Humanitarian Exchange

Special feature
Mental health and psychosocial support in humanitarian crises

Humanitarian Exchange

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This edition of *Humanitarian Exchange*, co-edited with Anne Harmer, Manager of Elrha's Research for Health in Humanitarian Crises (R2HC) Programme, focuses on mental health and psychosocial support (MHPSS) in humanitarian crises. M. Claire Greene and her co-authors highlight opportunities for integrating MHPSS programming in humanitarian response, and discuss ways to overcome the challenges associated with introducing multi-sectoral interventions into existing systems. Davin Mpaka Mbeya and colleagues and Courtney Welton-Mitchell and Leah Emily James share research and operational experience from the Central African Republic and Haiti. Catherine Panter-Brick, Jon Kurtz and Rana Dajani reflect on how academics and practitioners can partner effectively to produce actionable evidence in humanitarian settings. Alison Schafer and her co-authors make the case for scaling up MHPSS interventions to reach more people at lower cost.

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Editorial photos:
Left: Nyarugusu refugee camp in the western province of Kigoma, Tanzania.
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Top: Rohingya children in a UNICEF child-friendly space at Batukhali refugee camp in Bangladesh draw pictures of what they witnessed in Burma.
© Anna Dubuis/DFID

Middle: Women at a lactating and pregnant mothers' group meeting in Saptari district, Nepal.
© UNFPA

Bottom right: Children playing in Hebron, West Bank.
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Nyarugusu refugee camp in the western province of Kigoma, Tanzania.

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Mental health and psychosocial support in humanitarian crises

Improving humanitarian assistance across sectors through mental health and psychosocial support

M. Claire Greene, Samuel L. Likindikoki, Jessie K. K. Mbwambo and Wietse A. Tol

If you are consumed by worries, can you focus on your work? If you are overpowered by anger because of what they did to you, can you manage the challenges of life in a refugee camp? If you are too sad to get out of bed in the morning, do you have the energy to breastfeed? If you do not sleep because of nightmares, can you be an attentive caregiver? Such questions challenge us to look beyond the material and physical needs in humanitarian settings, and raise the importance of the mental health and psychosocial wellbeing of people affected by humanitarian emergencies. Research has shown that mental health and psychosocial wellbeing are important factors in successful programming in economic development and livelihoods, child development and education, protection and human rights, nutrition and, ultimately, individual and collective recovery from conflict and disaster. With regard to health, this can be summed up under the slogan 'no health without mental health'.[1] In this paper we describe opportunities for integrating mental health and psychosocial programming into humanitarian response, and discuss strategies for overcoming the challenges associated with introducing multi-sectoral interventions into existing systems.

The Inter-Agency Standing Committee (IASC) provides specific recommendations for integrating mental health and psychosocial support (MHPSS) programmes into humanitarian response sectors including food security and nutrition, education, shelter and site planning and water and sanitation.[2] These recommendations are supported by a growing recognition of the relationship between mental health and psychosocial wellbeing on the one hand, and on the other the objectives of humanitarian programming, such as safety and meeting basic needs. For example, gender-based violence is a well-known factor in worse mental health outcomes. The reverse is also true: women who are experiencing negative mental health consequences of violence are more vulnerable to suffering further violence. Intimate partner violence and mental health, as well as poverty and mental health, appear

to form vicious circles. Such vicious circles may best be broken through integrated programming.

Points of integration for MHPSS into humanitarian assistance

Physical and mental health

The integration of mental and physical healthcare has been a goal of many health systems in both low- and high-resource settings. Given the well-documented relationship between mental and physical health, the health system may be an obvious starting point for integration. Currently, mental health services are often provided in parallel to physical health services and focus almost exclusively on treatment. Integrating screening and effective brief interventions into primary care may serve to identify people in need of referral to specialised services, prevent mental disorder for people displaying sub-threshold symptoms, increase awareness about mental health and the consequences of displacement and disaster, reduce the stigma commonly associated with seeking mental health services by delivering care in neutral settings and improve outcomes for a variety of chronic and infectious diseases.

Basic needs

A critical priority in humanitarian assistance is meeting basic needs. The stressors associated with not meeting one's basic needs have a significant impact on wellbeing, which can further impair nutritional status, hygiene and safety. Equitable delivery of food and non-food items that enables autonomy, dignity and safety can increase the effectiveness of humanitarian assistance. Recommendations for integrating social and psychological considerations into activities focused on the provision of basic needs may include respecting cultural practices surrounding food and shelter, consideration of pre-existing socio-political tensions between groups, protecting the privacy of beneficiaries, avoiding discrimination, planning distribution and community development activities in such a way that they do not create environments that enable violence (e.g. crowded distribution lines with limited supply and inequitable distribution) and designing policies that avoid amplifying power imbalances and perpetuating marginalisation. With regard to nutrition,

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1 M. Prince, 'No Health without Mental Health', *Lancet* 370(9590), 2007; World Health Organisation, 'Mental Health: Facing the Challenges, Building Solutions', in *Report from the WHO European Ministerial Conference,* WHO Regional Office for Europe, 2005.

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

research shows that the promotion of exclusive breastfeeding may greatly benefit from attention to maternal mental health.

Education
Education programmes commonly aim to promote the social, cognitive and emotional development of children and adolescents affected by humanitarian crises, and provide a source of stability in situations of displacement or disruption. The degree to which education incorporates MHPSS principles may vary, from programmes developed to provide a safe environment for learning to those that intentionally strengthen coping strategies, disseminate information related to survival and protection and train teachers to identify mental health and psychosocial challenges in their students and manage mild behavioural problems. A recent call to action for global child mental health identified the education sector as a critical entry point for coordinated efforts to promote wellbeing in children in low-resource settings.[3]

Protection
The objectives of MHPSS and protection programmes are clearly aligned. For example, in many humanitarian settings interpersonal violence, particularly gender-based violence, is a particularly salient protection and MHPSS concern for women. In an effort to explore the feasibility of an integrated protection and MHPSS intervention to address these related challenges for Congolese refugee survivors of intimate partner violence in Tanzania, we designed an eight-session intervention building upon an evidence-based mental health treatment, Cognitive Processing Therapy,[4] and incorporated safety planning and advocacy components to be delivered by protection staff in a refugee camp. We conducted qualitative research to inform the development and implementation of an integrated intervention, and subsequently conducted a randomised pilot trial to explore the feasibility, relevance and acceptability of such a programme.

Designing the intervention required community engagement to identify local priorities and explanatory models describing the relationship between violence and mental health. The main mental health problems affecting female survivors of intimate partner violence were stress, sadness and fear. Counselling was recommended to address these problems in Nyarugusu refugee camp. The intervention began with an individual session with a locally trained facilitator, who conducted a danger assessment and assisted the woman in developing a safety plan to mitigate risks and consequences of partner violence. The remaining seven sessions were delivered by a pair of trained facilitators to a group of 10–12 women.

Sessions two to six consisted of Cognitive Processing Therapy components, including an introduction to the relationship between thoughts and feelings, relaxation training, exploring stuck points and thinking errors, changing thoughts and feelings and other self-care strategies. In the final session, women reviewed their safety plans as a group and discussed empowerment, coping and support methods.

Through extensive piloting and a qualitative process evaluation we determined that, with dedicated efforts to promote ownership and buy-in among partners across sectors, it is possible to integrate MHPSS services into protection activities in humanitarian settings. Despite the well-recognised relationship between violence and mental health, as well as guidance from both the MHPSS and protection community to integrate these activities, we do not know of rigorous evaluations of integrated protection and MHPSS interventions for survivors of gender-based violence in humanitarian settings. The aforementioned example in Tanzania[5] may serve as a model for designing, piloting, implementing and evaluating a dedicated integrated protection and MHPSS intervention.[6]

Restoring livelihoods, empowerment and early recovery
The capacity to participate in and contribute to rebuilding one's community is directly related to mental health and psychosocial wellbeing. One of the fundamental challenges that can stifle progress towards recovery is poverty. Poverty alleviation interventions, specifically cash transfer and asset promotion programmes, have been found to improve mental health and, similarly, mental health interventions have been shown to reduce poverty in low- and middle-income countries.[7] What is lacking from the evidence is the effect of combined poverty reduction and MHPSS interventions. Poverty alleviation efforts represent one mechanism by which humanitarian activities could be sustained throughout the early recovery period, and the integration of MHPSS services may be one way of magnifying that effect.

Overcoming implementation challenges

Despite efforts to strengthen humanitarian coordination, including through the cluster system, connecting work across (and for that matter within) sectors is still challenging. Based

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3 A. E. Ordonez and P. Y. Collins, 'Advancing Research to Action in Global Child Mental Health', *Child Adolesc Psychiatr Clin N Am* 24(4), 2016.

4 Cognitive Processing Therapy (CPT) is an evidence-based manualised group or individual intervention. CPT aims to help participants recognise and modify thinking patterns related to experiencing severe trauma that are associated with worse mental health outcomes (for example, blaming yourself for having experienced violence, or thinking that you are worthless).

6 W. A. Tol et al., 'An Integrated Intervention to Reduce Intimate Partner Violence and Psychological Distress with Refugees in Low-resource Settings: Study Protocol for the Nguvu Cluster Randomized Trial', *BMC Psychiatry* 17(1), 2017; 'Nguvu: Empowering Survivors of Intimate Partner Violence', *r2hc Project Blog*, elrha, 2016; 'First Pilot of Nguvu: What Did We Learn?', *r2hc Project Blog*, elrha, 2017; 'Developing Integrated Psychosocial Interventions in Refugee Settings', *r2hc Project Blog*, elrha, 2017.

7 C. Lund et al., 'Poverty and Mental Disorders: Breaking the Cycle in Low-income and Middle-income Countries', *The Lancet* 378(9801), 2011.

on our experience in Nyarugusu refugee camp, we present some of the implementation challenges for integration, along with possible strategies for overcoming them.

The first challenge lies in aligning programme priorities across sectors. This challenge is reinforced by the way humanitarian response is structured, with sector-specific implementation partners and mandates, funding streams that are allocated within sectors and human resources with focused capacity. Overcoming coordination and resource challenges requires buy-in from all sectors involved. Engaging partners and building ownership of integrated projects that span sectors is imperative to their successful adoption and sustainability. Dedicating sufficient time in the early phases of integrated interventions to present a rationale for introducing multi-sectoral strategies, harmonising theories of change and generating enthusiasm around the programme will strengthen stakeholder commitment and resource investment. In our experience, training protection staff in MHPSS service provision was possible, but it was difficult to protect their time for training and the delivery of services that did not fall within their mandate. Implementing the integrated mental health and protection intervention we introduced earlier required that we negotiate how staff time would be allocated and compensated given their new dual role as protection and MHPSS providers.

Obtaining funding to support multi-sectoral interventions is another challenge that may call for creative solutions. A shift in how funds are earmarked may require stronger evidence surrounding the effectiveness of integrated interventions in improving humanitarian assistance. Strengthening the evidence base for integrated programming is challenging because of the complex design of integrated interventions. Experimental, randomised-controlled trials are considered the strongest evaluation design, but they are resource-intensive. In addition, investing in controlled trials (for example, in checking implementation quality and ongoing supervision) may not be feasible in many humanitarian contexts. Non-experimental designs and implementation-focused studies may serve as an alternative to experimental studies and, with an adequate design, may also provide indications of intervention effects. Comparing integrated interventions to sector-specific interventions delivered in parallel and/or usual care requires large sample sizes and long follow-up periods, which further increases resource requirements. Additional efforts and flexibility from donors, practitioners and evaluators are needed to bridge this gap in knowledge and strengthen the evidence on integrated MHPSS strategies in humanitarian assistance.

Making progress towards integration of MHPSS in humanitarian response

Conflict, disaster or displacement can disrupt access to shelter, economic opportunities, social support, food and clean water, health services and education. A unifying theme of that disruption is that it may threaten one's psychological and social wellbeing due to fear and uncertainty, adverse and potentially traumatic experiences and a sense of loss across these domains. In order to bolster humanitarian response, a coordinated, multi-sectoral approach that integrates activities to address these threats to wellbeing is needed. Through the strategies outlined above, MHPSS services can be integrated into each of these sectors in a complementary, as opposed to competing, manner. To date, there are few examples documenting the implementation of integrated efforts; however, guidelines exist for a range of MHPSS activities specific to humanitarian settings that are accessible to non-specialised providers.[8] Efforts to develop and evaluate potentially scalable interventions (i.e., interventions requiring fewer resources than traditional evidence-based mental health interventions) that may be prime candidates for integration into multi-sectoral programmes are also under way.[9] At the very least, programmes should consider the social and psychological implications of what, how, when and to whom aid is delivered, and design activities in a way that promotes wellbeing for all beneficiaries in humanitarian settings.

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8 *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*; WHO and UN High Commissioner for Refugees, *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies* (Geneva: WHO, 2015).

9 'SH+ Trial Completed: What Are the Next Steps?', *elrha Project Blog*, elrha, 2018.

Integrating mental health into primary healthcare in the Central African Republic

Davin Mpaka Mbeya, Natalya Kostandova, Ashley Leichner and Rebecca Wener

The Central African Republic (CAR) has experienced decades of turmoil and instability, marked by civil unrest, military coups and conflict. The last five years have seen the development of a humanitarian crisis of immense proportions, with over 680,000 internally displaced people (IDPs) and over 543,000 refugees. Almost 2 million people are in need of humanitarian assistance.[1]

Over the last decade, International Medical Corps, a non-governmental humanitarian organisation, has run programmes in six of the CAR's 16 prefectures, working with healthcare providers and providing emergency relief and protection services. In Haute Kotto prefecture in the east of the country, International Medical Corps has been implementing mental health and psychosocial support (MHPSS) activities since 2015, with a focus on providing direct consultations and building the capacity of local staff to meet mental health needs. These activities are supported by funding from the Bêkou Trust Fund.

International Medical Corps' mental health and psychosocial support

Conflict and displacement lead to increased mental health needs. When combined with a dearth of qualified medical providers to meet these needs, the effects on a country's health system can be acute. According to World Health Organisation (WHO) estimates, the prevalence of mild and moderate mental disorders can increase from a baseline of 10% to an estimated 15–20% in the context of humanitarian crises. The prevalence of severe mental disorders can increase from 2–3% to 3–4%.[2]

In CAR, where the latest wave of violence began in May 2017, lack of access to and availability of appropriate care can be the difference between life and death for some people affected by mental disorders. Fearful for the safety of relatives affected by mental disorders, families see little choice but to restrain the individuals affected. In Bria, a city in Haute Kotto prefecture, one of the epicentres of the recent violence, one 22-year-old man with mental illness was kidnapped by an armed group unfamiliar with the area. Unsettled by the man's incoherence and inability to answer their questions properly, the group

held the man for five days, during which he was beaten. On his release his family tied him up to ensure that he did not put himself or others at risk, leading to wounds and infection from the ropes. In another case, a five-year-old child was physically restrained by his family and locked up inside the home whenever they went out. Countless others are affected by mental health issues compounded by conflict, displacement and insecurity.

