with sectors to integrate these indicators into response plans.

TIP
This step should ideally occur during the HPC or regular response planning so that the indicators can be included in funding proposals and strategic plans.

STEP 4.
SHARE INFORMATION ON LESSONS LEARNED

Information sharing is key to raising the quality of MHPSS services and promoting accountability to affected persons.

CO-CHAIRS' ROLE
Facilitate regular M&E information sharing during MHPSS TWG meetings.

STEP 5.
USE M&E TO IMPROVE PROGRAMMING[1]

M&E data collected should be used to inform and improve the response and to hold humanitarian actors accountable. MHPSS TWGs should be used as transparent forums to discuss data and identify solutions to strengthen services, fill gaps and address issues identified by the people affected.

CO-CHAIRS' ROLE
Facilitate dedicated MHPSS TWG meeting sessions or workshops focused on improving services based on M&E data.

TIP
Workshops can be organized around key areas of work.

HOW CAN THIS FUNCTION BE MEASURED?

OUTCOME
Improved monitoring and evaluation of MHPSS programming.

INDICATORS
- **% of affected people reporting active involvement in monitoring and evaluation of MHPSS programming**
- **% of MHPSS TWG members reporting M&E of MHPSS programmes.**

MEANS OF VERIFICATION
- **Participatory evaluations**
- **Survey or interviews of MHPSS TWG members**
- **Annual review and revision of TWG workplan and strategy, based on M&E data and feedback from affected populations**
- **Workplan review workshop report.**

CASE STUDY 6
INTER-AGENCY WORKSHOPS ON MHPSS M&E

Joint inter-agency orientation workshops on the IASC M&E Common Framework have taken place in Afghanistan, the Caribbean, Cox's Bazar in Bangladesh, Iraq, Sri Lanka, Syria, Turkey and Ukraine.

The workshops have provided agencies with the opportunity to learn about the framework and most importantly to apply its goals and outcomes and the relevant data collection tools to their ongoing projects and use them for future programme design. Some workshops have also included sessions focusing on adaptation of the framework's elements (e.g. goals, outcomes, indicators) to the local context and sharing it across sectors or clusters. For instance, in 2016 the South Sudan MHPSS TWG developed MHPSS indicators and shared them with priority clusters, including health, protection (including AoRs), camp coordination and camp management and nutrition. These indicators were eventually used as part of the Humanitarian Response Plan for that year and were adapted and used further in subsequent programme cycles.

1 For more information on operationalizing accountability to affected populations, please see: IASC. Accountability to Affected Populations (AAP): A brief overview. https://interagencystandingcommittee.org/system/files/iasc_aap_psea_2_pager_for_hc.pdf

Resources For additional resources to support implementation of this core action, please see Annex 14.

Core Action 6

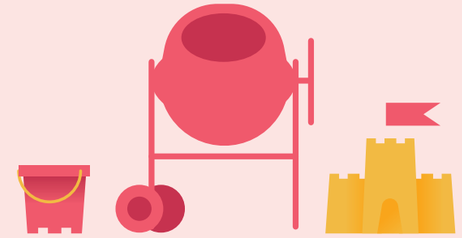
PROMOTING LONG-TERM SUSTAINABILITY

Mental Health and Psychosocial Support

WHY IS THIS FUNCTION IMPORTANT?

Despite the challenges, humanitarian emergences also present significant opportunities to build back better.[1]

Many emergencies draw attention to MHPSS, often for the first time in affected areas, through media coverage, policy-maker awareness and donor interest. Thus, the actions taken during the immediate and medium-term response to emergencies can either support or limit the potential to create sustainable and durable systems. Therefore, a key consideration of an MHPSS TWG, and an outcome of better MHPSS coordination, is long-term sustainability. However, during crises, rapid and pragmatic solutions can seem like the only options, even if they are not sustainable in the long term. Even in settings where strong leadership, collaboration or support exists, securing long-term commitments for MHPSS after the emergency phase can be challenging. Still, in any setting, sustainability can be enhanced when it is identified as a foundation of the approach, from the beginning, and considered throughout.



CASE STUDY 7 BUILDING SUSTAINABLE MENTAL HEALTH SYSTEMS: 15 YEARS OF PROGRESS

In 2004, Sri Lanka was devastated by the worst natural disaster ever recorded in the country's history. Prior to the tsunami, the country had endured three decades of civil war.

Mental health and psychosocial well-being had not been a priority in the country, but in the aftermath of the tsunami massive international attention led to an influx of resources and actors focusing on MHPSS. However, their capacities varied and activities were at times inefficient and in some cases potentially harmful. Sri Lanka's head of state recognized the challenges, and the importance of MHPSS, early on, and established a presidential taskforce to coordinate the response. From the outset, stakeholders also took a long-term view. The MoH and WHO collaborated with the Sri Lanka College of Psychiatrists and relevant national mental health professionals to develop a 10-year (2005–2015) National Mental Health Policy, which was approved just 10 months after the tsunami and served as a coordinating guide. The policy emphasized community-based systems and services and also placed an emphasis on national leadership and local professionals. Over time, MHPSS stakeholders worked together to ensure that the immediate response actions also effectively helped to reform the mental health system. In 2008, consistent with the national mental health policy, a National Mental Health Advisory Council (NMHAC), chaired by the Secretary of the MoH and including representatives from other relevant ministries, professional bodies, UN agencies, NGOs and service users' and carers' organizations, was formed to oversee implementation of the mental health policy. In 2015, revisions of the policy began and in 2020 a final policy was completed. As of 2021, the number of districts with acute inpatient units in general hospitals had increased from 10 in 2005 to 25. Outreach clinics now exist in almost all health divisions of the country, representing a total of 291 clinics offering community-based mental health care. Building on these successes, MHPSS was also recently included in the "COVID-19 Sri Lanka Strategic Preparedness & Response Plan 2021".

1 For in-depth discussion and case examples of building back better mental health systems in emergencies, please see: WHO (2014). Building back better: sustainable mental health care after emergencies. https://apps.who.int/iris/bitstream/handle/10665/85377/9789241564571_eng.pdf?sequence=1

WHAT ARE POSSIBLE STEPS?

STEP 1.
IDENTIFY AND BUILD ON LOCAL RESOURCES AND CAPACITIES

MHPSS TWGs should work to link the activities of the group with local systems, resources and capacities. Where new systems or services are established by international actors, the TWG can serve as a forum to discuss issues around their sustainability and to plan for transition and handover from very early on.

CO-CHAIRS' ROLE

▸ Advocate with MHPSS TWG members to ensure that programming builds local capacities, supports self-help and strengthens local resources.

▸ Where international actors are involved, initiate regular discussion of localization, including planning for transition and handover from early on.

▸ If the TWG is co-chaired by a representative of an international agency, identify a local counterpart as co-chair, ideally early in the emergency.

TIP

Use a "shadowing" approach in settings where international actors are co-chairing and local actors are hesitant to co-chair in order to build capacity.

STEP 2.
ALIGN WITH NATIONAL POLICIES OR PLANS

MHPSS TWGs should align their work with relevant national policies or plans (e.g. mental health, education, social welfare). In some cases, they may also support the development or strengthening of these where they do not exist or are outdated. Where this is not possible, developing consensus-based MHPSS standards can be an alternative (e.g. see the MHPSS MSP).

CO-CHAIRS' ROLE

▸ List alignment with national policies and plans as a regular agenda item and monitor for opportunities to support the strengthening of these.

▸ Where plans do not exist, engage stakeholders to support their development, or the development of minimum standards for MHPSS.

STEP 3.
PLAN FOR LONG-TERM SUSTAINABILITY

MHPSS TWGs should aim to develop MHPSS systems that address broad needs, from the community to the tertiary level. In the long term, this can include support for pre-service training and other development activities. The TWG can play a key role in collectively advocating for resources to support sustainable system-building, rather than short-term projects.

CO-CHAIRS' ROLE

▸ Facilitate regular review of service sustainability among MHPSS TWG members (see Annex 13 sustainability checklist).

▸ Develop a sub-working group to focus on sustainable resource mobilization.

TIP

Work to bring together emergency and development actors and donors to support sustainability. Response activities can demonstrate a proof of concept to advocate for longer-term funding and support.

STEP 4.
ADVOCATE FOR THE INCLUSION OF MHPSS IN NATIONAL FINANCING SYSTEMS

Advocating for MHPSS components within national financing systems, such as health financing (e.g. including mental health services as part of a national basic package of health services) is crucial to long-term funding.

CO-CHAIRS' ROLE

▸ Engage in or support advocacy with key stakeholders (e.g. ministries of health, finance, social services, education, emergency response).[1]

▸ Consider organizing a workshop on cases for investment in MHPSS services.[2]

STEP 5.
PROMOTE CARE AND SUPPORT FOR STAFF AND VOLUNTEERS

Promoting the mental health and well-being of staff and volunteers is crucial to sustainability. TWGs can promote both self-care and organizational supports to staff and volunteers within each agency.

CO-CHAIRS' ROLE

▸ Facilitate self-care within the TWG (e.g. retreats, discussions on self-care).

▸ Develop a sub-group to identify and promote strategies for staff care.

TIP

Be proactive about deadline and timing requests to TWG members to reduce deadline fatigue, and prepare for intense work periods.

HOW CAN THIS FUNCTION BE MEASURED?

OUTCOME

The MHPSS response leads to sustainable systems and services.