International Medical Corps' intervention in Haute Kotto aims to build the capacity of general healthcare providers in the identification, management and treatment of common mental health concerns. It includes training and supervision of prescribers (health assistants, nurses and doctors) and non-prescribers (first-aid workers, traditional birth attendants and community health workers) using the WHO mhGAP-Intervention Guide, which entails the provision of care due and access to psychotropic medication for people with mental health problems, and the integration of mental health in primary care sites, in this case six health facilities, two mobile clinics and the hospital in Bria.

In humanitarian settings, it is critical to adapt the approach to meet the needs of the community and to adjust plans as the operational context changes with changing security and access conditions. While training and supervision to build local capacity was the primary pillar of the original approach, capacity-building was delayed as insecurity in the region deepened and potential trainees fled to safer areas. The strategy was reoriented to focus on direct consultation by International Medical Corps MHPSS staff, including our programme psychiatrist and a Central African nurse with mental health experience, until formal training and subsequent supervision of prescribers could take place.

Another adaptation was necessitated by geographical constraints. Since May 2017, Bria has experienced massive displacement, with more than half of the city's population relocating to the PK3 IDP site. As a result, the population of PK3 increased from approximately 2,500 residents in 2017 to over 39,000 by February 2018. While PK3 is only three kilometres from Bria, movement between the two is limited by instability and the presence of armed groups along the road between the two locations. As a result, people with mental disorders from PK3 are unable to seek treatment at the hospital in the city. Beginning in July 2018, consultations are planned at multiple locations including Bria hospital, a nearby health facility at Bornou and two mobile clinics at PK3 and Gobolo, where large concentrations of IDPs are present. It has not been possible to provide consultations in peripheral health facilities due

A woman is examined by an International Medical Corps psychiatrist in a mobile clinic located in PK3.

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to insecurity on the roads. In some cases entire villages have been abandoned, reducing the need to provide consultations at nearby health facilities. Pillaging and looting have rendered two health facilities completely non-operational.

Treatment and care

Community-based mental health services and treatment approaches are tailored to individual needs. Clients with moderate and severe disorders can be treated by staff with skills and knowledge in appropriate mental health diagnosis and treatment, which sometimes includes medication. Unstable and agitated patients, or patients who have been abused in their homes or communities, are often hospitalised for up to a week under surveillance and psychotropic treat-ment. Each is then assigned to a community health worker, who makes home visits to assure adherence to medical treatment, to identify the challenges clients face, to monitor living conditions and to conduct sensitisation activities with a clients' families.

Capacity-building: training and supervision

International Medical Corps has held two training sessions since August 2017, with a total of 13 non-prescribers and eight prescribers taking part. After completing the course, each participant is then supervised by an International Medical Corps psychiatrist and nurse to ensure development of skills for proper diagnosis, referral and prescription. Trainees who

are prescribers spend one month shadowing an International Medical Corps psychiatrist or nurse providing consultations, and then spend at least two months providing consultations under supervision. International Medical Corps MHPSS staff intervene only when absolutely necessary, and provide feedback to the trainee after a consultation is completed.

Programme outcomes

Between March 2017 and February 2018, 1,489 mental health consultations were provided at Bria hospital and other health facilities and mobile clinics across Haute Kotto prefecture. Of those, 762 were new and 727 follow-up clients. Males comprised 53% of the clients seen, and females 47%. Of the total consultations, 880, or 59%, were provided in the PK3 IDP site. The four most common conditions seen were depression, epilepsy, psychosis and Post-Traumatic Stress Disorder (PTSD). Together, these four conditions accounted for 690, or 91%, of all new diagnoses during this period.

The profile of diagnosis distribution has changed over time, probably due in large part to International Medical Corps' capacity-building training course. As shown in Figure 1, which presents the distribution of the top four morbidities over time, epilepsy was the leading cause of new admissions from March 2017 to July 2017. However, following training on the identification of mental disorders in August 2017, depression

Figure 1. Distribution of new admissions by morbidity (top four)
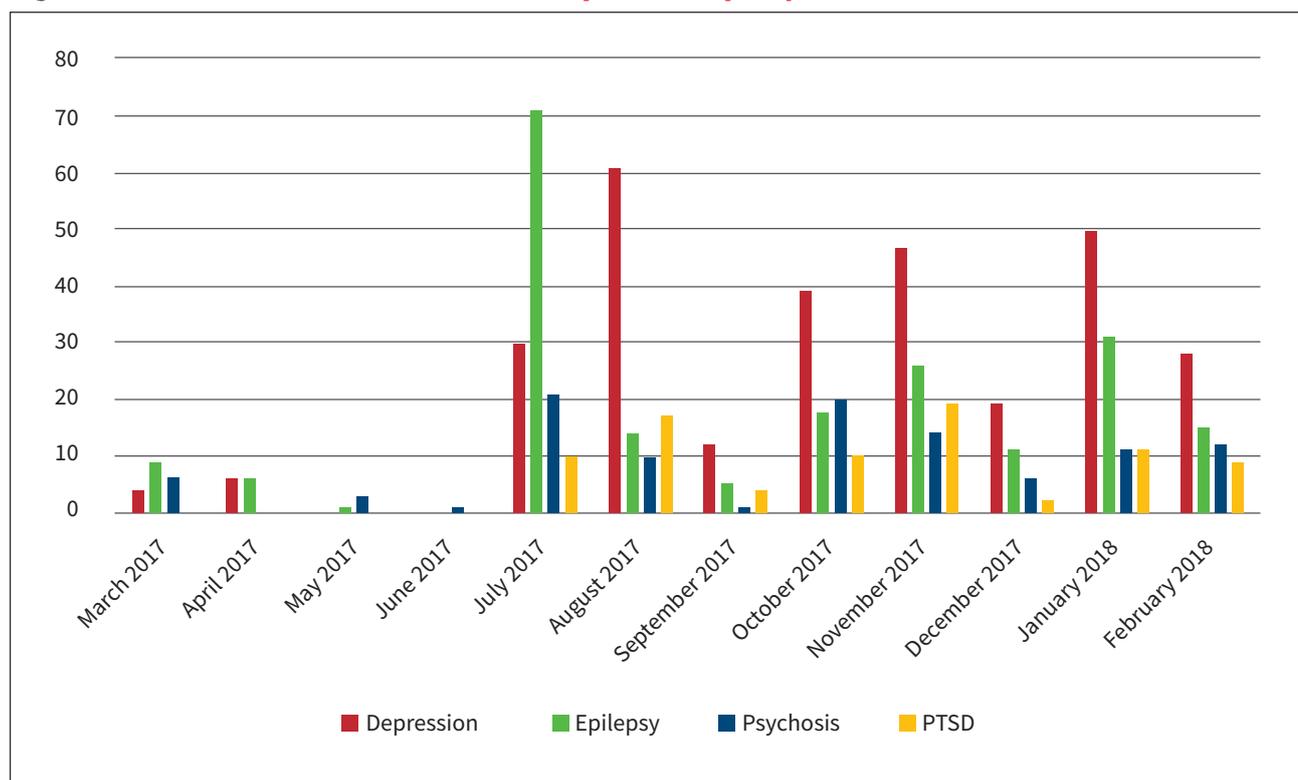
became the most commonly diagnosed morbidity among new clients. Diagnoses of psychosis and PTSD have also increased.

Before the specialised training in August 2017, the majority of people with mental disorders were self-referred, and epilepsy – which is easier for general healthcare providers to identify than conditions such as depression – was the most common diagnosis at admission. After International Medical Corps training, the ability of general healthcare staff to appropriately identify and diagnose various mental disorders improved. This training, combined with community sensitisation to raise awareness of mental health issues and the availability of free care, served to increase the identification of morbidities other than epilepsy. This is especially important given the links between psychological distress linked with conflict and adverse experiences and presentation of conditions, such as depression, PTSD and psychosis.

Barriers to identification and treatment

While the mental health programme has produced many positive outcomes, there have been challenges. Many are inherent to working in CAR, and would have been a factor in any part of the country. However, in certain cases they have been exacerbated by the conflict in Haute Kotto.

Human resources
The lack of primary healthcare staff trained in mental health is a significant barrier to high-quality, community-based mental health services. This is true for CAR as a whole, but the situation is particularly dire in Haute Kotto. Currently, only three Ministry of Health staff in Bria and its surroundings are qualified to provide mental health treatment. This is a critical obstacle to planning for the eventual transfer of activities from International Medical Corps to the Ministry of Health.

Cultural barriers
There is still a strong perception within these communities that some mental disorders are caused by sorcery or disrespect of tradition, leading to a reluctance to seek treatment. Seeking help from traditional healers or using spiritual healing are the preferred coping methods, further delaying appropriate care and, at times, aggravating the condition. For example, in a religious centre in Madomale, in Ouaka prefecture, people with mental disorders are bound by chains and made to fast for a week at a time, after which the congregation prays to rid them of the disorder. For one man this process was repeated over seven months, most of which he spent in chains.

Insecurity
Continuous population displacement and the presence of armed groups makes adherence to treatment extremely difficult, as travelling from home to the nearest point of care presents a security risk to both clients and care providers. Armed groups have looted and pillaged health facilities, forcing clients to travel even further to receive care. Movement restrictions limit not only access to care, but also household visits and case identification by community health workers. Disruption of community structures and access to basic services and community support may also contribute to poor treatment adherence.

Lessons

Implementing mental health programmes in an emergency context requires preparedness and flexibility, as continual adjustments have to be made to ensure that high-quality services are available in a way that takes into account insecurity, cultural context and existing and arising challenges. Programmes, as well as the donors that fund them, must allow for a high level of flexibility in implementation, including building in the possibility of modifying mechanisms of training, supervision and service delivery that can be adapted as appropriate as conditions change on the ground.

Holistic approaches to the provision of relief and services should also be considered in order to increase adherence to mental health treatment. During conflict and displacement, meeting basic needs like food and water may eclipse other priorities, including seeking mental health care. Thus, food assistance or income-generating activities for clients and/or their families should be considered in future programming, as should distribution of non-food assistance to assure the basic dignity of clients who do not have access to basic personal items. As noted above, the disruption of basic services was a significant barrier to effective mental health services, so programming that addresses these basic and interconnected needs should also help to increase access and adherence to services.

Cultural context must be respected and carefully considered in programme planning. Local authorities, religious leaders, traditional healers and community influencers must be engaged in the programme at all stages, from planning to implementation to handover. These stakeholders can help inform programme design by ensuring that the cultural context is taken into account, and they can help increase patient referrals and treatment adherence, inform community members of services, reduce the stigma around mental health issues and ensure appropriate treatment is provided. The importance of mental health and psychosocial programmes, particularly in conflict-affected communities, cannot be overestimated. Mental health care is essential and lifesaving, and efforts must be made to ensure that high-quality mental health programmes are integrated into all health system interventions in crises.

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Evidence-based mental health integrated disaster preparedness in Nepal and Haiti
Courtney Welton-Mitchell and Leah Emily James

Mental health integrated disaster preparedness (MHIDP) was inspired by an observation, made by ourselves and our colleagues in Nepal and Haiti, that some community members seemed resistant to engaging in disaster preparedness. Some Nepalis living in areas at high risk from natural hazards such as flooding and landslides seemed uninterested in putting in place even relatively easy disaster risk reduction strategies. Similarly, in makeshift settlements on hillsides in Port-au-Prince, regularly flooded by seasonal hurricanes, some community members did little to try to mitigate impact. This behaviour could not be explained purely by lack of funds or insufficient knowledge; some community members failed to adopt even low-cost or free measures such as developing household emergency action plans or the safe storage of documents. This behaviour is not specific to communities at risk in Nepal or Haiti; rather, studies have shown that households across the world are generally underprepared for disaster.[1]

Those involved in emergency management have spent years asking themselves why some people seem to ignore risk. Research points to a range of reasons, including psychological biases, such as a tendency to underestimate risk,[2] demographic factors such as gender, education and age, levels of trust in the preparedness efforts of others and social values and norms.[3] Some individuals, such as those with physical and mental challenges, the elderly and the homeless, may face particular barriers to engaging in disaster mitigation.[4]

In our early work with earthquake- and flood-affected communities in Haiti and Nepal, we began to wonder whether mental health difficulties might exacerbate vulnerability and interfere with preparedness. The communities we worked with were struggling, not only from exposure to recurring natural hazards, but also due to stress associated with poverty, displacement and lack of healthcare, education and employment. Pilot data indicated that symptoms of depression and PTSD were

1 S. Kohn et al., 'Personal Disaster Preparedness: An Integrative Review of the Literature', *Disaster Medicine and Public Health Preparedness* 6(3), 2012.

2 R. L. Dillon, 'Book Review: The Ostrich Paradox: Why We Underprepare for Disasters. Robert Meyer and Howard Kunreuther. Philadelphia: Wharton Digital Press, 2017', *Risk Analysis* 37(12), December 2017.

3 C. Solberg, T. Rossetto and H. Joffe, 'The Social Psychology of Seismic Hazard Adjustment: Re-evaluating the International Literature', *Natural Hazards and Earth System Sciences* 10(8), 2010.

4 V. Walters and J. C. Gaillard, 'Disaster Risk at the Margins: Homelessness, Vulnerability and Hazards', *Habitat International* 44, October 2014.

Participants creating a community map during the intervention in Bhaktapur, Nepal.
© Leah James

common, and those reporting higher levels of distress were less likely to prepare for disasters than other community members.[5] These findings are consistent with other research indicating that people with mental health concerns may be less likely to engage in preparedness.[6] Mental health symptoms might interfere with preparedness in various ways, ranging from depression-related lack of motivation and low efficacy to avoidance of disaster- and preparedness-related thoughts stemming from symptoms of PTSD. Some anxiety-prone individuals may be reluctant even to discuss preparedness.

Tackling mental health and preparedness simultaneously, within a single intervention, may benefit both wellbeing and preparedness-related outcomes. Despite this potential, disaster preparedness training curricula typically do not address mental health concerns. With this in mind, we developed a three-day MHIDP intervention, working with Soulaje Lespri Moun (SLM) in Haiti and Transcultural Psychosocial

Organization in Nepal. The intervention has been tested across three studies involving flood- and earthquake-affected communities in Haiti and Nepal, using randomised controlled trials and a matched cluster comparison.[7] MHIDP has been shown to be effective in increasing disaster preparedness, decreasing mental health symptoms and increasing social cohesion. It has also been associated with increased use of specific coping skills, and both disaster- and mental health-related help-seeking and help-giving.

Key elements of the approach

Engaging in-country colleagues in the development of the MHIDP model is crucial.[8] In Haiti, the earliest version of the intervention was created by Leah James and founding members of SLM in the aftermath of the 2010 earthquake.[9] Elements of this initial

5 L. E. James, 'A Pilot Assessment of Psychological Factors Associated with Hurricane Sandy Preparedness in Post-earthquake Haiti', Quick Response Grant Report series, Natural Hazards Center, Institute of Behavioral Sciences, University of Colorado, Boulder, 246, 2013.

6 D. P. Eisenman et al., 'Variations in Disaster Preparedness by Mental Health, Perceived General Health, and Disability Status', Disaster Med Public Health Prep. 3(1), 2009.

7 Funding for the study was provided by Elrha's Research for Health in Humanitarian Crises (R2HC) programme, supported by the UK Department for International Development and the Wellcome Trust.

8 L. Ferrer-Wreder, K. Sundell and S. Mansoory, 'Tinkering with Perfection: Theory Development in the Intervention Cultural Adaptation Field', Child & Youth Care Forum 41(2), 2012.

9 L. James, J. Noel and Y. Roche Jean Pierre, 'A Mixed-Methods Assessment of the Experiences of Lay Mental Health Workers in Postearthquake Haiti', American Journal of Orthopsychiatry, 84(2), 2014.

framework, including coping mechanisms drawing on Haitian stories, songs, dance and humour, and discussion around culturally specific belief systems (such as religious attributions for mental health problems and disasters) were integrated into the MHIDP model, along with specific preparedness training.

Subsequently in Nepal, the Haiti-specific intervention was revised and adapted through formal and informal meetings with Nepalese team members from Transcultural Psychosocial Organization, including members of the local communities targeted for programming. Team members commented on drafts of the manual, shared ideas about experiential exercises and provided examples of culturally specific stories, including one highlighting the relationship between karmic beliefs and preparedness. Although some components used in Haiti were changed for Nepal, there were some surprising examples of cultural compatibility between the two contexts. For example, some coping exercises developed by Haitian team members were well received in Nepal.

In addition to tailoring the curriculum to the cultural context, it was important to ensure that the MHIDP intervention was implemented by local teams. This both maximises the possibility that the content will fit the community and increases the likelihood that associated messages will be well received. In both Haiti and Nepal, we provided training and supervision for lay mental health workers and early career clinicians, all of whom directly facilitated the three-day intervention.

This process of co-creation, adaptation and facilitation by local staff helps to ensure that the MHIDP intervention does not challenge or undermine existing belief systems or practices – a key consideration, not only in terms of ethical practice, but also to increase the likelihood of community acceptance and the effectiveness of the intervention. Prior research suggests that spiritual/religious narratives for explaining natural hazards such as earthquakes can exist in parallel with scientific explanations.[10] Religious attributions for disasters and spiritual and religious practices to mitigate risk are common in both Haiti and Nepal. For example, some community members in Nepal derive comfort from engaging in offerings designed to appease the gods after an earthquake or flood. Families may also use traditional, culturally specific approaches to preparedness, such as storing food on the ceiling using woven mats and a rope and pulley system.

Such pre-existing beliefs and behaviours do not preclude the adoption of new preparedness techniques, including household emergency action plans and the collaborative development of community risk and resource maps. Indeed, results from our work in both settings indicate that such beliefs and practices continued alongside the new knowledge

and skills acquired during the intervention. As explained by a Haitian lay mental health worker involved in the early phases of the project: 'If we take the time to teach them a technique to use to feel better, they will listen. They may see a Houngan (voodou practitioner) also, but in the meantime, they have a technique they can use'.

Other elements of MHIDP include small group discussion, experiential components and a peer-based framework. Small group discussions involve community members sharing opinions (and sometimes engaging in spirited debate) about topics such as local idioms of distress, beliefs about the causes of mental health symptoms and related stigma and local preparedness techniques, rather than simply receiving content from facilitators. Experiential components include opportunities to practice new coping skills, such as breathing and relaxation techniques, and interactive and engaging means of sharing content, including games. The peer-support approach entails creating opportunities for community members to provide and receive social support regarding mental health needs and to encourage collective approaches to disaster preparedness.

The intervention curriculum

Day 1 begins with establishing ground rules and explaining the importance of the peer support framework, including guided opportunities throughout the workshop to provide support to other group members. Day 1 also entails discussion about mental health and psychosocial reactions to disaster-related stress and associated coping strategies, with the purpose of teaching immediately applicable coping skills and self-soothing techniques. Utilising coping strategies during workshop discussions about stressful topics helps to encourage engagement and reduces the risk that participants may shut down or disengage in order to avoid anxiety-provoking content. Specific activities during Day 1 include self-reflection through a 'drawing feelings' exercise; observing bodily reactions through a mildly stress-inducing game; self-calming through breathing; culturally adapted grounding, mindfulness and muscle relaxation exercises; and small group discussion about mental health symptoms. Throughout Day 2 and Day 3, participants practice, with increasing autonomy, the coping skills learned on Day 1.

On Day 2, participants continue the mental health and peer support focus through an art-based activity entailing creation of culturally specific symbols of safety. The workshop then transitions to focus on disaster preparedness, including facilitated discussions regarding the links between common attributions for disasters (natural causes, will of the gods) and preparedness motivation. Facilitators introduce common scientific explanations for disasters such as earthquakes and floods and share recommended preparedness strategies. This is done without discouraging pre-existing cultural and religious beliefs or indigenous approaches to preparedness, which participants are encouraged to maintain alongside new information.

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10 L. E. James et al. 'Challenges of Post-disaster Intervention in Cultural Context: The Implementation of a Lay Mental Health Worker Project in Post-earthquake Haiti', *International Perspectives in Psychology: Research, Practice*, Consultation 1, no. 2, 2012.

Ending Day 2 and moving into Day 3, participants work on providing disaster- and mental health-related peer support to each other, drawing on techniques associated with Psychological First Aid (PFA), and role-playing a variety of brief disaster scenarios. Day 3 also entails discussion about the impact of disasters on particularly vulnerable groups – children and people with more serious mental health challenges – and practical skills for supporting them. Finally, a 'Tree of Hope' exercise is used to encourage individual goal-setting and future planning, and a 'Forest of Hope' is constructed to demonstrate community-level resilience through collaboration. The workshop concludes with a 'mini-disaster simulation', in which participants demonstrate skills learned over the three days. At the closing ceremony participants receive certificates and disaster preparedness materials and discuss achievements and next steps.

Mechanisms of change

The research methodology and associated mediation models have allowed us to begin to understand the potential mechanisms of change underlying intervention results. Specifically, the impact of the intervention on social cohesion and mental health symptoms appears to partially explain the increase in preparedness. Similarly, the influence of the intervention on preparedness and social cohesion partially explains the positive mental health outcomes. Feedback collected from participants after the intervention provides additional insights into the importance of the peer support framework, disaster preparedness knowledge and mental health components. When asked about the training, we received the following responses: 'After taking this training we learned the importance of helping each other more. Without depending on any other organisation or government, we learned that we can do much better if we work together in the community'; 'We have learned to share the information with family and friends about disaster preparedness'; 'We were very much scared and disturbed, but because of this training, it has helped us to come out from this fear. It has brought peace in our lives.'

Given the effectiveness of this model in increasing preparedness and social cohesion and decreasing distress, we suggest MHIDP should be scaled up for use elsewhere in Nepal and Haiti, and in other countries prone to natural hazards. The intervention can be culturally adapted relatively easily. It is cost-effective and can be implemented by lay mental health workers or trained clinicians, using standardised curriculum manuals.[11]

Those interested in similar models should also be aware of the challenges we encountered during implementation. During the initial planning stages, we met community leaders and

local government officials to address scepticism about the value of an intervention focused on mental health and low-cost preparedness. Various stakeholders, including some participants, initially suggested that we should provide tractors, building materials or other material goods instead. Some project staff were directly impacted by the earthquake and flooding and were experiencing associated distress. In the aftermath of the Nepal earthquake, we incorporated staff care training modules into the intervention and emphasised regular debriefing sessions. Occasionally we noted power differentials between group members, with men and those from ethnic groups with greater influence dominating discussions. To address this, facilitators organised small group discussions with individuals of similar social status. We also struggled with how best to address culturally specific beliefs that were potentially harmful to some group members. For example, during one discussion in Nepal some members evoked karma to suggest that those who had lost family members in the earthquake were to blame for their deaths. Facilitators created space for alternative views within the group, and during breaks we checked in with those who had lost family and offered referrals for follow-up support.

On a final note, it is important to highlight the need for additional research examining the efficacy and specific components of the intervention. We need to determine whether three days is the optimal timeframe for the intervention, especially when considering the duration of effects. While many of the results were sustained many months after the intervention, the impact did diminish over time. Might an intervention of longer initial duration, or a one-day 'booster' mid-year, be useful? Future research should also compare a standard disaster preparedness curriculum to the mental health integrated version (in our research the intervention was compared to a waitlist control condition). It is also essential that we examine the relationship between the intervention and mental health outcomes more closely. Unlike the robust results for disaster preparedness and social cohesion across two countries and three studies, the impact of the intervention on mental health outcomes varied by context, with stronger results in communities facing more acute disasters. Regardless of the challenges and the work that remains, MHIDP has brought us one step closer to building an evidence base to determine what type of mental health and psychosocial interventions work in humanitarian crises.

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11 MHIDP manuals are available for Nepal and Haiti (in English, Nepali and Haitian Creole) at: http://www.elrha.org/research-database/?searchTerm=community-based+disaster+mental+health+intervention&searchSubmit=searchSubmit

What strong partnerships achieve: innovations in research and practice

Catherine Panter-Brick, Jon Kurtz and Rana Dajani

Humanitarian practitioners and policy-makers increasingly recognise the importance of mental health and psycho-social support (MHPSS) for conflict-affected children and adolescents. The consequences of inaction are grave: profound stress can negatively affect decision-making, social behaviours, learning abilities and even earning capacities. In contexts of significant adversity, effective MHPSS programming responses can have positive impacts on young people's lives in the short term, and help improve the chances of a flourishing life in the long term. Yet resources for psychosocial support as part of humanitarian responses remain scarce. Increasing investment for this priority hinges largely on providing credible, actionable evidence on what works in MHPSS programming. Researchers, practitioners and funders are searching for innovative, practical ways to rigorously evaluate existing programmes to produce both context-specific insights and transferable lessons.

In this article, we reflect on ways to meet such demands for actionable evidence in humanitarian settings, drawing from a case study that evaluated the health impacts of Mercy Corps' Advancing Adolescents programme, a youth-focused psychosocial intervention in Jordan. In the course of the 18-month project (2015–17), we came across many challenges, which sparked a process of deep reflection. Challenges to leveraging robust impact evaluations include:

- Short-term humanitarian funding cycles, which restrict timelines for scientific evaluation (e.g. randomised trials featuring waitlisted control groups to assess the added value of interventions; longer periods of follow-up observation to test for sustained impacts).
- Slow academic timelines, as publishing research often involves extensive data analysis and lengthy peer review processes of critical evaluation.
- Deep engagement to create trust and build strong academic–humanitarian community partnerships (moving from processes of 'cultural adaptation' to 'cultural engagement').
- Identification of the 'active ingredients' or key elements of specific interventions, in order to understand what works, for whom, why and for how long, in specific contexts (moving beyond the basic question of 'what works' in mental health and psychosocial programming).
- Sustainability of partnerships over time, to foster new ways of working (funds are rarely geared to sustaining dialogue in order to achieve a more effective dissemination of findings).

The Advancing Adolescents programme

Mercy Corps' Advancing Adolescents programme, funded as part of the No Lost Generation initiative, was launched in 2013 in response to the Syria and Iraq crises. It is a psychosocial intervention of structured, group-based activities (technical, vocational and art skills) targeting 8–15-year-olds. This brief, scalable intervention (16 sessions across eight weeks) has been implemented in Jordan, Lebanon, Iraq and Syria. Its goals are to alleviate profound stress, build resilience, strengthen social cohesion and heal conflict. It is strategic in focusing on adolescence, a key time for protecting the next generation and building its future, and in serving both Syrian refugee and host communities. Key elements of the programme are common to other psychosocial interventions, including group-based skills-building sessions (e.g. vocational skills, technical skills, fitness, arts and crafts) run by trained local community volunteers. The programme emphasises stress management, relationships and personal achievement (following the International Child Development Programme manual).[1]

Three innovations

Our programme impact evaluation was independently funded by Elhra's Research for Health in Humanitarian Crises (R2HC) programme, supported by the UK Department for International Development and the Wellcome Trust. Funding was contingent on a partnership between academics and humanitarian practitioners. We formed a re-search consortium[2] drawing on expertise from Mercy Corps, five universities and one in-country research partner to provide a robust impact evaluation.

The research[3] had two main goals: to test programme impacts on mental health and psychosocial wellbeing, adopting a robust scientific approach; and to develop tools that were relevant to contexts experienced by refugee and war-affected youth. We introduced three major innovations: an experimental research design that enhanced both scientific rigour and

1 J. MacPhail et al., 'Conflict, the Brain, and Community: A Neurobiology-Informed Approach to Resilience and Community Development', in R. Phillips, S. Kenny and B. McGrath (eds), *The Routledge Handbook of Community Development: Perspectives from Around the Globe* (London: Taylor & Francis).

2 For details on the consortium, see: http://www.elrha.org/map-location/yale-psychosocial-call2.

3 C. Panter-Brick et al., 'Insecurity, Distress, and Mental Health: Experimental and Randomized Controlled Trials of a Psychosocial Intervention for Youth Affected by the Syrian crisis', *Journal of Child Psychiatry and Psychology*, October 2017 (http://onlinelibrary.wiley.com/doi/10.1111/jcpp.12832/full).

cultural engagement; methods of assessment that tracked mental health and psychosocial wellbeing over time and corroborated self-reports with biological measures of stress; and activities to promote awareness and uptake of results and recommendations.

Innovation 1: research design and ownership

We sought to overcome common challenges of impact evaluations, including the lack of a control group, which can lead to unreliable evidence of impacts, and reliance on self-reports of programme participants, which can lead to response bias. We employed a waitlisted randomised control trial design, conducting the study at three time-points, with a gender-balanced sample of refugee and non-refugee youth (n=817) who were registered and eligible for the Advancing Adolescents programme. We recruited a separate research team to ensure operational independence between the staff responsible for research evaluation and programme implementation.

Our main challenge was to randomise the trial (namely, randomly allocate youth to 'intervention' or 'control' groups). The short and unpredictable funding timeline for humanitarian programming made it more difficult to establish waitlisted controls, and we could not ethically randomise participants until Mercy Corps was certain it could continue programming in Jordan, with renewal of donor funding. The trial also had to be fair from the standpoint of local participants. We talked with the community to establish an open and fair process, and settled on a lollipop draw. With twice as many young people recruited to start the next round of programme sessions, all of whom completed baseline assessments, we asked youth to draw a lollipop from an opaque bag (containing lollipops of two different colors, randomised with a coin flip to either treatment or control). This process of randomisation was transparent to families, who agreed to a chance allocation for accessing the programme at that point and two months later.