INDICATORS

- **% target communities where local people report being actively supported to design, organize and implement MHPSS activities themselves**
- **Evaluation of sustainability of the MHPSS response**
- **Regular review of localization, transition and handover (where international actors are involved).**

MEANS OF VERIFICATION

- **Participatory evaluation**
- **Sustainability checklist (see Annex 13)**
- **Localization assessment[1]**

1 Tools for monitoring and evaluating progress in response localization are growing in availability. For example, see: NEAR (2021). Localisation performance measurement framework. https://reliefweb.int/report/world/localisation-performance-measurement-framework

CASE STUDY 8
BUILDING SUSTAINABLE MENTAL HEALTH SYSTEMS IN LEBANON DURING AND AFTER HUMANITARIAN CRISES[3]

Lebanon has experienced a long history of political unrest and conflict. It is also home to several large refugee communities fleeing adversity in neighbouring countries. As the current emergency has progressed in Syria, Lebanon has received a massive influx of displaced persons, leaving many systems and services overwhelmed, including an already underfunded mental health system. In response, the Ministry of Public Health (MoPH) partnered with many stakeholders, including WHO, UNICEF and International Medical Corps, to launch the National Mental Health Programme (NHMP), a collaboration aimed at national mental health reform and building sustainable systems to address the challenges posed by the current emergency and beyond. In 2015, because of the NMHP and through a widely inclusive process involving key stakeholders in the country, the Mental Health and Substance Use Strategy for Lebanon 2015-2020 was created. This guiding strategy was key to ensuring that programmes and services were aligned from the outset, and contributed to a longer-term vision that guaranteed universal access, including for refugees, and emphasized a shift in focus towards a community-based model. Additionally, the NMHP established an MHPSS Task Force (an MHPSS TWG), co-chaired by the MoPH, WHO and UNICEF, to coordinate the MHPSS response to the Syrian refugee and other crises. The group now includes over 60 responding partners and aims to harmonize the MHPSS response, with sustainability in mind. To do this, it establishes a yearly action plan to address key challenges. For instance, in 2016, the strengthening of national and intersectoral referral systems was prioritized and led to the establishment of strong links between MHPSS, protection, shelter and other sector partners. The MHPSS Task Force has also played a key role in coordinating responses to the COVID-19 pandemic and the emergency caused by the explosion in Beirut's port in 2020.

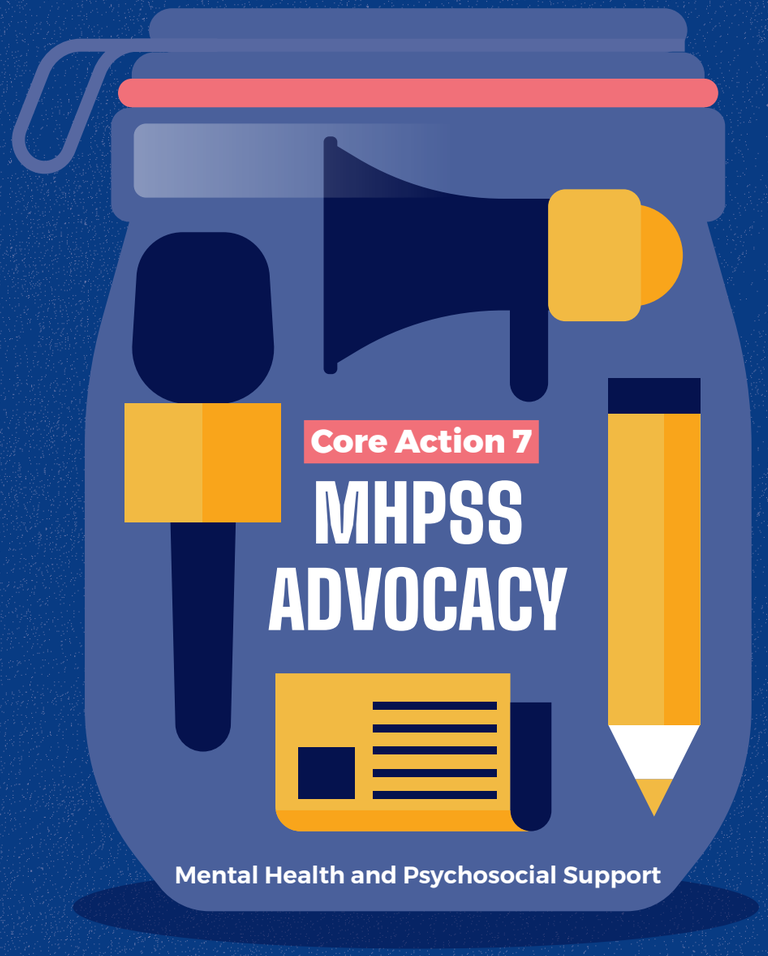
1 For further guidance on advocating for MHPSS financing with ministries, please see: Global Mental Health Action Network (2021). Demonstrating the Case for Mental Health Investment to Finance Ministers A Guide for Campaigners and Advocates. https://unitedgmh.org/sites/default/files/2021-04/How%20To%20Guide_%20Urging%20Ministries%20to%20Invest%20in%20Mental%20Health.pdf

2 For further guidance on national cases for investment in mental health, please see: WHO (2021). Mental health investment cases: a guidance note. https://www.who.int/publications/i/item/9789240019386

3 Adapted from: MHIN. Humanitarian crisis and mental health reform in Lebanon. https://www.mhinnovation.net/innovations/humanitarian-crisis-and-mental-health-reform-lebanon?qt-content_innovation=0#qt-content_innovation

Resources

For additional resources to support implementation of this core action, please see Annex 14.




WHO / Hayley Goldbach

WHY IS THIS FUNCTION IMPORTANT?

MHPSS advocacy refers to actions and messages intended to influence decision-makers, donors and other stakeholders to consider and prioritize the MHPSS needs of affected persons.

Awareness-raising also falls within the broader scope of MHPSS advocacy and can include efforts to increase knowledge of MHPSS, including the mental health and psychosocial impacts of emergencies, reducing stigma and increasing awareness of effective (and also harmful) ways of coping.

Advocacy is a crucial function of an MHPSS TWG. However, the exact approach and the nature of these activities can vary across settings, depending on the cultural context, forum, intended outcomes and specifically assessed and prioritized issues. In some settings, key stakeholders and decision-makers may take actions or positions that limit the ability to engage in MHPSS advocacy, and MHPSS actors may find themselves in complex and challenging situations, questioning how to respond. A key consideration is to approach all MHPSS advocacy with humanitarian principles in mind.

A number of tools and packages have been developed that are useful for MHPSS advocacy, including for specific MHPSS topics and areas of work.

WHAT ARE POSSIBLE STEPS?

STEP 1.
ASSESS AND PRIORITIZE ADVOCACY NEEDS

Key issues for advocacy should be prioritized according to local needs and challenges.

CO-CHAIRS' ROLE
- Facilitate the development of an MHPSS advocacy plan for the TWG.
- List advocacy needs as a regular item in MHPSS TWG meeting agendas.

TIP
Using needs assessments, identify priorities for advocacy or awareness-raising.

STEP 2.
DEVELOP AND DELIVER KEY MHPSS ADVOCACY MESSAGES[1]

Having an agreed plan and a shared set of messages ensures consistency, supports partners and increases collaboration. MHPSS TWGs can include advocacy activities as budgeted items in their workplans.

CO-CHAIRS' ROLE
- Facilitate the development of key MHPSS messages.
- Advocate for MHPSS in larger coordination meetings (e.g. cluster/AoR meetings, ICCT meetings) and with relevant stakeholders.

TIP
Find local leaders and champions (who may or may not be MHPSS experts) to better deliver the chosen messages.

STEP 3.
DISSEMINATE INFORMATION ON MHPSS SERVICES

The development and dissemination of information, education and communication (IEC) materials, including MHPSS-related information, can be coordinated within the MHPSS TWG. Materials should be appropriate to the context and the affected populations, and should take account of culture, literacy and access to technology.

CO-CHAIRS' ROLE
Facilitate the dissemination of IEC materials, in line with the TWG's advocacy plan.

TIP
Radio, drama, round table discussions, newsletters and other formats can be useful for awareness-raising activities and can increase reach.

STEP 4.
CONDUCT MHPSS BRIEFING SESSIONS

MHPSS briefing sessions can influence different humanitarian actors to recognize the value of MHPSS. Likewise, briefing partners on the MHPSS needs arising from the emergency, the response, and the gaps and challenges can be critical to increasing support.

CO-CHAIRS' ROLE
- Link with donors and key stakeholders to coordinate MHPSS briefings.
- Coordinate orientation sessions with interested agencies or sectors (see Annex 14).

TIP
Developing briefs with key messages can be a useful method for dissemination.

STEP 5.
SUPPORT TOPIC-SPECIFIC ADVOCACY OR AWARENESS RAISING

MHPSS TWGs can also support advocacy and awareness-raising for relevant topics through joint activities, campaigns or sessions and in partnership with existing community groups and other stakeholders.

CO-CHAIRS' ROLE
- Facilitate identifcation of the central issues for advocacy among TWG members.
- Support planning for advocacy activities through the MHPSS TWG workplan.

TIP
Use global events, such as World Mental Health Day (10 October), for joint activities. The TWG can support coordination of these activities.

HOW CAN THIS FUNCTION BE MEASURED?

OUTCOME
MHPSS is recognized as a cross-cutting priority for action.

INDICATORS
- **# MHPSS awareness-raising activities completed**
- **Adapted set of key MHPSS messages developed**
- **# and types of key response plans, strategies (e.g. national plans, Humanitarian Response Plans, multisectoral strategies) or calls for funding that include references to MHPSS.**

MEANS OF VERIFICATION
- **Event reports**
- **Pre and post surveys on MHPSS knowledge, attitudes and feedback**
- **Annual analysis of calls for proposals, budgets and response plans (e.g. during HNO and HRP cycles; see Annex 12).**

1 IASC Reference Group on MHPSS (2011). Advocacy Package: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. 2011. https://interagencystandingcommittee.org/system/files/1304936629-UNICEF-Advocacy-april29-Enghlish.pdf

CASE STUDY 9
RAISING AWARENESS IN CARIBBEAN ISLAND COUNTRIES

In 2017, many Caribbean Island countries were severely affected by Category 5 hurricanes Irma and Maria. These events were not entirely unique but represented the frequent natural hazards that many Caribbean countries face.

During the emergency response, MHPSS needs were often unmet, even though some countries did have MHPSS response plans in place. The problem was that, while plans were comprehensive and properly constructed, their implementation was limited by a lack of awareness and knowledge of MHPSS, a lack of prioritization and a lack of resources and capacities on the ground. To address these issues, the Caribbean Development Bank (CDB) and the Pan American Health Organization (PAHO) partnered to implement a project with four objectives: 1) capacity-building; 2) communication and awareness-raising; 3) monitoring and evaluation; and 4) country-specific development of realistic plans, including standard operating procedures (SOPs) for decision-making in response to emergencies.

A major goal of communication and awareness-raising was to address the influence of mental health stigma and traditional roles among Caribbean communities. To address these issues, actors implemented a campaign to raise awareness on MHPSS issues within communities regularly affected by hurricanes, including many rural island communities, where emergency response relies heavily on community support and local actors. Based on the "one love, one family" principle of many Caribbean cultures, an awareness campaign and a slogan, "Stronger Together", were developed to disseminate information on better coping and to reduce stigma around help-seeking. This campaign consisted of public service announcements, radio and social media messages and testimonials and illustrated comic strips depicting how to provide basic psychosocial support, such as PFA, for friends, family members and neighbours.

In November 2021, ministers and national government authorities from the Americas region adopted a declaration on the implementation of the Sendai Framework for Disaster Risk Reduction (2015–2030). MHPSS was included in the declaration in para 24: "Promoting mental health and psychosocial wellbeing by strengthening psychosocial responses and support mechanisms in disaster risk reduction and recovery planning."

Resources **For additional resources to support implementation of this core action, please see Annex 14.**

WHO / Lyndsey Mackenzie

WHO / Blink Media - Nana Kofi Acquah

WHO / Lyndsey Mackenzie

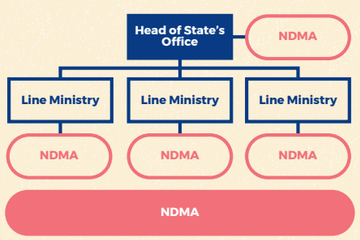
ANNEXES

Annex 1 Brief overview of common coordination structures

National coordination mechanisms

In many settings, countries with pre-existing and prepared structures, policies and systems lead the coordination of emergency response, and external actors and other systems, such as the cluster system, may be less active. Many of these same countries have also begun to emphasize preparedness and disaster risk reduction (DRR), establishing coordination structures prior to emergencies and bridging the humanitarian and development nexus. In these contexts, UN agencies and INGOs[1] often take a supporting role and a national disaster management agency (NDMA; or risk management (NDRMA)) or similar body manages preparedness and response and coordinates actors, including various government ministries. As mandated response agencies in auxiliary roles to governments, Red Cross and Red Crescent (RCRC) National Societies are also always active in national coordination mechanisms where they operate. However, these

Variations of national disaster management agencies



models of coordination can vary greatly. Collaboration between international actors and government-led coordination models can present both challenges and opportunities. Governments and external actors may be less familiar with one another, including each other's goals and mandates, and may struggle to align priorities; they may hold differing attitudes or ideas about coordination or may face competition between political and humanitarian imperatives. However, at its best, government leadership in coordination strengthens accountability, emphasizes national autonomy and establishes a sustainable link between response and long-term development.[2]

Cluster coordination[3]

The cluster approach is the current basis of the international humanitarian response coordination system and emphasizes sectoral-based approaches, organized around the humanitarian programme cycle. A "sector" refers to a discrete technical area of work (e.g. education, health, logistics). The implementation of the cluster approach strives to improve coordination through grouping humanitarian organizations, both UN and non-UN, according to these over-arching sectors of humanitarian action, while formalizing the responsibilities of agencies tasked with leading each cluster. Clusters are activated when 1) response and coordination gaps exist due to major changes in or deterioration of the situation and 2) existing national response or coordination capacity is unable to meet needs in a manner that aligns with humanitarian principles.[4]

1 In December 1991, the United Nations General Assembly Resolution 46/182 created the Inter-Agency Standing Committee (IASC) as the highest-level coordination forum in the UN system.[5]

2 In 2005, a major reorganization reform, the Humanitarian Reform, introduced the Cluster Approach. The goal was to support governments in strengthening the coordination of external assistance in emergency response (except refugee settings) in partnership with the UN Office for the Coordination of Humanitarian Affairs (OCHA).

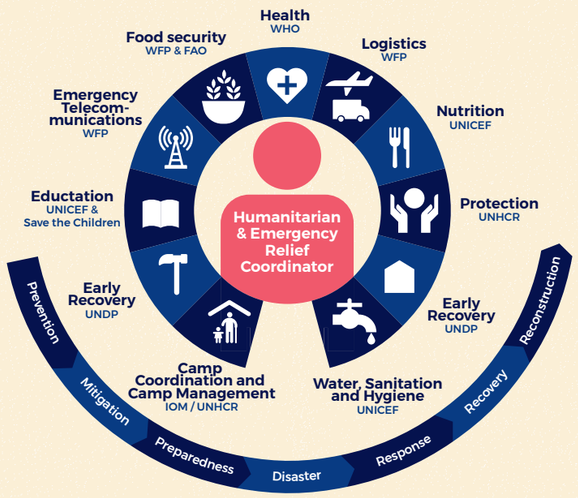
3 **Clusters:** The IASC established 11 clusters at the global level, each of which may or may not be activated by the IASC in an emergency according to the needs of the situation. Ideally, clusters encourage equal, accountable and democratic partnership among members and facilitate similarly focused national NGOs, Government line ministries, international NGOs, Red Cross and Red Crescent National Societies and UN agencies coordinate assessments, identify gaps and solve issues. Ideally, clusters support and complement national response mechanisms, rather than create parallel ones. Within the Protection Cluster, there are Areas of Responsibility (AoRs; sometimes referred to as "sub-clusters", focused on specific areas of work (the Global Protection Cluster has four specialized AoRs: Child Protection; Gender-Based Violence; Housing, Land and Property; and Mine Action).

4 **Humanitarian coordinator (HC):** The HC is responsible for the organisation and delivery of the international humanitarian response at the country level, coordinated through clusters, and overseen by the Humanitarian Country Team (HCT) and under the overall authority of the Emergency Relief Coordinator (ERC) who oversees global emergency response.[6]

5 **Inter-Cluster Coordination Group (ICCG):** The ICCG (sometimes referred to as the "Inter-Cluster" or "Inter-Sector" Group) is a collaborative forum between sectors/clusters that reports to the HCT and works to ensure coordination across clusters while aligning goals and reducing duplication.

6 **Cluster (or AoR) lead agencies (CLAs):** CLAs are IASC-mandated agencies that take responsibility for facilitating clusters in-country. AoRs also have lead agencies. Where possible, these agencies work in co-leadership with, or in support of, government actors. They are selected based on their capacity, operational presence and ability to scale up. They also agree to be "provider of last resort", meaning that where there are critical gaps, cluster leads are responsible for calling on partners to address them, or filling them themselves.

The cluster approach to humanitarian emergencies



7 **Cluster coordinator:** The cluster coordinator is the individual tasked with facilitating individual cluster activities in-country and working on behalf of the cluster.

8 **Cluster members:** Cluster members are agencies working in the sector and active in the cluster.

Refugee and "mixed setting" coordination[7]

In refugee settings, the United Nations High Commissioner for Refugees (UNHCR) is mandated to coordinate assistance, provide protection, obtain durable solutions and advocate for the rights of refugees and stateless persons. Refugee response coordination is similar to cluster coordination, but it is typically structured according to sectors (i.e. discrete technical areas) rather than formal clusters (i.e. official groups with lead agencies and formal accountabilities).

Many humanitarian contexts globally involve both internally displaced persons (IDPs) and refugees in the same area. These are often referred to as "mixed" settings. In these situations, UNHCR, the host government and the Humanitarian Coordinator (appointed by OCHA) determine which inter-agency coordination mechanism is most appropriate. If there are refugee camps or a concentration of refugees in one area, then a separate refugee coordination model led by the host government may be developed and UNHCR may co-lead. The number of sectors activated depends on discussions between UNHCR and the governmental authorities and can vary greatly across contexts.

Coordination in public health emergencies

Public health emergency (PHE) response is organized around strategic pillars (e.g. risk communication, case management, vaccination). A functional PHE management programme and an emergency operations centre (EOC) are both key to coordination at the national level. The International Health Regulations (IHR; 2005) provide a regulatory framework for management of PHEs at national, regional and global levels. The IHR require that State Parties (national governments) develop, strengthen and maintain their capacity to respond to public health risks. Under the IHR, countries are also required to notify the WHO of all events that may constitute a PHE of international concern, at which time international systems for coordination and response may be activated. Each country signatory to the IHR is also required to establish a national IHR focal point, to develop a national emergency plan that sets out clear protocols and to strengthen and maintain their surveillance and response capabilities. Where they exist, these structures are an entry point for engagement with local authorities. However, the COVID-19 pandemic has had a considerable impact on how PHE response is coordinated. At a global level, the COVID-19 response has been coordinated through many new mechanisms, tools and platforms.[8] To support national-level coordination, the COVID-19 Strategic Preparedness and Response Plans for 2020 and 2021 were developed, along with the accompanying operational planning guidelines,[9] which set out objectives and actions arranged around 10 pillars of COVID-19 response. Pillar one of the SPRP 2021, Coordination, planning, financing and monitoring, advocates for countries to establish multi-sectoral coordination mechanisms to facilitate coordination, engage in information sharing and develop national response plans.

Area-based coordination[10]

Area-based coordination organizes efforts around local contexts and existing structures and systems, while emphasizing a locally driven response. These approaches are driven by sub-national entities or actors, such as local actors, mayors, municipalities or governorates/provinces, and place external international actors in the role of working with and through existing systems. Area-based coordination aligns well with the localization agenda of the Grand Bargain, an agreement across many donor and aid organizations that aims to put more means into the hands of people in need and improve the effectiveness and efficiency of humanitarian action. While area-based approaches take different forms, three defining principles have been identified. These are: 1) the programmes are organized and targeted geographically, recognizing differing contexts within individual crises; 2) they are multi-sectoral and multi-disciplinary, rather than being grouped into individual sectors or clusters; and 3) they are designed through local participation and ownership.[11]

1 In WHO's Mental Health Atlas 2020, Member States reported for the first time on programmes integrating MHPSS and preparedness or disaster risk reduction, indicating growing attention and effort in this area. In total, 28% of Member States reported that such programmes were in place in their country.