In this way, we were able to put in place one of the very few randomised control trials undertaken in a humanitarian setting. Our experience confirmed that bottom-up approaches to community engagement are key. It also showed that in-country scholars could be powerful champions of the scientific process, helping to develop a sense of ownership through a deeper engagement with local communities.

Innovation 2: a multi-level toolkit

Our main research questions were: what are the psychosocial, physiological and cognitive impacts of this eight-week intervention, and which tools best capture these multiple dimensions of wellbeing? Figure 1 illustrates these three main health outcomes: psychosocial measures through face-to-face surveys with youth, with paper and pen, in private locations; physiological outcomes through stress biomarkers, by tracking the biological signature of stress hair cortisol concentrations;

Figure 1: Interdisciplinary toolkit to measure health intervention impacts on the mind, body and brain

Survey responses: Perceived stress (psychosocial outcomes)

Biomarkers: Stress under the skin (hair cortisol, physiological outcome)

Executive function: Tablet-based tests (cognitive outcomes)
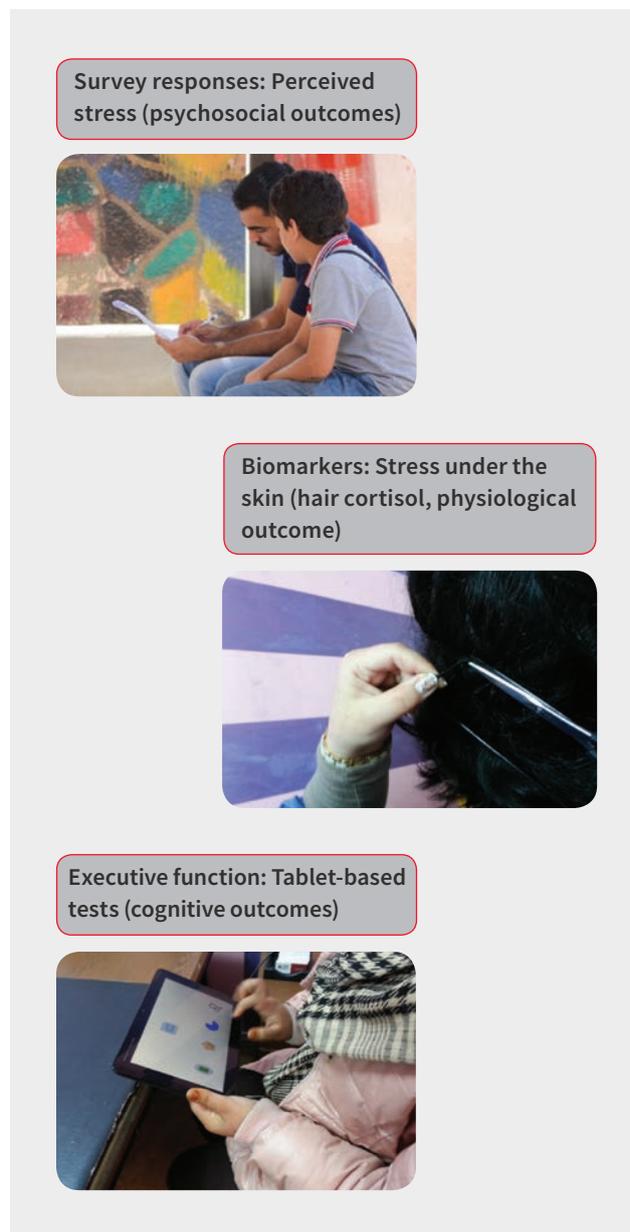
and cognitive impacts through tablet-based tests of general attention and executive functioning. We reflect here on the value of surveys and the challenges they can present.

Surveys: ensuring context specificity and cultural relevance
Insecurity, distress, mental health difficulties (anxiety/depression), traumatic stress and resilience are distinct dimensions of human wellbeing, but are often conflated in everyday speech and scientific measurement. We took steps to capture all these different dimensions of mental health and psychosocial support.[4] For instance, we used the Human Insecurity scale,

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4 *Ibid.*

developed for conflict-affected regions of the Middle East. This scale asks questions such as: to what extent do you fear for your family in daily life; worry about losing your source of income or your family's source of income; fear displacement or being uprooted? Responses capture levels of fear or insecurity, which in conflict zones is qualitatively different from common understandings of 'stress'. In assessing lifetime trauma, we used a checklist developed for conflict-affected populations, which includes questions such as: have you directly witnessed bombardment as a result of war; seen someone else severely beaten, shot or killed; had your life put in danger; been expelled from your home?

We also developed a culturally relevant, Arabic-language measure of resilience,[5] manifested in the ways people overcome adversity and sustain wellbeing. Appraising resilience was an explicit request from the youth themselves, who disliked a survey exclusively focused on trauma and risk, and asked why we did not look at their strengths and the positive aspects of their lives. The challenge was to develop a brief but valid metric that captured the individual, relational and cultural understandings of resilience – a word locally translated to *muruuna* (literally 'flexibility'). Through qualitative interviews, we listened attentively to the vocabulary that expresses lived experience, and in surveys piloted several measures. We found the Child Youth Resilience Measure (CYRM, 12 items) to be a brief and reliable measure for use in population surveys. This measures the extent to which youth feel strong as a person, in their relationships with others and in their community. It thus covers three culturally-relevant dimensions of resilience: individual, inter-personal, and social dimensions.

Stress biomarkers: a biological stress diary
Stress biomarkers help provide a biological signature of adverse experiences. Cortisol is a hormone secreted in the body associated with the regulation of energy and psychosocial stress. It can be measured in saliva and hair, to capture an individual's stress profiles over time to evaluate health and development. Measuring cortisol in human hair reveals a 'stress diary' that tracks the cumulative effects of stress in the body. By measuring hair cortisol concentration levels in samples of hair, we were able to test, beyond self-reports, the effectiveness of the intervention in reducing stress over time.[6]

Incorporating this major methodological advance into our study was no mean feat. Some local staff and parents had

serious questions as to why this was necessary. However, the youth themselves were open to this type of scientific measurement. Again, community engagement was key to getting staff and families on board. We explained the science behind measuring stress and its impacts in the body, which capitalised on the youths' eagerness to learn like scientists. We also hired male and female local hairdressers as part of our field team to give young people a professional haircut when taking their hair samples, which was greatly appreciated.

We sent three hair samples per participant (each around 100 strands, pre-/post-intervention and 11-month follow-up) for laboratory analysis. We assessed changes in cortisol levels in response to programme participation, lifetime trauma events, perceived insecurity and mental health difficulties. In tracking cortisol over time, we identified individuals whose cortisol profiles were chronically high, and also chronically low.[7] Both hyper-production and hypo-production of cortisol can raise health concerns, indicating a heightened versus blunted sensitivity to environmental challenges. We thus saw that a biological 'sensitivity' to life experiences could lead to blunted cortisol responsiveness, as well as put the body on high alert, such that the positive impacts of an intervention might lie in cortisol regulation, raising chronically low levels as well as reducing chronically high levels. One cannot assume a one-to-one relationship between exposure to extreme stressors in the environment and the biological stress response.

Tablet-based tasks: measuring cognitive performance
Lastly, we tested whether our measures of risk and resilience impacted cognitive performance, as measured by long-term memory, working memory and inhibitory control. We used the Rapid Assessment of Cognitive and Emotional Regulation (RACER) tasks, a set of cognitive tasks designed for use in low- and middle-income countries to measure general attention and executive functioning, as games run on tablet computers. For Syrian refugees, we found that feelings of high insecurity were associated with shortfalls in general cognitive resources: the more fear and worry the adolescents felt, the poorer they performed in trials.[8] This highlights the importance of current insecurity – rather than past trauma – in shaping self-regulatory skills and cognitive performance, and by extension learning abilities. We also found that the Advancing Adolescents intervention did not impact cognitive function, suggesting that brief interventions that can improve mental health and reduce physiological stress do not necessarily improve cognitive function.[9]

5 C. Panter-Brick et al., 'Resilience in Context: A Brief and Culturally-grounded Measure in Syrian Refugees and Jordanian Host-community Adolescents', *Child Development*, June 2017 (http://onlinelibrary.wiley.com/doi/10.1111/cdev.12868/epdf).

6 We measured cortisol in hair, rather than saliva; the former measures chronic stress levels. This required cutting around 100 strands of hair, covering a scalp area smaller than a pencil head, three times for each participant (pre-/post-intervention and 11-month follow-up). R. Dajani et al., 'Hair Cortisol Concentrations in War-affected Adolescents: A Prospective Intervention Trial', *Psychoneuroendocrinology*, 89, 2018 (http://www.psyneuen-journal.com/article/S0306-4530(17)31207-6/fulltext).

7 *Ibid.*

8 A. Chen et al. 'Minds under Siege: Cognitive functioning in Syrian refugee adolescents impacted by aremed conflict and displacement', *Child Development* (under review).

9 K. Hadfield et al. 'How Malleable Is Cognitive Function in War-affected Youth? A Randomized Controlled Trial with Refugee and Host Populations', *Development Science* (under review).

A blood sample being taken for analysis of immune function.

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Innovation 3: translating research into practice

Our ultimate goal was to promote the uptake of rigorous academic research to improve health-related programming in humanitarian crises. To bridge the traditional gaps between academics, humanitarian practitioners and donor decision-makers, we organised and co-presented at multiple conferences and thoroughly discussed the findings with funders, scholars, humanitarian stakeholders and local communities. Regular, in-person discussions have been essential in translating the research findings and recommendations into practice. This process informed programmatic decisions on targeting and scaling up the Advancing Adolescence programme: for example, Mercy Corps integrated stress-attunement elements into livelihood interventions in the region, and included measures of resilience and human insecurity in evaluation surveys. The research has also prompted learning from negative findings, where we observed no direct or sustained impacts for certain outcomes. For example, Mercy Corps was led to consider how to engage whole families in resilience-building efforts.[10] We also shared insights regarding the fundamental roles that donors can play in supporting strategic collaborations to enable rigorous and longer-term impact evaluations. At national and local levels, we shared results with Syrian and Jordanian research staff and community youth, which created palpable excitement about the goals and achievements of 'science'.

10 Panter-Brick et al., 'Resilience in Context'.

Conclusion

This research partnership holds valuable lessons with important implications for psychosocial programming. First, young people – even those who live in very difficult conditions – are willing and curious to participate in a scientific study, but ask that the scientific community focus on their resilience and human dignity, not just their trauma and vulnerability. In crisis settings, researchers and practitioners need to better understand how people experience and communicate psychosocial distress or support for wellbeing as a prerequisite to effective responses. They need to take 'culture' seriously, and when choosing assessment tools or implementing key programme components, move from surface cultural adaptation to deep cultural engagement.

Second, the signatures of stress are malleable and changeable. This tells us that evidence-based interventions can influence stress physiology and benefit young people living in adversity. The Mercy Corps programme evaluated was effective in regulating stress physiology and reducing the time that youth spent experiencing high levels of insecurity. Modest but demonstrable impacts (Box 1) are important for meeting the humanitarian imperative to improve lives and alleviate suffering in the short term. How this can translate to improving young people's learning abilities, social relationships and economic potential in the longer term remains an important question.

Third, establishing lasting partnerships between academics, humanitarians, funders and local communities can make major

Box 1: What were the effects of the programme?

The impact evaluation revealed both positive impacts as well as null findings, pointing to the need for improvements to programmatic approaches. Importantly, programme impacts are assessed for youth participating in the intervention, over and above changes that may be observed for youth in the 'control' group.

Psychosocial outcomes: measuring stress in the mind

We saw small to moderate impacts across several dimensions of mental health and psychosocial wellbeing,[11] as measured by international and regionally validated measures of Human Insecurity, Human Distress, Perceived Stress, Arab Youth Mental Health and Strengths and Difficulties questionnaires. We found no programme impacts on prosocial behaviour or post-traumatic stress reactions. More unexpectedly, given intervention goals to boost resilience as well as alleviate profound stress, resilience levels did not change over the period of study.

Impacts on levels of insecurity were sustained over time, lasting over 11 months of observation. The programme was thus effective in accelerating recovery, namely in reducing the time youth spent experiencing feelings of heightened insecurity.[12]

Biological and cognitive outcomes: measuring stress in the body and brain

We found that hair cortisol concentrations declined by a third in response to the intervention. Participation in the programme reduced chronically high cortisol levels, but also up-regulated chronically low cortisol levels, showing improved regulation of cortisol production.[13] There were no short-term improvements in some of the cognitive skills that underscore learning and social development.[14]

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contributions to generating credible evidence and improving its uptake by frontline agencies. Such partnerships are crucial to help us strengthen the evidence for strategic investments that put children and families at the heart of humanitarian efforts to boost health and dignity. However, we need to structure partnerships with sustained funding: it requires time and effort to establish productive dialogue between academics and humanitarians, and then communicate insights to wider audiences, including donors and the media.

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11 Panter-Brick et al., 'Insecurity, Distress, and Mental Health'.

12 *Ibid.*

13 Dajani et al., 'Hair Cortisol Concentrations in War-affected Adolescents'.

14 Hadfield et al. 'How Malleable Is Cognitive Function in War-affected Youth?'.

Scalable psychological interventions for people affected by adversity
Alison Schafer, Melissa Harper-Shehadeh, Kenneth Carswell, Edith van't Hof, Jennifer Hall, Aiysha Malik, Teresa Au and Mark van Ommeren

There is a need to improve mental health outcomes in humanitarian settings. This includes strengthening community, family and other psychosocial support mechanisms, as well as improving access to psychological interventions. This paper provides a rationale for developing scalable psychological interventions and describes the World Health Organisation (WHO)'s work to encourage training of non-specialist mental health care workers to deliver evidence-based psychological interventions.

With the emergence of several potentially scalable psychological interventions, attention should be paid to ensuring the quality of the care provided. This includes adapting interventions to the local culture and context and ensuring that non-specialist staff are trained and clinically supervised to safely and effectively deliver the intervention, while taking a careful, considered approach to scaling up. Field experiences and the strategies of successful psychological intervention programmes need to be shared to continue improving access and quality.

Rohingya children in a UNICEF child-friendly space at Batukhali refugee camp in Bangladesh draw pictures of what they witnessed in Burma.
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Mental health in crises

Globally, an estimated one in four people will experience a mental disorder at some point in their lives, but less than 20% will receive or have access to evidence-based treatment. Unsurprisingly, this disparity between needs and access is most pronounced in low-resource settings, and in humanitarian emergencies, where people's mental health and psychosocial support (MHPSS) needs are increased. The Inter-Agency Standing Committee (IASC) *Guidelines for MHPSS in emergency settings* sets out agreed ways to provide MHPSS during humanitarian responses, and the right to the highest possible psychological and social wellbeing is affirmed in a range of humanitarian standards and initiatives, including the Sphere standards, the Central Emergency Response Fund (CERF), the *Child Protection Minimum Standards* and the IASC *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*.

In 2015, the WHO and the UN High Commissioner for Refugees (UNHCR) published the mental health Global Action Programme's Humanitarian Intervention Guide (mhGAP-HIG). The mhGAP-HIG is a clinical guide for the assessment and management of mental, neurological and substance use disorders in humanitarian health-care settings. In line with the forthcoming Sphere standard on mental health, programmes are encouraged to train staff as non-specialist mental health care workers (i.e. staff without specialised licences for mental

health care) to deliver brief, evidence-based psychological interventions, such as cognitive behavioural therapy and interpersonal therapy. Use of a non-specialist mental health care workforce acknowledges that not every country, and especially not lower-resourced ones, has enough mental health specialists to reach and treat the number of people requiring care.

Evidence-based psychological interventions commonly used in high-resource settings can be effective in low-resource contexts, including when they are delivered by trained and supervised non-specialists. These interventions have proved helpful in the treatment of common mental health problems, such as depression, anxiety and traumatic and chronic stress, as well as other difficulties, such as harmful alcohol use. Cultural and contextual adaptations can increase the effectiveness of psychological interventions, and make them more accessible to people affected by crises. Treatments are best delivered in local languages, using recognisable terminology and case examples, and implemented in ways that do not exacerbate stigma or exclusion. Humanitarian settings demand psychological interventions that are as brief and as low-cost as possible, and which optimise limited human resources.

Scaling up

In recent years, WHO has committed to disseminating a range of easily adaptable and potentially scalable psychological

interventions. While there is no hard-and-fast definition of 'scalable', interventions can be described as being scalable when they are able to reach more people at lower cost. The premise of psychological interventions promoted by WHO is that they are evidence-based (i.e. tested in randomised controlled trials), relatively brief, deliverable by a non-specialist workforce, culturally and contextually adaptable, affordable, feasible in a range of contexts, potentially incorporate technology (e.g. online or pre-recorded self-help), publicly available and cost-effective.

WHO's psychological interventions (see Box 1) are empirically supported and specifically designed for a non-specialist mental health care workforce. The interventions use simple core techniques that are as generic as possible, to enable easier adaptation and scalability. They also use simplified (non-

Box 1: Scalable psychological interventions presently disseminated by WHO in developing and humanitarian contexts

Group Interpersonal Psychotherapy for Depression (Group IPT): An eight-week group programme for adults and adolescents experiencing depression. Uses interpersonal therapy approaches, where the group facilitator utilises relationships within the group and their personal relationships outside the group as a means for change (http://www.who.int/mental_health/mhgap/interpersonal_therapy/en/).

Thinking Healthy: An intervention for the management of perinatal/postpartum depression. The treatment – based on cognitive-behavioural therapy – is delivered during routine community health worker home visits. Thinking Healthy focuses on the mother's wellbeing, the mother–infant relationship and the relationship of others around the mother and infant (e.g. other/extended family and community members) (http://www.who.int/mental_health/maternal-child/thinking_healthy/en/).

Problem Management Plus (PM+): A five-session individual face-to-face treatment for adults with non-specific common mental health problems. Treatment is determined based on high emotional distress and impaired daily functioning. The evidence-based strategies used include problem-solving, behavioural activation, strengthening social support and stress management (http://www.who.int/mental_health/emergencies/problem_management_plus/en/).

In addition, WHO is in the process of developing and testing technology-supported interventions for different age groups. These interventions are being field-tested and will only be available once data on effectiveness is confirmed:

Step-by-Step: An online intervention that primarily uses behavioural activation, stress management and social support therapeutic strategies for adults with symptoms of depression. Step-by-Step uses an illustrated story of a person who learns to self-manage their mood. The programme is designed to be used over five weekly sessions (with practice between sessions recommended) and is supplemented by up to 15 minutes per week of email or phone guidance from a non-specialist support worker. The online version for computers, tablets and smartphones is being field-tested, with randomised controlled trials planned for 2018 (http://www.mhinnovation.net/innovations/step-step-e-mental-health-lebanon).

Self-Help Plus (SH+): A guided self-help programme comprising five sessions of pre-recorded audio and a supplementary picture-based self-help book, delivered to large groups (up to 30 people) with the support of a minimally trained facilitator. SH+ is based on acceptance and commitment therapy (ACT), a type of cognitive-behavioural therapy, and includes stress management techniques (based on mindfulness) and values-based action planning. SH+ is currently being tested in two randomised controlled trials.

Early Adolescents Skills for Emotions (EASE): EASE is a group-based intervention for 10–14-year-olds with high distress and impaired functioning. EASE provides seven weekly group sessions, including psychoeducation, stress management, behavioural activation and problem-solving. Three sessions are provided for caregivers. These sessions aim to improve the caregiver–child relationship and enable the caregiver to better support their child during periods of emotional distress. To guide the sessions, which are delivered by a trained facilitator, the approach uses an illustrated story of a child who has learned strategies to manage distress. EASE is currently undergoing testing in four sites.

All of these psychological interventions are intended for scalability and implementation with a non-specialist mental health care workforce. For more information about WHO's resources for mental health and psychosocial support in emergencies, visit: http://www.who.int/mental_health/emergencies/en/.

diagnostic) approaches to determine if an individual needs the intervention. This means that interventions may address multiple mental health problems without needing to be specific about a mental disorder or diagnosis. Through gradual field use and experience, these interventions have shown potential for scale-up in different cultures, languages, systems, age groups and populations affected by adversity, whether in humanitarian contexts or elsewhere.

It may be tempting to roll out en masse what the evidence has shown to be effective. However, the scaling up of psychological interventions in any context poses particular challenges and risks. If done badly, interventions could harm prospective clients, the non-specialist mental health care workforce delivering the interventions and wider health systems. For example, mass scale-up without adequate systems, management, supervision or monitoring could lead to a poorly trained or clinically unsupervised workforce. Inappropriate implementation could see clients lose confidence in mental health services, increase stigma and discourage people from seeking help.

The effectiveness of a range of psychological interventions in humanitarian settings has been established. However, monitoring, evaluation and further research on implementation is needed, particularly when implementation is happening at scale. The core competencies of non-specialist mental health care providers also need to be determined across the different interventions and quality standards for programme design. Even so, there is now a strong rationale and sufficient evidence for humanitarian actors to include psychological interventions as part of their broader MHPSS programmes. Based on field experience and learning to date, taking a considered approach to scaling up psychological interventions would include:

- Carefully examining the training needs of non-specialist providers of psychological interventions, as well as those who train and supervise them.
- Exploring approaches to ensure that psychological interventions are delivered as intended (sometimes referred to as 'fidelity'), such as assessing the com-

petencies of non-specialists, using technology to minimise human error and project monitoring.
- Advocating as non-negotiable the need for regular and skilled clinical supervision of non-specialist mental health care providers, for the protection of both clients and helpers.
- Encouraging programme designers to consider the potential burden of adding psychological interventions to the workload of non-specialist workers.
- Working with existing community and government structures to ensure capacity development of local services.
- Monitoring and evaluating the effectiveness – or potential harm – of psychological interventions, where such data is shared for ongoing inter-agency/global learning.
- Allowing for the adjustment of programme implementation approaches, such as meeting growing demands for remote training (e.g. in conflict settings) and remote assistance (e.g. online programs).
- Making resources available in order to adapt psychological interventions to account for contextual and cultural differences.

Like all humanitarian action, MHPSS response is a growing and evolving area. With interventions such as Problem Management Plus (PM+), evaluated in Pakistan with support from Elrha's Research for Health in Humanitarian Crises Programme (R2HC), the desire and need to scale up are both pressing. However, care is essential to ensure that reaching more people does not mean reaching them in a less effective way. Scalable psychological interventions are being developed as an outcome of technical inputs, field-testing and scientific rigour. The next step is testing approaches to scaling up, and exploring the training needs of intervention providers to ensure the sustained quality of psychological support in humanitarian settings.

Alison Schafer, Melissa Harper-Shehadeh, Kenneth Carswell, Edith van't Hof, Jennifer Hall, Aiysha Malik, Teresa Au and Mark van Ommeren are employed as technical staff or consultants with WHO's Department of Mental Health and Substance Abuse.

Psychosocial support in the Syrian refugee response: challenges and opportunities
Emma Soye

Since the start of the conflict in Syria in 2011, over 5 million Syrians have fled to neighbouring countries. At least 1.5 million school-age Syrian children now live in Jordan, Lebanon and Turkey. Around half of these children do not have access to formal education, with many working informally to provide for their families. Domestic violence is increasingly reported as Syrian parents struggle to cope

with their circumstances. Bullying is said to be on the rise, reflecting tensions between host and refugee communities caused by the tremendous pressure on basic services. These daily stresses have severe and lasting impacts on Syrian children's psychosocial wellbeing, and for some children can worsen the effects of trauma.

Figure 1: Intervention pyramid for mental health and psychosocial support in emergencies

Specialised
services

Focused,
non-specialised supports

Community and family supports

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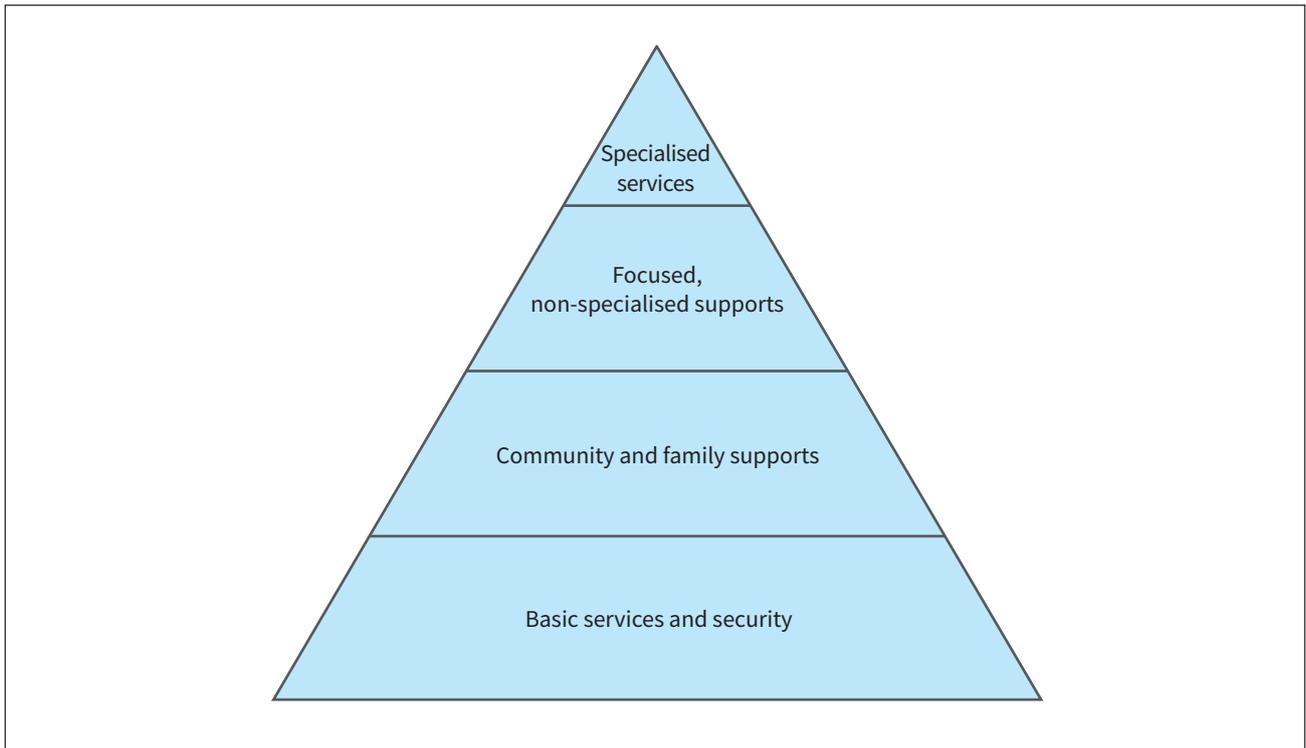
Source: Inter-Agency Standing Committee (IASC), *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (Geneva: IASC, 2007).

Psychosocial support (PSS) programmes in Jordan, Lebanon and Turkey aim to help Syrian refugee children and their families to deal with these issues. In 2014, at least 47 organisations were providing PSS services to Syrian refugees in Jordan alone. As the 2007 Inter-Agency Standing Committee (IASC) guidelines for mental health and psychosocial support show, PSS services vary in type and intensity – ranging from community-level interventions, such as child-friendly spaces, to case-specific clinical management of mental disorders. PSS is also increasingly being provided to children in schools, in the form of social and emotional learning (SEL) programmes.

Although the IASC guidelines are explicit that PSS programmes should be 'contextually appropriate', very little is known about the extent to which this guidance is followed in practice. This gap in research led to a short Save the Children UK study which aimed to understand the contextual factors around the implementation of PSS in the Syrian refugee response.[1] Twenty semi-structured interviews were conducted with education, child protection and monitoring and evaluation specialists from 15 organisations working in the Syrian response, including national and international NGOs, government agencies, international organisations and donor agencies. This article explores some of the findings of the research in the areas of inter-agency coordination, family and community support, specialised interventions for trauma and monitoring and evaluation in the Syrian refugee response.

1 E. Soye and M. Tauson, *Psychosocial Wellbeing and Socio-Emotional Learning in the Syrian Refugee Response: Challenges and Opportunities* (London: Save the Children, forthcoming).

Coordination

Restrictive refugee policies on work, housing and legal status are sources of chronic stress for Syrian refugees and their families. This points to the clear need for changes in national refugee policy. On the more immediate local level, the IASC pyramid for PSS highlights the importance of providing basic services, in recognition that a failure to meet basic needs will have a knock-on effect in other areas of children's wellbeing. In the Syrian response, this usually works in practice through cross-sectoral referrals.

When asked about inter-agency coordination in Jordan, an education advisor pointed to referrals for assistance with basic needs such as cash, food and shelter. Other respondents noted that inter-sectoral working groups and coordination mechanisms in Syrian refugee camps were generally working well due to the high concentration of NGOs present and relatively generous funding. Coordination outside the camps, however, is reportedly still lacking, especially in peri-urban and rural areas. A child protection respondent in Jordan highlighted that NGOs are mostly based around Amman, and in general services are limited to capital cities.