2 For further discussion of the opportunities and challenges of government coordination and leadership, please see Section 3.4.2 in: Knox-Clarke P and Campbell L. Exploring Coordination in Humanitarian Clusters. 2015. ALNAP Study: London. https://www.alnap.org/help-library/exploring-coordination-in-humanitarian-clusters

3 For more on the cluster approach, please visit: https://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach

4 For more information on cluster activation, please visit: https://www.humanitarianresponse.info/en/coordination/clusters/activation-and-deactivation-clusters

5 For more information on the IASC, please visit: https://interagencystandingcommittee.org/

6 For more information about the various actors involved in the cluster system, please see: https://www.humanitarianresponse.info/en/coordination/clusters/who-does-what

7 For more on refugee and mixed setting coordination, please visit: https://emergency.unhcr.org/entry/38270/refugee-coordination-model-rcm

8 For example, please visit the WHO COVID-19 Partners Platform for Health in Emergencies, available at: https://covid19partnersplatform.who.int/en/

9 For more information, please visit: https://www.who.int/publications/i/item/draft-operational-planning-guidance-for-un-country-teams

10 For more information on area-based coordination, please visit: https://reliefweb.int/sites/reliefweb.int/files/resources/inclusive-coordination-konyndyk-saez-worden.pdf

11 Parker E and Maynard V. Humanitarian Response to Urban Crises: a Review of Area-Based Approaches. IIED Working Paper. London: IIED; 2015. http://pubs.iied.org/10742IIED.html?k=maynard&r=p

Annex 2 MHPSS across PHE response pillars

PHE pillar	Examples of MHPSS activities
Coordination, planning, financing and monitoring	• Establish a functioning multi-sectoral mental health and psychosocial support (MHPSS) technical working group. • Establish an MHPSS strategy that addresses fear, stigma and negative coping mechanisms and builds on community supports. • Establish monitoring, evaluation, accountability and learning mechanisms to measure the effectiveness of MHPSS activities.
Risk communication and community engagement	• Include messages on coping with stress and access to self-help and MHPSS services in risk communication and community engagement. • Facilitate community dialogues to promote community reintegration and avoid stigmatization of survivors.
Surveillance, epidemiological investigation and contact tracing	• Strengthen capacities of all frontline workers (e.g. health workers, burial team members) to provide basic psychosocial skills and supportive communication, including during case detection and patient isolation/ management/referral. • Include culturally specific MHPSS issues, needs and available resources in surveillance and risk assessment systems and activities.
Points of entry, international travel and transport, mass gatherings	• Disseminate information at points of entry, in transportation and at mass gatherings by providing materials (posters, videos) that increase 1) awareness of the PHE; 2) safe practices; 3) positive coping strategies to promote mental health and well-being. • Make MHPSS services available for transportation workers affected by protective measures (e.g. seafarers prevented from taking shore leave).
Laboratories and diagnostics	• Make MHPSS services available for all laboratory workers and staff. • Develop a system to identify people with mental health conditions and link to evidence-based care in each health facility.
Infection prevention and control, water, sanitation and hygiene	• Facilitate communication between patients in isolation or quarantine and family members through organized visits or telephone contact. • Wherever possible, ensure that children remain with their caregivers and are cared for in child-friendly spaces, considering their specific needs.
Case management, clinical operations and therapeutics	• Ensure that MHPSS is made available for all persons exposed or infected as well as health workers, regardless of location or unit of care. • Provide basic MHPSS for all persons who have recovered following exposure and support their reintegration into families and communities.
Operational support and logistics	• Include mapping (e.g. 4Ws) of available MHPSS services and resources in operational support and logistics (OSL) planning and assessment.
Maintaining essential health services & systems	• Include MHPSS services in country-specific lists of essential services and within mechanisms to govern essential health service delivery. • Adapt existing MHPSS services and operations to maintain access during PHEs in line with infection prevention and control measures.[1] • Assess and monitor ongoing availability and access to MHPSS services to identify gaps and revise disrupted referral pathways.
Vaccination	• Provide basic psychosocial support as part of vaccination procedures and to persons experiencing adverse effects following vaccination.
Safe and dignified funeral rites	• Support communities to engage in safe and dignified funeral practices while ensuring infection control. • Train teams responsible for carrying out safe and dignified funeral rites, burial practices and decontamination in the provision of basic psychosocial support.

1 For examples of guidance for the COVID-19 pandemic, please see: Operational Considerations for Multisectorial MHPSS Programmes during the COVID-19 Pandemic. IASC. 2020 https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-guidance-operational-considerations-multisectoral-mental-health-and-psychosocial-support

Annex 3 Resources for integrating MHPSS across sectors

Sector	Resources
Multi-sector resources	• IASC (2007). IASC Guidelines on MHPSS in Emergency Settings. Available in many languages. • MHPSS.net Emergencies Toolkit Version 2.0. Available here. • WHO, UNICEF, UNHCR & UNFPA. MHPSS Minimum Services Package. Available in English, Spanish and Ukrainian.
Education	• ECW (2021). Technical Guidance Note on MHPSS in Education in Emergencies and Protracted Crises. Available here. • INEE (2019). Psychosocial Support: Social and Emotional Learning Training Module. Available in Arabic, English, French, Portuguese, Spanish. • MHPSS.net (2021). MHPSS and Education in Emergencies Toolkit. Available here.
Nutrition	• Action Contre la Faim (2013). Manual for the Integration of Child Care Practices and Mental Health into Nutrition Programmes. Available here. • Inter-Agency Working Group on Infant and Young Child Feeding in Emergencies (IFE) (2017). Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Programme Managers Version 3.0. Available in many languages.
Health	• IASC (2010). MHPSS in Emergency Settings: What should health actors know? Available here. • Sphere (2018). Sphere Handbook: Health Standard. Available in many languages. • WHO (2022). Introducing Mental Health and Psychosocial Support (MHPSS) in emergencies. Available here.
Protection	• IASC (2010). MHPSS in Emergency Settings: What should protection managers know? Available here. • Global Protection Cluster (2020). MHPSS and protection outcomes: Why joint action to improve mental health and psychosocial wellbeing of people affected by conflict, violence and disasters should be a priority for all protection actors. Available here.
Child Protection	• Alliance for Child Protection in Humanitarian Action (2019). Child Protection Minimum Standards and Associated Resources. Available here. • Child Protection AoR. Remote training video series: Orientation of frontline workers delivering community based mental health and psychosocial support. Available in English, French, Spanish.
Mine Action	• Anti-Personnel Mine Ban Convention (2011). Assisting Landmine and Other ERW Survivors in Disarmament, Disability and Development. Available here • Anti-Personnel Mine Ban Convention (2016). Guidance on Victim Assistance Reporting. Available here. • Humanity and Inclusion. How to implement victim assistance obligations factsheet: Topic 3. Available in many languages.
Gender-Based Violence	• GBV AoR (2019). Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming. Available here. • GBV Guidelines Reference Group & Gender-Based Violence AoR (2018). How to support survivors of gender-based violence when a GBV actor is not available in your area. A step-by-step Pocket Guide for humanitarian practitioners (version 2.0). Available in many languages. • UN Women, UNFPA, WHO, UNDP & UNODC (2015). Essential Services Package for Women and Girls Subject to Violence. UN Joint Programme on Essential Services for Women and Girls Subject to Violence. Available here.
Shelter / CCCM	• IASC (2010). MHPSS in Emergency Settings: What should camp coordination and camp management actors know? Available here. • CCCM Cluster (2015). Camp Management Toolkit. Available here. • Webb S and Weinstein Sheffield E (2021). Mindful Sheltering. Oxford: Oxford Brookes University & CARE International UK. Available here.
WASH	• IASC (2007). IASC Guidelines on MHPSS in Emergency Settings: Action sheet 11.1. Available in many languages.

Annex 4 List of indicators for Core Actions

Overall goal: reduced suffering and improved mental health and psychosocial well-being through better MHPSS coordination

Core Action	Outcome	Indicators	Means of verification
1. (Re) establishing and maintaining a functioning TWG	A functional MHPSS TWG is established and facilitates better coordination	● Existence of a functional workplan developed in collaboration with local actors and affected persons ● % of workplan objectives achieved in specific period (e.g. one year) ● % of MHPSS TWG members who are local or national actors	● Workplan review ● Meeting minutes
2. Information management	The size and nature of the MHPSS response is known and needs and gaps are identified	● # of gaps addressed following mapping/ gaps analysis ● % of needs assessments or workplans integrating MHPSS	● Mapping and gaps analysis report ● Assessment or workplan reviews
3. Establishing links between stakeholders	MHPSS is integrated within the work of relevant clusters, sectors and partners	● # of joint initiatives or activities ● Establishment of a functioning referral system ● # of sectors and AoRs represented in MHPSS TWG meetings	● Activity reports ● Referral records ● Meeting minutes
4. Building capacity, knowledge exchange and peer support	Humanitarian actors demonstrate increased MHPSS knowledge, skills and capacities	● Existence of MHPSS TWG capacity-building plan with clear indicators ● # of humanitarian actors oriented on MHPSS guidance and on how to avoid harm (e.g. on the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, the MHPSS MSP, disaggregated by type of workshop, and by sector/field of work) ● # of identified capacity gaps addressed via capacity-building initiatives	● Capacity-building plan ● Inter-agency training needs assessment reports ● Training or workshop evaluation reports
5. Ensuring monitoring and evaluation (M&E)	Improved monitoring and evaluation of impacts of MHPSS programming	● % of affected people reporting active involvement in monitoring and evaluation of MHPSS programming ● % of MHPSS TWG members reporting M&E of MHPSS programmes ● Annual review and revision of TWG workplan and strategy, based on M&E data and feedback from affected populations	● Participatory evaluations ● Survey or interviews of MHPSS TWG members ● Workplan review workshop report
6. Promoting long-term sustainability	The MHPSS response leads to sustainable systems and services	● % target communities where local people report being actively supported to design, organize and implement MHPSS activities themselves ● Existence of transition/handover plans (if external actors involved) ● Regular review of localization, transition and handover (where international actors are involved)	● Participatory evaluation ● Localization assessment ● Sustainability checklist (Annex 13)
7. MHPSS advocacy	MHPSS is recognized as a cross-cutting priority for action	● # MHPSS awareness-raising activities completed ● Adapted set of key MHPSS messages developed ● # and types of key response plans, strategies (e.g. national plans, humanitarian response plans, multisectoral strategies) or calls for funding that include references to MHPSS	● Event reports ● Pre and post surveys ● Stakeholder plans/ budgets