Relatable support while fighting stigma

The second layer of the IASC pyramid recognises the significant impact of community and family support on children's psychosocial wellbeing. Syrian refugee children often depend on parents who are highly stressed. Many organisations are now beginning to recognise the need to promote the psycho-

social wellbeing of parents themselves through 'positive parenting' and stress management sessions, as well as through cross-sector referrals. An education advisor in Jordan spoke about introducing referral mechanisms in their organisation's PSS programmes:

> We introduced a referral mechanism in programmes because of these issues seen in parents – we saw that this was an obstacle to the success of the programmes. Fine, school is going great, everything is going great, it's a safe environment for the kids, but once they go back home, it's not the same thing. There's more stress, there might be yelling, there might be beating … the parent is under stress, and it's going to affect the child.

Despite these increased efforts, interview respondents emphasised that involving parents in PSS programming in the Syrian response remains a challenge. Several participants noted that the staff who deliver parent support sessions are often very young. A child protection respondent in Lebanon talked about seeing a twenty-five-year-old practitioner with no children (and with a middle-upper-class background) deliver positive parenting sessions to Syrian refugee mothers. The respondent doubted the extent to which that staff member could relate to Syrian parents. Another international child protection advisor commented: 'How do you comfort a mother whose child is lost or missing if you've never gone through that, as a twenty-one-year-old, yourself?'. Regional child protection and education staff also said that stigma around the term 'psychosocial' may deter parents from getting involved in, or even allowing their children to engage in, PSS programmes. An education specialist in Jordan commented that 'Any sort of mental weakness is largely taboo, so it is difficult to prioritise it'. Accordingly, it is recommended that staff avoid using 'PSS' to describe their activities where possible. Using teachers to provide PSS to children in classroom contexts through the SEL channel may also help reduce stigma.

Interview participants highlighted the importance of community programming in enhancing children's resilience to stressful and challenging environments. One noted that, in the context of displacement, children 'need some stability, safe spaces, and relearning of principles of fairness and friendship and safety, and normality'. One child protection manager thought that 'normality mainly comes through peers, and families, and schools and youth clubs, and the mosque'. Another said that programming at the community level in the Syrian response often tends to be very unstructured, so that PSS becomes 'a little bit everywhere, and therefore, nowhere'. This lack of structure is reflected in attitudes that anyone can work at the level of community-based interventions, or that it does not require skill or expertise. Several respondents described seeing PSS staff implementing community activities 'thrown together off the top of their heads'. Others emphasised the importance of involving skilled facilitators in community engagement: 'the more sensitised and trained people you have that can facilitate a healthy process, the better'. Teachers

may provide a particularly effective conduit for community engagement, and working with local religious leaders can also go some way towards building social bonds between refugees and host communities.

Zooming in on daily stressors

It is unsurprising that Syrian refugee children often show signs of distress as a result of everyday experiences in displacement. This research found, however, that these commonplace reactions to difficult everyday life are often presumed by PSS practitioners to be post-traumatic stress disorder (PTSD) or trauma related to war exposure. The pathologisation of normal reactions to chronic stress in Syrian refugee children may be leading to over-diagnosis of mental health issues and an unbalanced focus on clinical interventions. While recognising that a certain proportion of Syrian children are suffering from trauma and therefore require specialised treatment, one regional child protection manager felt that too many are getting clinical treatment for mental health problems that aren't actually there. The same respondent also warned against over-training PSS practitioners, in this case teachers, on identifying mental disorders:

> If for instance, a big agency comes in [with a lot of diagnostic tools and referral mechanisms for depression or PTSD to specialised services], I think that's a terrible idea. You always find what you're looking for. You end up diagnosing and labelling two-thirds of your class as having a mental disorder … I'm absolutely against these teacher trainings to make little 'detectives' of mental disorders.

One respondent emphasised that interventions for one-off traumatic events ignore the huge opportunity to reduce psychosocial distress by targeting the stressful conditions of everyday life in a displacement context. Programmes targeting day-to-day sources of stress for Syrian refugee families might include livelihoods, poverty reduction, life skills training and community-based child protection. The same respondent thought that these types of programmes may not be as 'flashy' as trauma interventions, but are 'probably more important'.

The conundrum of measuring wellbeing

The dominant research focus on PTSD or trauma in the Syrian response can be explained in part by the limited funding available, which increases the need for organisations to demonstrate measurable outcomes. One interview respondent commented that the outcomes of one-to-one interventions for trauma are easier to measure than non-specialised interventions for psychosocial wellbeing on a group level. A regional child protection manager pointed out that 'wellbeing' is very difficult to quantify because it is a process and not just an outcome, and means different things to different people. They also pointed to the difficulties of using linear log-frame models and the push to quantify PSS outcomes:

Mahmoud (right) is a five-year-old Syrian boy from Al-Raqqa.
© Nour Wahid/Save the Children

[the donors] ask you questions like 'How many men, how many boys, how many women, how many girls are leading a better life because of your programme?' … This is really a slap in the face of all social science, you can't really do it like that.

Interview participants emphasised the need for a more adaptive, qualitative approach to explore local concepts of wellbeing and to meet the IASC's recommendation of tailoring assessment tools to the local context. One respondent thought that organisations should use monitoring and evaluation tools that find out 'what is a problem for people, and not so much the pre-construed scales that are simply coming from a different context'. Both child protection and education participants noted that evaluative surveys need to be designed with children in mind. One respondent was horrified by a questionnaire for children that included the question 'Do you think life has meaning?', noting that this type of question would 'probably depress an adult, let alone asking it to a child'. Another participant recommended asking open questions:

I think that the way to approach it would be to look at, 'Why are you not feeling good? What are the biggest conflicts, the biggest stressors, the biggest fears, the biggest feelings of loss around you that are weighing on your shoulders?' and then take it from there.

One participant suggested that the recently published IASC and IFRC tools for monitoring and evaluating PSS programmes were two 'bits of light at the end of the tunnel' – both tools are adaptive and offer a combination of quantitative and qualitative assessments to explore local concepts of wellbeing. Gaining donor and government support for these less linear methods of evaluation will be key.

The benefits of an everyday, qualitative approach

Organisations providing PSS in the Syrian refugee response confront many challenges. First and foremost, they face the formidable task of helping refugee families to deal with wide-ranging daily stressors. Interviews conducted with PSS practitioners in the Middle East suggest how these challenges might be overcome through NGO programming. First, organisations need to improve inter-agency coordination in non-camp settings. Skilled and experienced facilitators, including teachers, can help ensure the inclusion of parents and communities in PSS programming. Programmes which target daily stressors for families through livelihoods, poverty reduction, life skills training and community-based child protection all have the potential to help reduce psychosocial distress in Syrian children. Finally, monitoring and evaluation tools that use qualitative as well as quantitative methods, as well as being more adaptive than linear log-frame models, can help organisations assess the strength of their programmes against what wellbeing really means to Syrian refugees and their hosts in the Middle East.

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Psychosocial support for adolescent girls in post-conflict settings: a social and gendered norms approach

Fiona Samuels, Nicola Jones and Bassam Abu Hamad

There is a growing body of evidence exploring the links between mental health, gender and adolescence. However, these issues have been neglected in health systems debates in many developing countries, especially with regard to the mental health and psychosocial needs of adolescent girls in fragile and post-conflict settings. This article draws on qualitative[1] fieldwork conducted in 2014–15 in three conflict-affected contexts – Gaza, Liberia and Sri Lanka – to explore adolescent girls' (10–19 years[2]) psychosocial vulnerabilities and the psychosocial service environment. The study concludes that, unless gender, age and related gendered social norms are taken into account in psychosocial service provision, responses are likely to be inadequate and may even perpetuate discriminatory norms.

Why adolescents – and in particular adolescent girls?

Adolescence is a critical stage in life, when girls and boys start experiencing a range of changes, including physical and emotional. It is also the stage when they start to feel the influence of gendered social norms on many areas of their lives (e.g. education, marriage, mobility). For many girls and young women, this period is one of deprivation, danger and vulnerability, including an increased risk of sexual and domestic violence.

Adolescence and pathways beyond are also influenced by contextual and societal factors, including customs, policies and the external environment. In this study, the external environment is one of post-conflict fragility, where countries, households and individuals are recovering or continuing to deal with violence, disruption, displacement and loss of livelihoods. These experiences are often gendered, as social norms shape how families react to and cope with external shocks and stresses, often with negative outcomes for girls.

Evidence tells us that the majority of mental health and psychosocial problems begin during adolescence and continue into adulthood if not appropriately treated.[3] While

adolescence is an already stressful phase, it becomes even more difficult in conflict/post-conflict situations: children and adolescents miss out on education, economic and social opportunities, and many are exposed to violence, lose their parents, or are abused, abducted or forced to fight. All of these factors can lead to serious mental health and emotional consequences, changing the way adolescents see themselves, relate to each other and think about their future.

Understanding adolescent psychosocial vulnerabilities in fragile contexts

Figure 1 maps the key wellbeing domains surrounding adolescent girls. The girls themselves are then situated within their households or families, their communities and the state. These are in turn influenced by a changing global context, including global trends and learning with regard to adolescent and MHPSS programming. The service environment also plays a key role in girls' ability to achieve psychosocial wellbeing.

Access to education was seen by adolescent girls and their parents as critical to shaping their psychosocial wellbeing. Access to household-level economic opportunities and assets also played a vital role in girls' psychosocial wellbeing in all countries. In Liberia, lack of access to economic opportunities and assets not only causes distress and psychosocial suffering, but it also leads to adolescents engaging in risky behaviour, including transactional sex:

> We engage in sexual activities because at times, the things we wish to have our parents are not able to afford them … At times our parents coerce us to get involved in early sex … don't you see your friends going out there (adolescent girl in FGD, New Kru Town).

Sustaining and building social connections and relationships was another vital ingredient in psychosocial wellbeing. Most adolescents in Sri Lanka said one or both parents were the closest person to them and provided the most support. However, many also felt a sense of frustration or disappointment with their parents due, for instance, to a father's drunken behaviour or being punished by a parent. In Liberia, even if not living with their biological families, both boys and girls indicated that having relationships with close kin and extended family members, peers and neighbours played a vital role in their psychosocial wellbeing. In Gaza, the role of family support was also mixed. While a number of adolescents highlighted that they turned to family members for advice and solace, others expressed concern that parents did not listen to them or pay attention to their needs.

Figure 1: Pathways towards adolescent girls' psychosocial and broader wellbeing
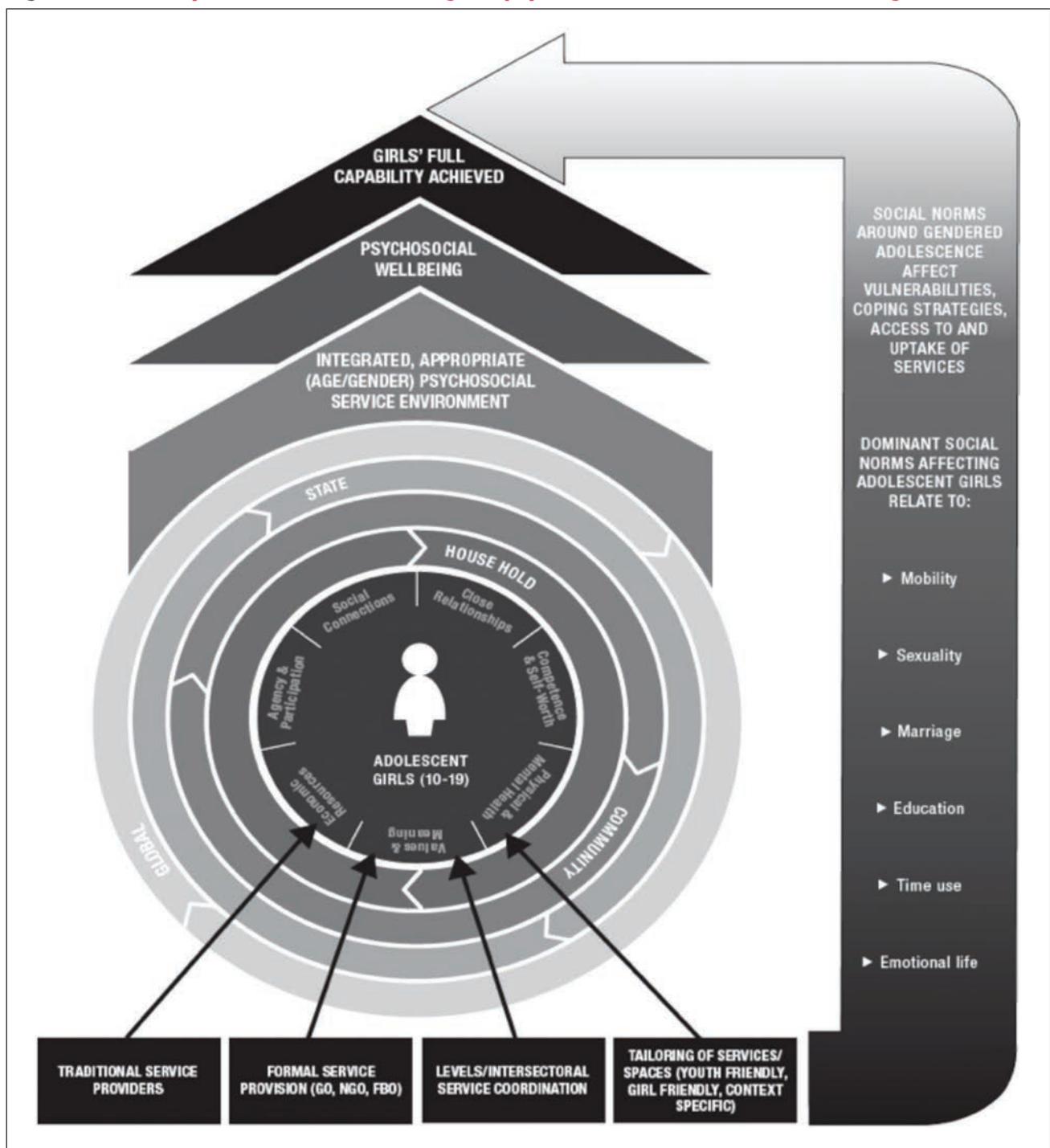
Adolescents feel that they are not adequately valued by the family and the community. Families don't understand the needs of adolescents. There are many communication gaps between adolescents and their families: adolescents don't understand parents' concerns and worries about them and also parents don't understand needs, aspirations and desires that adolescents have. It's a mutual mis-understanding (social protection specialist, Gaza City).

An inability to participate in family and community decision-making and to exercise agency about important life decisions was a key psychosocial risk experienced by adolescent girls.

In Sri Lanka and Liberia, despite more responsibilities being assigned to both girls and boys as they reach adolescence, they are still considered children in public life and are not given the space to participate and be heard in household or community decision-making processes. Similarly in Gaza, adolescent girls' ability to participate is constrained by social norms which place strong restrictions on their mobility and social activities outside the home.

An inadequate sense of self-worth is another risk to psycho-social wellbeing repeatedly raised by adolescent girls. Enablers and indicators of self-worth in Sri Lanka included:

Adolescent girls in Harper, Liberia.
© Ingrid Gercama

having the affection and support of parents and extended family members; participating in school or community events; and having aspirations for the future. Barriers to self-worth included: living in remote locations and a lack of opportunities for young people to use their skills; the absence of an encouraging environment or socially accepted spaces where girls can congregate; and negative labelling of adolescents. In Gaza, adolescent girls interviewed repeatedly complained that they were not accorded the same value as their male counterparts by family and community members.

Inadequate protection and security – in terms of physical and psychological harm – was another key theme in all the study sites, but especially in Liberia, where unhappy family relationships and physical and sexual abuse of girls were major risks. Nearly all adolescent girls in the study reported being subjected to physical beatings as part of how their parents or guardians disciplined them. A significant proportion of sexual violence was perpetrated by relatives or teachers. As this 14-year-old girl noted: 'in school if a girl fails a particular subject and asks the teachers to help her, the teacher will want to sleep with her; she may accept to sleep with the teacher; then the teacher exploits the girl'.

Other risks to physical and mental wellbeing found in all countries include aggression or violence at home, separation of parents and families, the migration of one or both parents and parents' remarriage. All can result in adolescents having to live with their extended families, where they often have to take on heavy workloads, lack support to continue their education and are frequently subjected to scolding and insults. In Gaza, there was the added vulnerability of displacement, and distress at living in mixed-sex shelters in the immediate aftermath of the 2014 Gaza–Israel conflict.

Informal support and coping

In all the countries in our study, adolescent girls had developed strategies to cope with psychosocial vulnerability. Girls spoke about drawing on 'inner strength', reading, painting, writing stories, using social media and day-dreaming. Religion, spirituality or traditional healing were another important means of coping. Family support, both nuclear and extended, was an important coping strategy in all countries; aunts in particular were frequently mentioned since they were often closer in age to adolescent girls and were better able to understand the issues and challenges facing girls than their

mothers. In the wider community, friends, teachers and formal service providers were mentioned by respondents as being important elements in a girl's coping repertoire.

Formal service provision

Despite different levels of MHPSS service provision in these three countries, generally speaking tailored age- and gender-sensitive services and programmes for adolescent girls are extremely limited. In Gaza and Sri Lanka, programmes often focus on younger children, overlooking adolescents. In Liberia, while some health and social service programmes target adolescents, they vary in quality. In terms of gender sensitivity, in Gaza some (male) health providers were reluctant to treat adolescent girls unless they were accompanied by a family member. According to one caregiver in Gaza:

> The general physician stopped following up my daughters, especially the older one, and he asked me to stop treating her because she is now a young lady, and continuing receiving mental health services will affect her reputation and she will be stigmatised forever … he said 'It is enough. Don't take her to any doctor. This will affect her if people know about her case'.

In Sri Lanka, service providers' attitudes were similarly influenced by gendered social norms and notions of what constituted appropriate moral conduct for adolescent girls.

A consistent theme in our research was the negative role of stigmatising and discriminatory community attitudes towards mental health service uptake generally, and by adolescent girls in particular. In Gaza, although multiple strategies have been developed to reduce stigma, they have proved largely ineffective, and often result in delayed access to services as traditional healers are consulted first. In Sri Lanka, social norms also played an important role in hindering effective uptake of MHPSS services, with social and religious priorities often overshadowing a girl's right to access appropriate services. In Liberia, despite training in child and adolescent services, of mental health clinicians have largely focused on adults and those with serious mental illness.

Several gaps in MHPSS provision were identified. First, there are few preventive activities targeting adolescents or activities to identify groups at greater risk of mental health problems. Second, there is significant service fragmentation and MHPSS services in all three contexts are poor-quality. Third, there is limited overarching strategic direction for MHPSS, including a short-term perspective and lack of systematic follow-up mechanisms. Fourth, there is a lack of evidence-based practice. Fifth, although adolescent girls' psychosocial wellbeing is a complex multi-dimensional phenomenon, service provision remains siloed both within and across sectors, and is poorly coordinated. And sixth, in all three contexts there is a significant problem with under-resourcing in terms of budgets and competent human resources.

Conclusions and recommendations

Reflecting on the implications for future policy and practice, we highlight three broad areas.

First, measures for addressing the risk of psychosocial ill-health among adolescent girls in fragile contexts include: providing adolescent- and gender-friendly safe spaces and training adolescents and their caregivers on basic coping strategies. Working with supportive teachers and the education sector more broadly to help develop adolescents' self-esteem and self-confidence is critical. The persistent stigma that hinders access to psychosocial services needs to be addressed through the integration of services, media and education and community mobilisation.

Second, building capacities of service providers is critical. Areas for capacity-building include the early detection of psychosocial and mental health disorders, provision of GBV-related services and treating substance abuse. The service environment should also include space for productive activities, creative expression and recreational activities.

Third, enhancing policies to regulate and coordinate actors providing MHPSS services at different levels (community, sub-national and national) is also critical. There is also a need to strengthen national institutions and ministries so they become recognised as legitimate regulators of psychosocial services, and can provide improved licensing and accreditation processes. Finally, greater evidence-informed programming, including more robust data collection focused on adolescents, is needed.

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This article is based on one submitted elsewhere. This version is substantially rewritten for publication here. See: https://academic.oup.com/heapol/article/32/suppl_5/v40/4718142.

Youth FORWARD: scaling up an evidence-based mental health intervention in Sierra Leone

Theresa S. Betancourt

Mental and substance use disorders are leading causes of disability worldwide, affecting around 20% of the world's children and adolescents. There is immense inequality in the distribution of skilled practitioners in mental health.[1] The level of untreated mental disorders is especially high in low- and middle-income countries, where war, violence and poverty are commonplace. Armed conflict and violence disrupt social support structures, exposing people to high levels of stress and trauma. According to the Centers for Disease Control and Prevention, 30%–70% of people who have lived in war zones suffer from symptoms of post traumatic stress disorder (PTSD) and depression.[2] In young people, psychological distress due to trauma exposure is often expressed in higher rates of aggression and hostility and withdrawal and social isolation.[3] If not effectively addressed, their long-term mental health and psychosocial wellbeing may be affected.[4]

Mental health care in Sierra Leone

Sierra Leone has limited healthcare infrastructure, including mental health services. According to the World Health Organisation (WHO), the country, with a population of seven million people, has just two psychiatrists, two clinical psychologists, 19 mental health nurses and four nurses specialised in child and adolescent mental health.[5] Given high rates of mental health problems in Sierra Leone,[6] the

constraints on the health system and the government's limited capacity, alternative delivery platforms for evidence-based psychosocial interventions are critical. The government recognises the need to address the effects of trauma on the mental health and daily functioning of young people exposed to violence and adversity, and recent government and non-government investment in youth development programming creates a favourable context for integrating mental health interventions into existing employment programmes.

Youth FORWARD and the Youth Readiness Intervention

Youth FORWARD (Youth Functioning and Organizational Success for West African Regional Development) is a co-ordinated plan to establish research partnerships and a regional hub for scaling up evidence-based mental health interventions for young people in West Africa. In Sierra Leone, it is providing the framework for scaling up the Youth Readiness Intervention (YRI), a mental health intervention for war-affected youth. The YRI builds on 15 years of research on the effects of war, violence and other post-conflict adversity on the mental health of young people in Sierra Leone, starting immediately after the end of the brutal civil war in 2002 with the Longitudinal Survey of War-Affected Youth (LSWAY). The study – the first of its kind in Sub-Saharan Africa – found high levels of mental health needs linked to past exposure to violence, manifested for example in poor emotional regulation and anger, depression and hopelessness. The study also explored protective factors, such as education, social support and community and family acceptance.

Preliminary research to inform the development of the intervention also highlighted gaps in mental health services for young people. Many programmes, for example, focused on classic symptoms of PTSD, but few focused on the anger and interpersonal difficulties young people were suffering. To address these issues, the team sought input from a range of local stakeholders. Focus groups with community leaders, young people and professionals highlighted the need for an intervention that could be delivered in communities by lay mental health workers. Interviews with mental health professionals, youth organisations, teachers, health care workers, religious and community leaders, officials in government ministries and Community Advisory Boards provided valuable input in the development of the intervention. The study team were also careful to incorporate common elements of evidence-based treatments that had been shown to work well in diverse settings and cultures.

1 World Health Organisation, *The Global Burden of Disease: 2004 Update* (Geneva: WHO, 2008).

2 Centers for Disease Control and Prevention, 'Global Health Protection and Security' (https://www.cdc.gov/globalhealth/healthprotection/errb/publications/mentalhealth_affectedpopulations_pib.htm).

3 K. Amone-P'Olak, N. Garnefski and V. Kraaij, 'Adolescents Caught between Fires: Cognitive Emotion Regulation in Response to War Experiences in Northern Uganda', *Journal of Adolescence* 30(4), 2007; R. Gerson and N. Rappaport, 'Traumatic Stress and Posttraumatic Stress Disorder in Youth: Recent Research Findings on Clinical Impact, Assessment, and Treatment', *Journal of Adolescent Health* 52(2), 2013; J. Drury and R. Williams, 'Children and Young People Who Are Refugees, Internally Displaced Persons or Survivors or Perpetrators of War, Mass Violence and Terrorism', *Current Opinion in Psychiatry* 25(4), 2012.

4 National Youth Commission, Ministry of Youth Employment and Sports, *Youth Development: Sierra Leone Youth Report*, 2012 (http://www.sl.undp.org/content/dam/sierraleone/docs/projectdocuments/povreduction/sl_status_ofthe_youth_report2012FINAL.pdf); Sierra Leone Ministry of Health and Sanitation, *National Health Sector Strategic Plan 2010–2015*, November 2009.

5 WHO Regional Office for Africa, 'Improving Access to Mental Health Services in Sierra Leone', 2017.

6 'Global, Regional, and National Disability-adjusted Life-years (DALYs) for 333 Diseases and Injuries and Healthy Life Expectancy (HALE) for 195 Countries and Territories, 1990–2016: A Systematic Analysis for the Global Burden of Disease Study 2016', *The Lancet*, 2016 (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32130-X/fulltext).

Children listening in a school in Sierra Leone.
© GPE/Stephan Bachenheime

The YRI incorporates two strategies: a common-elements approach, which adapts treatment strategies and techniques to fit new contexts and problems; and a transdiagnostic approach, which applies treatment across the full range of mental illness, rather than targeting a specific diagnosis. The YRI's six components are delivered in three phases common in trauma-informed interventions: stabilisation, integration and connection.[7] The intervention is divided into 12 sessions meant to be delivered over 12 weeks, with each phase building on the last. A group format encourages peer-to-peer learning and deepens social connections. The YRI can be delivered by lay counsellors, and does not require mental health professionals or specific educational requirements. The approach prioritises intensive training, supportive supervision administered in individual and group formats and fidelity monitoring via audio-taped intervention sessions and direct observation to bolster counsellors' skills, reinforce key YRI components and ensure the intervention is being delivered as intended. Following testing in a school, participants reported significant improvements in emotion regulation, social attitudes and behaviours and social support compared to the control group. Eight months after the intervention, YRI participants were more likely to stay in school, had better attendance and their classroom behaviour had improved.

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7 Stabilisation: youth receive psychoeducation about the impacts of trauma, and begin to develop initial coping skills; integration: youth explore their own struggles with anger and maladaptive coping as a group; connection: youth use self-awareness to practice skills essential to navigating their environment and managing interpersonal relationships.

The YRI and youth employment

Our current study will integrate the YRI within the youth Employment Promotion Programme (EPP) established by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). The EPP responds to market demand to ensure that young people obtain the qualifications they need for employment or self-employment. It consists of three training modules intended to strengthen skills relevant to the labour market, increase income and promote resilience to economic shocks. Our research will look at a range of implementation factors, including feasibility, barriers and facilitators, alongside a clinical effectiveness evaluation to measure changes in participants' mental health, notably emotion regulation.

Translating this research into effective implementation is filled with challenges. While many promising practices and programmes have been developed, they often fail to improve health outcomes, and over time key programme elements may become ineffective. Implementation models typically rely heavily on remote expertise and do little to develop local knowledge. Organisations often experience high levels of staff turnover because they do not have consistent funding, making it difficult to maintain institutional knowledge and sustain the intervention over time.

To remove the need for remote expertise for training and monitoring, our model uses a collaborative interagency approach to develop a core of local experts – a seed team – to provide training, coaching and support. Team members come

from a variety of organisations concerned with vulnerable youth in Sierra Leone, creating cross-agency collaboration and expanding institutional knowledge of YRI. Through a cascading process, the seed team will become an expert team, and then train, monitor and supervise a new seed team for additional EPP modules in a larger scale-up study. Through this process, seed team members become YRI expert facilitators, as well as developing critical skills related to collaboration, leadership, communication and quality improvement. Using these inter-agency collaborative teams and partnering with different non-governmental partners is a major innovation, and we hope that the expertise gained through this approach will result in broader investments in and commitments to evidence-based programming related to vulnerable youth in Sierra Leone.

To conclude, we share some core considerations for investments in research. First, concerted effort is required to study the effectiveness of interventions, and how mental health and psychosocial programming can contribute to the development of longer-term and sustainable systems of health and mental health care, in both low- and high-income settings. Second, ethical conduct and the safety of children, youth and local research staff must be prioritised. In addition to obtaining appropriate approval from local and international ethics review committees, community advisory boards can help ensure ethical implementation and the appropriate dissemination of findings. Third, research and interventions should be contextualised. Attention must be paid to the setting, including risk and protective factors at the individual, family, peer, community and societal and cultural levels. In work with young people, a child's developmental progress and growth must also be considered. Fourth, we strongly encourage participatory approaches, locally defined priorities and collateral respondents. Psychosocial interventions should be based on locally identified needs, rather than externally imposed services or researchers' assumptions, identifying priorities through community-based participatory approaches and collaboration with local service providers and Community Advisory Boards. Other considerations include addressing limited human resources for health, incentives, training, supervision and professional development for staff, financing and policy structures and strategies for monitoring and improving quality.

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Designing and implementing psychosocial interventions for children with severe acute malnutrition: Action contre la Faim's experience in Nepal

Karine Le Roch and Cécile Bizouerne

Severe Acute Malnutrition (SAM) is widespread in South Asia, and affects 2.6% of under-fives (about 76,000 children) in Nepal. It is treatable through the administration of ready-to-use therapeutic foods (RUTFs) and medico-nutritional treatment (vitamins, antibiotics). However, what is often missed in malnutrition treatment programmes is the opportunity to combine with early child development interventions to improve both nutrition and development outcomes.[1] Very few nutrition treatment programmes include a psychosocial intervention, and systematic evaluations of community programmes are few and far between.[2] Action contre la Faim's Follow-up of Severely Malnourished Children (FUSAM) project, which ran from 2014 to 2017 in Nepal, aimed to address this.