Annex 5 Checklist of Core Actions deliverables

Core Action		Key deliverables
1	**(Re)establishing and maintaining a functioning TWG**	☐ Consensus-based ways of working, such as ToRs ☐ Workplan ☐ Coordination procedures and mechanisms
2	**Information management**	☐ Desk review of existing information ☐ 4Ws mapping (and plan for regular updating)/gaps analysis ☐ List of MHPSS assessment questions ☐ Resource centre
3	**Establishing links between stakeholders**	☐ List of MHPSS TWG focal points for each sector ☐ Partners brief on referral pathways and procedures ☐ Agendas for MHPSS orientation sessions
4	**Building capacity, knowledge exchange and skills transfer**	☐ Inter-agency training needs assessment ☐ Training/workshop plan ☐ Repository of training materials/trainers
5	**Monitoring and evaluation**	☐ Inter-agency monitoring and evaluation workshop ☐ Common set of indicators and means of verification
6	**Promoting long-term sustainability**	☐ Transition/handover plan (if applicable) ☐ MHPSS minimum standards ☐ MHPSS sustainability checklist (see Annex 13)
7	**MHPSS advocacy**	☐ Key MHPSS messages and IEC materials ☐ Distribution channels for messages (e.g. newsletters) ☐ MHPSS briefing sessions

Annex 6 MHPSS Minimum Service Package (MSP) actions arranged by handbook Core Actions

The following table maps the Core Actions of this handbook against the core activities outlined in the Coordination section of the WHO, UNICEF, UNHCR and UNFPA MHPSS Minimum Service Package (MHPSS MSP), which describes a minimum set of actions to coordinate MHPSS activities, as well as additional activities for consideration, for agencies implementing the MHPSS MSP. For these agencies, the following table may be useful in understanding how this handbook is aligned with the content of the MHPSS MSP.

Core Action	MHPSS MSP section 1.1: coordinate MHPSS within and across sectors
(Re) establishing and maintaining a functioning working group	✔ **Facilitate coordination between different actors** to avoid duplication, address obstacles and **fill gaps in the response** based on the MHPSS MSP and relevant assessments. ✔ Meet with government and humanitarian actors to **establish MHPSS-specific roles and responsibilities in the emergency response** (e.g. government, INGOs, NGOs, CBOs and other key partners in Health, Protection, Education, Nutrition, CCCM and other sectors). ✔ Establish (further) **sub-national** MHPSS Working Groups if needed. ✔ Establish multi-disciplinary **taskforces** to work on urgent context-specific issues that are not being addressed elsewhere (e.g. addressing an upsurge in suicide, MHPSS for children associated with armed forces and groups, perinatal mental health, etc.
Information management	✔ Establish a single **cross-sectoral** MHPSS Technical Working Group (TWG) and, if required, sub-national TWGs.[1] ✔ Support **MHPSS needs assessments** and the inclusion of MHPSS in other needs assessments and ongoing monitoring by relevant sectors to inform response planning (e.g. Humanitarian Needs Overviews, Humanitarian and Refugee Response Plans). ✔ Conduct and distribute a comprehensive **mapping of MHPSS actors, services and activities** (e.g. 4Ws MHPSS service mapping, MSP gap analyses). Review gaps in services at regular intervals to inform planning. ✔ Regularly **share information** among humanitarian MHPSS and other actors (e.g. assessment reports, service directories and collated information in designated groups on MHPSS.net). ✔ Develop, strengthen, update and implement joint **referral pathways** to facilitate access to the full range of MHPSS services and activities and to additional support (e.g. Protection including Child Protection (CP) and GBV, Health, Education, Livelihoods and community-based support) as needed (e.g. a directory of services and referral information, common referral forms and pathways, standard operating procedures (SOPs)).
Establishing links between stakeholders	✔ **Coordinate with all relevant sectors, clusters or coordination groups** (e.g. Health, Education, CCCM, Nutrition, Protection, including AORs (e.g. CP, GBV, Mine Action, Housing, Land and Property (HLP) AoRs, and the disabilities TWG), with civil society (e.g. CBOs, CSOs) and with **government actors** (e.g. ministries of health, social welfare, education). This includes ensuring mutual **representation**, participation and contribution at coordination meetings.
Building capacity	✔ Disseminate and adapt **MHPSS guidance** (e.g. IASC resources, the MHPSS MSP) and conduct **rapid orientations** on this guidance for agencies funding, planning or implementing MHPSS activities.
Monitoring and evaluation	✔ Support **information management** and the reporting of MHPSS activities and indicators. This includes defining MHPSS M&E indicators for humanitarian information systems (e.g. inter-agency/ cluster reporting systems) and orienting agencies on how to use these systems.
Promoting long-term sustainability	✔ Support the development of **sustainable mental health, social care and education systems** as part of early recovery planning and during protracted crises. **Link** MHPSS emergency activities with **comprehensive and complementary development activities** in coordination with donors and government actors (e.g. supporting long-term planning with government and national actors centrally involved, workforce development activities, demonstration projects showing system reform across a geographical area).
MHPSS advocacy	✔ Advocate for the inclusion of MHPSS in **funding and resource allocations** (e.g. targeting donors, funding mechanisms). ✔ **Advocate for MHPSS considerations for adults and children in different sectors** and by different actors (e.g. delivering humanitarian aid in a way that reduces distress and promotes dignity, including MHPSS in referral pathways developed by other sectors). ✔ Make MHPSS a recurring agenda item at **inter-agency meetings** (e.g. Inter-Cluster Coordination Group (ICCG) and UN country meetings, cluster coordination and multi-sector refugee coordination meetings) and forums to help ensure an inter-sectoral response and support for MHPSS priorities.
(Re)establishing and maintaining a functioning working group	✔ Establish (further) **sub-national** MHPSS TWGs if needed. ✔ Establish multidisciplinary **taskforces** to work on urgent context-specific issues that are not being addressed elsewhere (e.g. addressing an upsurge in suicide, MHPSS for children associated with armed forces and groups, perinatal mental health, etc.).
Establish links between partners	✔ **Develop joint workplans for MHPSS** within MHPSS TWGs, linking and supporting collaboration in activities within and across sectors and organizations.
Capacity-building	✔ **Orient cluster coordination groups**, multi-sector refugee coordination groups and **AOR coordinators on MHPSS** to identify how their respective sectors contribute to MHPSS outcomes and how MHPSS activities can contribute to outcomes in other sectors, and to identify opportunities for effective integrated programming. ✔ Develop and maintain a register **of national expert trainers** for MHPSS curricula (e.g. basic psychosocial skills, WHO's Mental Health Gap Action Programme Humanitarian Intervention Guide (mhGAP-HIG), psychological interventions, social and emotional learning (SEL), positive parenting packages).
Promoting long-term sustainability	✔ Advocate for local and **national policies and interventions** to reflect international good practice guidelines for MHPSS, and support government actors in designing, implementing or strengthening services. ✔ Support the building of **national-level capacity** for the continuation of coordination by supporting or developing sustainable coordination structures, including government and civil society stakeholders.

Annex 7 Analysing existing coordination structures[2]

Key considerations in analysing existing coordination structures	
Key consideration: Is there a forum or platform that can support MHPSS coordination?	● What is the structure and function? ● Who are the members and who provides leadership? ● Does it have capacity to support MHPSS cross-sectoral coordination? Can it be adapted for this purpose? ● Are the members and leadership open to this?
Key consideration: Does the structure fit the needs of the emergency?	● How have previous emergencies been addressed? ● How large is this emergency and is this forum commensurate with that? ● Are all stakeholders equally represented? ● Is power shared equally among all stakeholders? ● Where are partners in this mechanism located or active? ● Are there gaps in coverage?
Key consideration: What role do the national authorities play, or plan to play, in MHPSS or coordinating MHPSS?	● Is there a national disaster management (or disaster risk management) agency? Is MHPSS included as part of its mandate? ● Is MHPSS part of national strategic preparedness and response strategies? ● Does the national authority have interest in or the capacity to facilitate an MHPSS TWG? ● How do the different sectors (education, health, protection, social services, disaster management, etc. work together?

1 To avoid fragmentation and duplication, it is important that only one MHPSS coordination group is operational. Where separate coordination groups exist (e.g. a mental health coordination group and a psychosocial support coordination group), they should be merged into one overarching group to coordinate the MHPSS response as a whole. See the IASC (2007) Guidelines on MHPSS in Emergency Settings, the IASC Principals Decision of 5 December 2019, the Sphere Handbook 2018 and the MHPSS and Protection Outcomes (Global Protection Cluster, 2020).

2 Adapted from The Global Nutrition Cluster. Nutrition Cluster Handbook (2013).

Annex 8 Potential stakeholder roles and responsibilities

Stakeholder	Potential roles and responsibilities
Affected populations	• Taking a leading role in identifying local needs, risks and capacities and collaborating with governmental and non-governmental actors to inform, design, implement and evaluate the MHPSS response. • Raising awareness of local mental health and psychosocial well-being issues, barriers to accessing support and reducing stigma. • Providing feedback about MHPSS activities and services that are part of the response, particularly the crucial cultural considerations that must be taken into account.
Local and national government	• Committing to the development and leadership of a national cross-sectoral MHPSS TWG and/or sub-national working groups, where necessary. • Actively participating in MHPSS TWG meetings and playing a key role in carrying out tasks in TWG workplans and ToRs. • Allocating necessary funding, resources and institutional supports to implement MHPSS coordination.
National and local DRR platforms and disaster management agencies[16]	• Integrating mental health and psychosocial support into relevant policy, planning and coordination platforms. • Ensuring that MHPSS actors and agencies are actively involved in all aspects of DRM.
Ministries of health, education, welfare or social services, and finance	• Engaging in advocacy for MHPSS both inside and outside of their sector and across other sectors. • Designating a focal point (or unit) for MHPSS to coordinate with larger response efforts, other agencies and actors, ministries, civil society and the private sector.
Community-based organizations (CBOs)	• Advocating for, supporting and participating in MHPSS response strategies and planning. • Creating enabling environments for particularly at-risk groups and empowering them to take a leading role in informing and participating in the MHPSS response.
Organizations for persons living with disabilities	• Empowering persons living with disabilities to actively engage in informing the MHPSS response and coordination across agencies. • Establishing strong linkages with governmental and non-governmental actors and leading advocacy for policies and approaches inclusive of persons with mental and intellectual disabilities.
Mental health service user organizations	• Empowering service users to actively engage in informing the MHPSS response and coordination across agencies. • Establishing strong linkages with governmental and non-governmental actors and leading advocacy for policies and approaches inclusive of persons with mental health conditions.
Youth groups and civil society organizations (CSOs)	• Advocating for community commitment, policy and action at multiple levels. • Engaging actively as leaders in identifying local risks and planning for and implementing MHPSS in sectoral and multi-sectoral response plans.
Agencies working in sectors (or clusters) with direct impact on MHPSS	• Actively engaging in and supporting the MHPSS TWG. • Ensuring consideration and integration of MHPSS within and across sectors.

Stakeholder	Potential roles and responsibilities
Humanitarian coordination agencies and structures (e.g. OCHA, ICCG)	• Develop bi-directional relationships with the MHPSS TWG to support coordination and make the group aware of upcoming funding opportunities. • Ensuring consideration and integration of MHPSS within and across sectors.
Donors and financing agencies	• Identifying and responding to areas of MHPSS with limited financial resources. • Promoting ethical and quality delivery of MHPSS services through strong benchmarks within grantees' projects and programmes. • Providing constructive feedback for the MHPSS TWG on accessing financial support for programme planning and operation.
Private sector	• Engaging in efforts to mobilize and raise awareness of MHPSS. • Sharing knowledge, expertise and resources and encouraging innovation for advancing the MHPSS response.
International agencies and organizations	• Actively engaging in and supporting the MHPSS TWG. • Providing financial, technical and human resources support to MHPSS efforts through capacity development, guidance and implementation support.
Academic and research institutions	• Providing support for obtaining funding and evidence-based programme development. • Supporting contextualization through local adaptation and testing of MHPSS activities.
Media agencies and journalists	• Providing responsible media coverage of distressing events in line with best practice recommendations and raising awareness of the importance of preparing for emergencies and investing in DRR and mental health and well-being.[17]
Military and peacekeeping forces	• Supporting peacebuilding activities, in coordination with the MHPSS TWG, to enable conflict-sensitive MHPSS programming. • Coordination with armed or peacekeeping forces may be necessary in complex emergency situations and should, where possible, be undertaken through established communication protocols. Any interaction must respect humanitarian law and must serve the primary purposes of relieving humanitarian suffering and assuring protection and assistance for all non-combatants affected by the situation.

16 National disaster management agencies (NDMAs) and the functions typically handled by them can be found within a variety of government ministries, agencies and offices, depending on the country. NDMAs or related functions are most commonly part of the civil protection agency, national DRR agency, environmental protection agency, ministry of internal affairs, ministry of planning and development or office of the prime minister.

17 Kawamoto K (2005). Best Practices in Trauma Reporting: Ideas and insights from award-winning newspaper articles. Dart Center for Journalism & Trauma. https://dartcenter.org/sites/default/files/da_best_practices_0_1.pdf

Annex 9 Tips for MHPSS TWG terms of reference and workplans

Tips for building ToRs and workplans **Goal:** Engage partners and build consensus		
Process of development	**a** Start from an existing draft (e.g. other TWG ToRs; see Annex 14 Core Action 1).	● Keep it simple and functional: ToRs and workplans are the agenda of the group.
	b Co-chairs adapt to country context and share with TWG.	● Base these on locally identified priorities through active engagement with stakeholders.
	c Group members participate in the revision process.	● Developing ToRs should take a few weeks at the most: too much time kills the process.
	d Feedback discussed at TWG meeting(s) until consensus is achieved.	● Make sure that the ToRs and workplans are realistic and relevant; schedule a regular review to keep them up to date.

Examples of workplan activities	Example ToR outline
● Assess needs, human resources and services by mapping (e.g. 4Ws). ● Coordinate programme planning and implementation. ● Integrate MHPSS in response plans. ● Review mental health laws and policies. ● Plan for broad capacity-building activities. ● Advocate for funding.	● Background. ● Definition of MHPSS. ● Guiding principles. ● Scope and objectives. ● Membership, roles and responsibilities. ● Key functions and general activities. ● Assessment, analysis and information-sharing.

MHPSS TWG workplans

Do	Don't
✔ Make the workplan context-specific and in collaboration with local populations.	✘ Develop workplans without considering local needs or priorities.
✔ Use workplans to operationalize the core actions described in this handbook.	✘ Develop unrealistic workplans that do not match local needs or capacities.
✔ Reflect the consensus-based objectives of the MHPSS TWG.	✘ Develop a workplan without consensus.
✔ Outline communication and collaboration mechanisms among TWG partners (e.g. referral pathways).	✘ Assume that TWG partners have aligned procedures for referral or communication.
✔ Identify roles and responsibilities in workplan activities.	✘ Develop a workplan without a clear division of labour.
✔ Maximize the use of resources, including time, in developing activities in the workplan.	✘ Implement a workplan that ends up being inefficient or leads only to a series of meetings and has little impact.
✔ Regularly evaluate the impact on affected local communities.	✘ Assume that the workplan will be effective.
✔ Use the workplan as a tool to address needs and priorities.	✘ View development of the workplan as the end goal of the TWG.
✔ View the workplan as a living document with a clear mechanism for regular review and update.	✘ View the workplan as a final product that cannot be changed.

Annex 10 Tips for integrating MHPSS into rapid needs assessments

In any emergency, needs assessments form a critical foundation of the response. Needs assessments inform priority-setting and in some cases are integral to the allocation of funding (e.g. such as in the HNO and HRP process in cluster settings). Many tools exist to ensure that needs assessments are integrated, well coordinated and rapid in order to conserve resources, reduce the burden on affected persons and harmonize response efforts.

Key integrated needs assessment tools and approaches	
● The Multi-Cluster/Sector Initial Rapid Assessment (MIRA) is a joint tool that can be used in sudden-onset emergencies, including IASC system-wide scale-up and response.	● The Joint Intersectoral Analysis Framework (JIAF) is a set of protocols, methods and tools design to classify humanitarian needs and inform decision-making. The JIAF was piloted in 27 countries to produce HNOs in 2021.
● The Assessment, Analysis, Planning & Monitoring Knowledge Management Platform (KMP) is a point of reference for users seeking good field examples, templates, guidance, tools and capacity-building materials relevant to coordinated needs assessment and analysis.	● Many other resources for integrated needs assessments exist. For more information, please see annex 14 Core Action 2.

Despite efforts to integrate needs assessments, actors in different sectors vary in the ways in which they collect data on people in need and priorities for response. Working to ensure that MHPSS needs are reflected in these assessments is key to ensuring that MHPSS is given proper priority and support across sectors. The challenge is that many integrated needs assessment tools and approaches do not explicitly include MHPSS, and many assessment teams face challenges in covering all the potential cross-cutting areas that could be included in designing these assessments. As a result, MHPSS TWGs should:

1. Advocate for an MHPSS expert to be included in multi-sectoral or integrated assessment teams (e.g. the MIRA team) to ensure that MHPSS is integrated appropriately.
2. Complement integrated needs assessment data with pre-existing data on MHPSS needs, where possible, to ensure that MHPSS needs are accurately reflected in response planning processes.
3. Provide solutions for assessment teams by writing text, providing guidance to assessment teams or offering potential questions for needs assessment instruments.

Dos and don'ts of integrating MHPSS questions in multi-sectoral needs assessments

Do	Don't
✔ Ask what are the most immediate and pressing needs, reactions and concerns of those affected.	✘ Use jargon or vague questions to ask about MHPSS (e.g. "What are your MHPSS needs?").
✔ Ask the affected population who they view as the most vulnerable groups.	✘ Assume that vulnerable groups are always the same across different contexts.
✔ Ask about the main sources of support and how people are coping with the situation.	✘ Assess levels or prevalence of mental health symptoms or disorders, particularly with tools that are not validated locally.
✔ Use existing guidance and toolkits to get started (see Annex 14 Core Action 2).	✘ Assume that all colleagues in the response are familiar with relevant guidance.

1 For more information and guidance on humanitarian needs assessments, please visit: https://www.humanitarianresponse.info/en/programme-cycle/space/page/assessments-overview

Annex 11 MHPSS assessments in the context of COVID-19 and PHEs

1. Background

Public health emergencies (PHEs) severely impact mental health and psychosocial well-being.[1] In this context, understanding the stressors that communities, families and individuals face, the supports available to them and their ability to cope is crucial for developing an effective response.

2. Purpose of this annex

This annex provides practical guidance on conducting MHPSS assessments in the context of PHEs. This guidance supplements resources for conducting MHPSS assessments in emergency settings[2, 3, 4] and for addressing MHPSS needs during PHEs.

3. Practical tips for conducting MHPSS assessments during PHEs

The approach to conducting MHPSS assessments will vary depending on the context and purpose of the assessment. In general, MHPSS assessments in emergency settings should be aimed at 1) providing an understanding of the situation from an MHPSS perspective; 2) analysing problems and the ability to cope; and 3) analysing resources to inform the response required.[5] The following "dos and don'ts" can be used to effectively design an assessment in order to address these aims in the context of PHEs.

Do	Don't
✔ **Rely on existing data** from all sectors, when possible. For example, existing data can inform prevalence estimates of MHPSS issues in humanitarian needs overviews.[6,7]	✘ **Duplicate assessments** or collect data that are unnecessary, will not add new information or are unsafe and may cause harm to those involved.
✔ **Prioritize critical activities** and proceed with extreme caution if conducting in-person assessments.	✘ **Carry out low-priority** or high-risk activities if these can be delayed until the situation is safer.
✔ **When new data are required, carry out rapid assessments** of the situation, needs and resources to inform response.	✘ **Carry out complex studies**, such as population-based studies, which are impractical in emergencies.
✔ **Protect people and staff** by prioritizing safety and adapting to avoid unnecessary contact.	✘ **Put people at risk of contracting COVID-19** by conducting unnecessary in-person contacts.
✔ **Ensure confidentiality, privacy and consent in** assessment.	✘ **Put people at risk of harm or stigma** from others.
✔ **Link assessment to action and advocacy** by analysing, sharing and acting on data collected.	✘ **Collect data without using them** or with unrealistic promises about how data will be used.
✔ **Tailor assessment tools** to the context and situation.	✘ **Implement a "one-size-fits-all" approach.**
✔ **Carry out participatory and inclusive assessments** as an opportunity to build trust and engage vulnerable groups.[7]	✘ **Exclude or overlook vulnerable groups** or those with limited access (e.g. without remote access).
✔ **Integrate MHPSS within both multi-sectoral and single-sector assessments** to inform a holistic MHPSS response.	✘ **Exclude MHPSS questions** in other sectors or assume that MHPSS is not relevant.
✔ **Coordinate MHPSS assessments across sectors.**	✘ **Carry out fragmented MHPSS assessments.**

1 United Nations Secretary-General (2020). UN Policy Brief: COVID-19 and the Need for Action on Mental Health. https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf

2 IASC Reference Group on MHPSS in Emergency Settings (2012). IASC Reference Group MHPSS Assessment Guide. https://interagencystandingcommittee.org/system/files/iasc_rg_mhpss_assessment_guide_.pdf

3 WHO and UNHCR (2012). Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. https://apps.who.int/iris/bitstream/handle/10665/76796/9789241548533_eng.pdf?sequence=1

4 International Medical Corps. Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings: Step 1. Assess & Plan for Mental Health Integration. https://www.mhinnovation.net/collaborations/IMC-Mental-Health-Integration-Toolkit

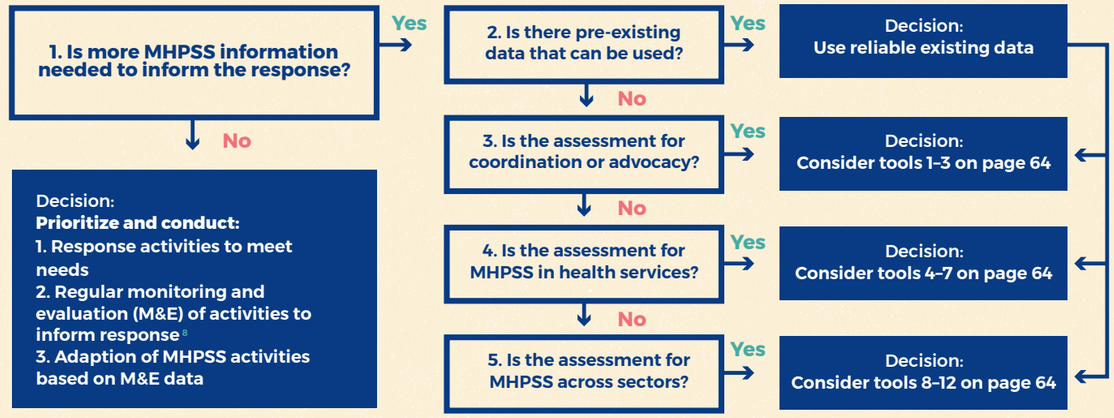
5 Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. The Lancet, 2019; 240-248. doi:10.1016/ S0140-6736(19)30934-1

6 Rogers JP, Chesney E, Oliver D et al. Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic. Lancet Psychiatry; 2020, 7(7):611-627. doi:10.1016/S2215-0366(20)30203-0

7 IASC (2020). COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement. https://interagencystandingcommittee.org/covid-19-how-include-marginalized-and-vulnerable-people-risk-communication-and-community-engagement

4. Selecting tools for MHPSS assessments

The following decision tree can be useful for quickly determining the most appropriate approach for gathering MHPSS data. This approach, along with the tools selected, must be adapted to the local context.



5. Tailoring MHPSS assessment tools to PHEs

MHPSS assessments in the context of PHEs will require many adaptations similar to those necessary for MHPSS operations and interventions generally.[9] Likewise, assessment teams must be given adequate training in adapting assessment approaches or using adapted tools that are currently available.[10] When carrying out MHPSS assessments during COVID-19, the following priority questions may be particularly relevant. Page 64 details specific adaptations that may be useful for recommended assessment tools.

PHE priority questions

- **What are the needs?** To clarify how the PHE has impacted communities' needs, including those of potentially vulnerable groups, and if these needs are being met.
- **How are services adapting?** To review pre-existing local response and changes in services across sectors in order to identify gaps and opportunities to further integrate MHPSS.
- **What MHPSS services are available?** To understand current access to MHPSS services across sectors, at all levels of the MHPSS intervention pyramid and for vulnerable groups.
- **Is MHPSS coordinated among actors?** To determin if there is an active MHPSS working group.
- **What is the capacity to adapt?** To assess if MHPSS actors have the capacity to provide adapted services (e.g. remote services) and identifying areas where increased capacity is required to continue services.
- **What safety precautions are necessary?** To identify safety needs to inform budgeting and planning.
- **Are human rights being protected?** To identify any needs for advocacy to ensure that all persons, including those with mental health conditions and in institutions, are considered in prevention and mitigation plans.
- **How have community and family supports changed?** To determin changes in community support networks, practices or structures (e.g. school closures) and impact on coping in the context of the PHE.
- **What are the local perceptions, myths and rumours about the PHE?** To gaug community attitudes and the attitudes of people who are ill.
- **Are remote tools available and used?** To determining if affected communities use and have equal remote access to inform service adaptation and identifying where MHPSS may be integrated.

8 IASC. (2021). IASC Common Monitoring and Evaluation Framework for MHPSS Programmes in Emergency Settings: Version 2.0 with means of verification. https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency

9 For further guidance, please visit: https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-resources-covid-19

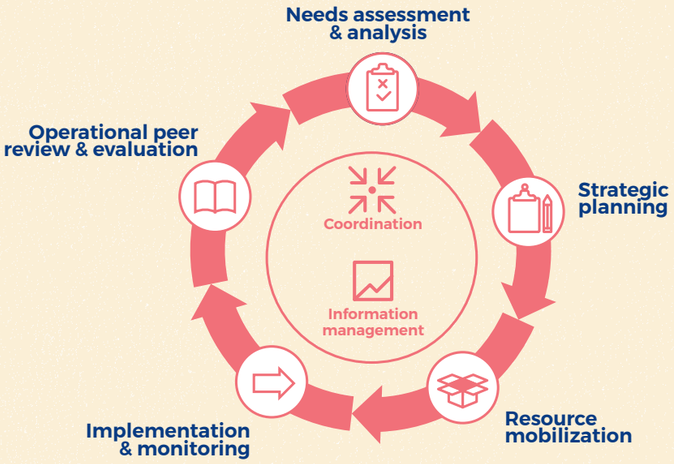
10 A resource group for sharing MHPSS assessment tools for COVID-19 is available on MHPSS.net. For more information, please visit: https://app.mhpss.net/groups/current-mhpss-emergency-responses/novel-coronavirus-international-health-emergency-2020/covid19-assessment/

	IASC & WHO/UNCHR assessment tools[1]	Examples of specific adaptations of tools for PHEs
Coordination and advocacy	**1.** Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support	● Assess service availability and adaptations required during PHE based on local measures, and identify gaps. ● Revise codes and sub-codes to include activities adapted for the PHE and relevant to the local context. ● Assess training on remote service provision and remote access, such as in Sheet 2 – Columns S, U or V.
	2. WHO-UNHCR Assessment Schedule for Serious Symptoms in Humanitarian Settings	● Decide whether there is a need to implement this tool to assess new problems related to the PHE or rely on existing data. ● If implemented, conduct remotely and develop a plan for ensuring access to vulnerable groups or remote locations.
	3. Humanitarian Emergency Setting Perceived Needs Scale (HESPER)	● Conduct interviews adapted to the PHE context (e.g. remote) and ensure that staff are trained in conducting adapted assessments where possible. ● Consider creating surveys or adapting physical spaces to allow for safe distancing if remote tools are not available.
MHPSS through health services	**4.** Checklist for site visits at institutions (e.g. hospitals, care homes, other residential facilities)	● Determine if inpatient units for mental health are included in PHE prevention and mitigation plans. ● Determine if precautions are in place to protect persons in institutions if someone is infected during the PHE.
	5. Checklist for integrating mental health into primary health care (PHC)	● Assess facilities' capacities to adapt MHPSS services and access to remote means, if necessary, including in assessing worker competency (Section 2), impact of the emergency (Section 6), and social indicators (Section 7). ● Review the files of all service users and prioritize care for people with severe conditions or distress to minimize health visits. Include estimated number of service users in relevant areas (e.g. Section 5). ● Assess plans to integrate MHPSS into infection prevention and control (IPC) measures, such as quarantine units.
	6. Neuropsychiatric components of the health information system (HIS)	● Adapt the HIS to deliver remote consultations and other adapted service delivery, if relevant locally.
	7. Template to assess mental health system resources	● Assess # of facilities with capabilities for remote services. ● Assess # of personnel with experience of providing remote services or available for home visits, if safe and feasible.
MHPSS through different sectors, and the community	**8.** Checklist on obtaining general information from sector leads	● Assess adaptations across sectors due to the PHE and impacts on access to various services (e.g. school closures). ● Identify opportunities to integrate MHPSS within adapted services.
	9. Template for desk review of pre-existing information relevant to MHPSS	● Review internal and external documents, guidance notes or recommendations related to the PHE response and concerning health, protection, risk communication and community engagement in the local context. ● Assess access to and acceptability of technologies (e.g. internet, cell services, cultural acceptance of technology).
	10. Participatory assessment: perceptions of general community members	● Prioritize vulnerable groups, such as older persons, persons with health issues or pre-existing mental health conditions, women and children, persons with limited access to services or support, and persons who have themselves or whose family members have been infected during the PHE and may be in quarantine or isolation.
	11. Participatory assessment: perceptions of community members with in-depth knowledge of the community	● Include targeted questions that ask about the PHE, such as "How are people who are infected treated?" and "What do people think is causing the PHE?" to assess perceptions of the pandemic and at-risk groups. ● Assess potential protection issues that may be amplified due to movement and other restrictions.
	12. Participatory assessment: Perceptions of severely affected people	● Assess participants' knowledge, fears, concerns, coping and needs regarding the PHE. ● Assess continued access to social support or unique barriers to seeking support, such as in Question 2.2.

1 WHO and UNHCR (2012). Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. https://apps.who.int/iris/bitstream/handle/10665/76796/9789241548533_eng.pdf?sequence=1

Annex 12 Tips for integrating MHPSS across sectors during the humanitarian programme cycle

In emergency settings where the cluster system is active, Humanitarian Country Teams (HCTs) follow a general response structure known as the humanitarian programme cycle (HPC; depicted right). The HPC consists of five main elements that are intended to coordinate humanitarian response efforts. Key outputs of the HPC are country-based Humanitarian Response Plans (HRPs), based on Humanitarian Needs Overviews (HNOs), that describe priority needs. HRPs generally inform the strategic plans of each cluster or AoR. As a result, they are typically key reference documents for priority-setting and for resource allocation. Therefore, it is essential that MHPSS requirements are integrated into HNOs and HRPs, where these are in place. For this to happen, MHPSS TWGs must work closely with cluster and AoR coordinators. However, challenges exist in some contexts. These are described below, along with potential solutions.



Challenges and potential solutions

Challenges	Potential solutions
● **HNOs and HRPs have limited space for each sector:** There is generally little space in HNOs and HRPS to describe the needs of each sector. As a result, there is often little space for lengthy paragraphs devoted to MHPSS or other cross-cutting areas. ● **There is massive pressure from many areas of work:** HCTS, cluster coordinators, AoR coordinators and others who develop HRPs experience massive pressures to include many areas of work, not just MHPSS, and can be overwhelmed with guidance in doing so. ● **Every cluster has its own methods:** Every cluster has its own methods to determine people in need and to prioritize geographic areas or response actions. Thus, what works in one setting or with one cluster may not work for another. ● **Opinions about MHPSS, and where it fits, vary:** Although the IASC (2007) Guidelines clearly establish the cross-cutting nature of MHPSS, actors do not always agree on where it fits within and across sectors.	● **Try to be part of the solution:** Assist coordinators in preparing relevant text, offer to review or rewrite text if needed, and be generally available to offer solutions, not problems. ● **Work bilaterally:** Every cluster is different, and so too is every cluster coordinator. It is essential to work in collaboration with these colleagues to identify the best ways to support their integration of MHPSS. ● **Be present at key moments:** Advocating for a "seat at the table" in HNO and HRP planning and development meetings, in ICCG meetings and on needs assessment teams (that will feed into the HNO process) is key to ensuring that MHPSS has an active voice in the process. ● **Remember the cross-sectoral nature of MHPSS:** Because MHPSS is by nature cross-cutting, try to make links across sectors in suggested text. For example, link areas of work that relate to one another, such as child protection and education.

Annex 13 MHPSS sustainability checklist[1]

Questions	Answer (Yes/No/In progress [IP])	Comments
1. Have we assessed existing services, including traditional ones, to see how they are functioning and what support they might need?	☐ Yes ☐ No ☐ IP	
2. Are MHPSS services being developed while considering the system as a whole (e.g. from informal community supports to tertiary care levels)?	☐ Yes ☐ No ☐ IP	
3. Are investments being made in local resources for MHPSS (e.g. investments in people and in services, rather than in buildings)?	☐ Yes ☐ No ☐ IP	
4. Have we engaged all local and international actors in this field to collaborate and coordinate?	☐ Yes ☐ No ☐ IP	
5. Do local staff represent the majority of the response, including decision-makers?	☐ Yes ☐ No ☐ IP	
6. Are local communities actively engaged in leading MHPSS assessments, programmes and systems?	☐ Yes ☐ No ☐ IP	
7. If the answers to questions 5 and 6 are no (due to the emergency necessitating short-term use of outside support), are we developing a transition strategy for handover?	☐ Yes ☐ No ☐ IP	
8. Are international MHPSS actors supporting and respecting the central role of national authorities?	☐ Yes ☐ No ☐ IP	
9. Are we aligning with relevant existing national strategies, policies and plans (e.g. national mental health plans)?	☐ Yes ☐ No ☐ IP	
10. If no relevant national plans or policies exist (e.g. national mental health strategy), are we advocating for and supporting their development?	☐ Yes ☐ No ☐ IP	
11. Are MHPSS actors supporting system, policy and service reform that is sustainable in the long term?	☐ Yes ☐ No ☐ IP	

1 Checklist adapted from: Patel et al. (2011). Transitioning mental health & psychosocial support: from short-term emergency to sustainable post-disaster development. Humanitarian Action Summit 2011. Prehospital and disaster medicine, 26(6), p.470.

Annex 14 Resources and materials

Core Action 1: (Re)establishing and maintaining a technical working group

- Sample MHPSS TWG ToR description (including competencies or minimum requirements for coordinator position, surge capacity deployments of coordinators). Available in English.
- Sample MHPSS TWG ToRs. English, English 2, French, French 2.
- IOM (2021). Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. Annex 1: Inter-Agency Coordination. Available in English.
- IOM (2021). Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement E-Campus Course. Module 9: Inter-Agency Coordination. Available in English.
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Core Action 3: Establishing links between stakeholders

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Annex 14 Resources and materials

Core Action 5: Ensuring monitoring and evaluation

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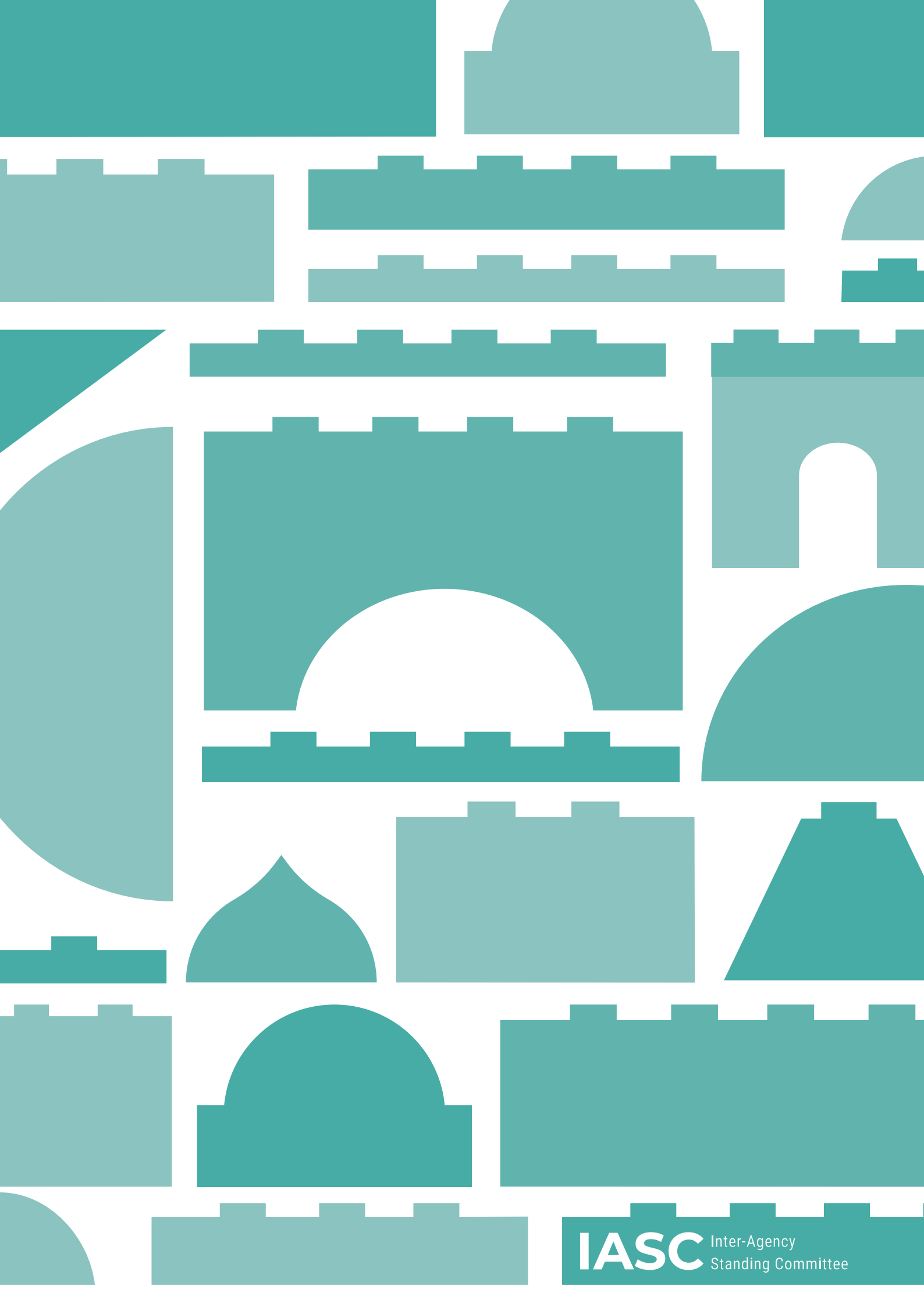
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Standing Committee