We wanted to assess the effectiveness of a brief psychosocial intervention on child nutrition, health and development by comparing the effects of a combined psychosocial and nutrition intervention to a stand-alone nutritional treatment of children with uncomplicated SAM aged six to 24 months admitted to a Community Management of Acute Malnutrition (CMAM) programme in Saptari district in the Eastern-Terai sub-region of Nepal, implemented in collaboration with the District Public Health Office (DPHO).[3] This article describes how we designed a psychosocial component for mothers and caregivers whose children were being treated for SAM. Our research highlights the value of including a psychosocial intervention to improve parenting skills, leading to enhanced child development. However, the direct impact on SAM treatment was found to be more limited than anticipated.

Designing the intervention: improving childcare practices to reduce under-nutrition

Saptari district is home to a variety of tribes and castes. Agriculture is the main occupation, though it is also common

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1 M. T. Ruel and H. Alderman, 'Nutrition-sensitive Interventions and Programmes: How Can They Help to Accelerate Progress in Improving Maternal and Child Nutrition?', *The Lancet* 382(9891), 2013.

2 P. L. Engle et al., 'Strategies for Reducing Inequalities and Improving Developmental Outcomes for Young Children in Low-income and Middle-income Countries', *The Lancet* 378(9799), 2011.

Women at a lactating and pregnant mothers' group meeting in Saptari district, Nepal.

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for husbands to work abroad or elsewhere in Nepal, coming home once a year or less. Women face strong social pressures, have few resources and a high workload and can lack the support of their in-laws. Mothers are often busy with other duties, such as household chores and agricultural work, leaving limited time for childcare, and young and single mothers in particular may not have the resources to provide proper care. Hygiene practices are very poor, and although food is available and dietary diversity does not seem to be a problem, children's diets are insufficient for optimal development and growth. Children may also be weaned too early (around three months) or too late (at one year). There is gender discrimination against girl babies because the family is expected to pay a dowry for marriage.

With the involvement of the local community, we designed psychosocial interventions to support behaviour change in both the mother and the child by:

- supporting mothers and children with stimulation activities;
- increasing mothers' knowledge of appropriate child-rearing practices;
- enhancing mothers' wellbeing and self-esteem; and
- promoting children's growth through better nutrition.

The psychosocial intervention portion of the FUSAM comprised fortnightly follow-up sessions on the same day as the nutrition follow-up. Five sessions were scheduled, of around 30 to 45 minutes each. Each session had a specific objective:

- Session 1: 'Family Welcome' aimed to welcome the mother and the child (or other family members), exploring their thoughts and feelings around nutrition and the future of the child.
- Session 2: 'Communication, play and have fun' aimed to sensitise mothers on the importance of communication and play in enhancing children's stimulation and development.
- Session 3: 'Breastfeeding and feeding practices' aimed to explore new strategies and skills for transforming these moments into positive experiences both for the child and for the mother.
- Session 4: 'Massage, bathing, sleep and relaxation' aimed to explore strategies of reassurance and relaxation for the baby that are feasible and enjoyable for both the child and the mother.
- Session 5: 'Family sharing' aimed to reflect with the mother on lessons learned and to share this information with other family members.

Implementing a psychosocial intervention as part of a CMAM programme

CMAM programmes rely on a range of community and health services, including Female Community Health Volunteers (one for around every 20 families), who provide services such as family planning and child immunisation, and refer children presenting signs of undernutrition to Outpatient Therapeutic Programme (OTP) centres. The psychosocial component was set up with a team of psychosocial workers recruited by the DPHO and trained by ACF. In OTPs, the nutrition focal point or general practitioners referred SAM children and their mothers to psychosocial workers, and their performance was regularly monitored by a supervisor, either on site or via video when insecurity did not allow field visits.

Integrating psychosocial interventions in CMAM programmes is challenging: it requires collaboration with various health professionals to set up a reliable referral system; it requires appropriate training for health practitioners and psychosocial workers; and it requires a safe and confidential space in the health premises. Even so, the intervention was practically feasible in this remote area of Nepal, and could be delivered more generally even in challenging contexts. Between August 2015 and February 2016, communal tensions stoked by changes to the Nepali constitution triggered regular strikes and violent demonstrations, forcing people to curtail their movements and reducing the number of mothers visiting OTPs. In order to allow the FUSAM team to continue its work despite restrictions on movement and curfews, changes were made in planning and remote supervision was organised in order to maintain minimum services. While initially only mothers were targeted for psychosocial sessions, this was extended to other family members and caretakers who accompany children to the OTP.

Challenges and successes

The intervention seems to have had a significant impact on child development (gross and fine motor skills, cognitive skills, language, problem-solving and personal/social development), and this improvement has been sustained. Levels of child stimulation at home have also increased. Most of the mothers (50% came to four or five sessions) appreciated the intervention. According to one psychosocial worker: 'at the beginning [of the project], some people were reluctant to bring their child to the OTP for nutritional treatment but they accepted and continued the treatment after individual or family counselling. Nowadays they thank us for opening their eyes to their child care'. Generally, counselling has made mothers more aware of malnutrition problems, prevention and treatment, parents' roles and responsibilities, hygiene and proper sanitation, proper feeding and access to health services. They also learned about child development, and felt better equipped to make decisions affecting their children.

We could not demonstrate that the intervention had any significant impact on recovery from SAM. Anthropometric measures were not reliable enough, and the intervention was too short to close the gap between SAM and non-SAM children in terms of development. In the opinion of psychosocial workers, facilitating behaviour changes would take more time than was included in the programme: 'there are several factors in the community that we can't change in a short period of time, like girls' education, family support mechanisms, prevention of early marriage, barriers due to cultural factors, lack of economic activities, and the burden of household activities on women'.

Next steps

Psychosocial workers have a vital role in sensitising health workers to the link between malnutrition and child development. In order to retain experience and knowledge among health staff, we trained all 62 auxiliary nurse-midwives working in OTPs and remote birthing centres and five health workers at the Nutrition Rehabilitation Home on the FUSAM psychosocial protocol and basic psychosocial support. Other DPHO representatives and staff as well as those responsible for OTPs received a one-day orientation on the psychosocial intervention programme. We have also provided low-intensity training for health workers at OTP centres in Rasuwa district in northern Nepal in an adapted version of the FUSAM protocol (with very similar content and without additional PSWs). A round of supervision provided additional information on adapting the protocol content and implementation modalities to reflect geographical and socio-cultural differences in the country. This is the first step in scaling up the intervention. There is also a new opportunity for a collaboration with the National Health Research Council (NHRC), which has invited us to join the technical team developing Nepal's first national mental health survey.

Conclusion

The psychosocial component of FUSAM was developed taking into consideration the psychosocial impact of SAM on children, their mothers and their relationships. Interventions were delivered despite numerous challenges and under adverse conditions. It had positive impacts, some expected and others not, and will require further study. In the meantime, the programme is being taken forward and adapted with the support of the Ministry of Health and Population.

The FUSAM project was innovative given the lack of clear national policies or guidelines on psychosocial interventions in nutrition programmes. There are multiple benefits in including a psychosocial component alongside SAM treatment, but the results show that it is unrealistic at this stage to expect psychosocial interventions to address the impacts of SAM.

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Responding to trauma during conflict: a case study of gender-based violence and traditional story-telling in Afghanistan
Ayesha Ahmad, Lida Ahmad and Jenevieve Mannell

The collapse of the health system during the Taliban regime means that Afghans rely overwhelmingly on health services provided as part of the humanitarian response. The focus is on addressing the physical effects of conflict and violence, rather than the mental health effects of trauma. The World Health Organisation (WHO) Afghanistan Humanitarian Response Plan 2017 describes Afghanistan as 'one of the most dangerous and crisis-ridden countries in the world'.[1] References to the health sector highlight the threat conflict poses to the physical safety and health of Afghans, with a particular focus on infant and maternal health, but there is no mention of mental health. Likewise, the European Civil Protection and Humanitarian Aid Operations (ECHO) overview of humanitarian assistance situates mental health as part of resilience programming, and makes no mention of specific mental health programmes for Afghanistan. WHO's Mental Health Gap Action Programme

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1 http://www.who.int/emergencies/response-plans/2017/afghanistan/en/.

2 https://ec.europa.eu/echo/what/humanitarian-aid/resilience_en.

Story-telling interventions could help Afghan women experiencing trauma from GBV.
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(mhGAP) is intended to provide training for primary healthcare professionals on diagnosing and treating mental illness, but implementing and sustaining such programmes is challenging in a context of conflict, the stigma and taboo attached to mental illness and a universalised model of trauma that may not be culturally valid.

This article explores the challenges of mental health and psychosocial support (MHPSS) in Afghanistan, with a particular focus on sexual and gender-based violence. We discuss the development of a therapeutic intervention using traditional story-telling for gender-based violence in conflict, drawing out lessons for the role of humanitarian actors in facilitating MHPSS in contexts with very little or virtually non-existent mental health infrastructure. Although the intervention focuses on GBV-related psychological trauma, stories of war and conflict are inescapable, and war narratives and GBV narratives are intertwined. At the same time, war and conflict can produce societal disruption, opening up spaces for social transformation and providing an alternative discourse to channel and transfer stories it might otherwise have been impossible to tell.

Traditional story-telling as a therapeutic intervention for GBV

A staggering 87% of Afghan women are estimated to be affected by at least one form of gender-based violence, and 62% multiple forms. There is a double burden of psychological trauma, both from the surrounding context and within the home. Afghan society is highly gendered; space to openly discuss GBV is extremely restricted, and violence is rarely

reported or disclosed and rarely recognised as a crime. The mental health impacts of GBV are heavily stigmatised, and psychological distress is not necessarily interpreted as an aspect of mental health, but instead situated within cultural and religious discourses. Lack of resources for therapeutic responses to GBV are another challenge. For these reasons, psychological interventions for Afghan women experiencing GBV have been extremely limited.

As the first point of contact for women escaping situations of violence, shelters for women, or 'safe houses', offer a key opportunity to mitigate the potential long-term harmful effects of GBV. However, in such a conservative society the idea of providing women with a refuge outside of the family is controversial: there are no government-run facilities, and in 2012 one senior government minister referred to safe houses as 'brothels' housing immoral women.[3] In the absence of government support, the estimated 30 safe houses currently in existence across Afghanistan[4] are supported by NGOs and the UN. The locations of safe houses have to remain secret, and there is a constant risk that the Afghan government will seize control of them.[5]

3 Dean Nelson, 'Afghan Women in Shelters Are Prostitutes, Says Justice Minister', *The Telegraph*, 21 June 2012 (https://www.telegraph.co.uk/news/worldnews/asia/afghanistan/9346779/Afghan-women-in-shelters-are-prostitutes-says-justice-minister.html).

4 'A Safe Place for Afghanistan's Abused Women', *The National*, 27 May 2017 (https://www.thenational.ae/world/a-safe-place-for-afghanistan-s-abused-women-1.67433).

5 'Afghan Women Fear Losing Safe Houses', *BBC News*, 18 February 2011 (http://www.bbc.co.uk/news/world-south-asia-12496381).

The psychological support provided by safe house staff typically involves offering women a consultation with a psychologist. However, this requires the women to disclose intimate details of the violence they have suffered in a context where disclosure as therapy does not resonate with cultural understandings of gender relations, and being identified as a victim of sexual violence is extremely risky for the woman, especially where the perpetrator is an individual of power. As a result, there is an urgent need for alternative approaches to therapy that fit with the local context and effectively address women's psychosocial needs.

My co-researchers and I developed a traditional story-telling intervention to create a way for women to speak about their suffering in a society that silences women's voices. Although women were banned from reciting poetry under the Taliban, story-telling has a significant symbolic role in Afghan culture, with a rich oral tradition of women story-tellers. Talking about violence as a story about one's life provides a means of understanding GBV experiences as part of broader structures of inequality, rather than as an individual responsibility or issue. Similarly, group story-telling provides a potential means for these highly vulnerable women to tell their stories through an act that represents freedom from extreme religious ideology.

The research comprised life-narrative interviews with 20 women who had experienced GBV and were currently residing, either temporarily or permanently, at two safe houses run by local NGOs.[6] A structured story-telling activity using different forms of stories representing GBV was also conducted in a focus group of five women in the safe houses, as well as eight in-depth interviews with staff working for the local NGOs.[7] All activities were recorded, transcribed and translated into English for analysis. The aim of this small study was to identify alternative approaches to interpreting and recovering from experiences of violence grounded in the local cultural context. Using a local researcher with pre-existing links to the safe house where we worked provided for a rich collaboration and dialogue with the women who participated because trust had already been established; the women were happy to be interviewed, although they were clearly informed beforehand as part of the consent process that they could withdraw at any point. The age range was from 18 to 45 years old. All the interviews and the focus group took place in the safe house to minimise the risks to the participants.

As Afghanistan is predominantly an oral story-telling culture and most of the women were unable to read or write, a range of media was used in the focus group. Poetry from well-known contemporary and ancient Persian women poets, such as Forough Farakhzad and Rabia Balkhi, was recited, and a

recent media article about the public stoning and murder of Farkhunda Malikzada, a 27-year-old woman falsely accused of burning a Quran, was discussed.[8] Folk stories were also shared. The focus group created connectedness and a sense of shared experience. Although some of the women said that they could not understand the poems because of their lack of education, they felt able to relate to the local researcher's interpretation of them, and the narratives surrounding the poets' lives had contemporary resonance and relevance.

Participants were also asked about a song, poem or story that they recalled from their childhood. This enabled the women to convey their story, or the meaning of it, in a way that did not centre on the violence they had experienced. For example, one woman did not remember any stories from her childhood because there had been no one to tell her stories, conveying a sense of sadness and loss because she had been alone as a child. The woman was nomadic, and instead of recounting a story she remembered being told she spoke about being with her sheep, reminding her of a time in her life without pain or suffering.

Although the women's reflections were violence-based narratives depicting the extent of GBV since birth, the act of story-telling allowed them to bring their own personalities, memories and expressions of hope into the interviews, rather than reducing their lives to a series of violent events. The women were still living through their trauma – there is no 'post-trauma' in this context, and thus the women are constantly connected to their experiences. However, the life-narrative interviews served to tell whole stories that contained more than violence, while at the same time creating an environment where all forms of GBV could be communicated in a therapeutic way. The therapeutic nature of the storytelling was related to the interaction with other people who shared similar experiences, and the relief the women felt from being believed.

This need to be believed was a significant theme throughout given previous negative experiences in telling stories, or parts of stories, relating to GBV to female relatives. Because of the serious consequences of disclosing GBV such as honour-related violence to family members (or anyone for that matter), and the shame associated with GBV, especially sexual violence, it is not safe for women to tell their stories even to female members of their own family. Some of the participants had suffered physical violence at the hands of their mothers and sisters.

Therapeutic outcomes, analysis and future work

As an alternative to Narrative Exposure Therapy (NET), an evidence-based short-term therapeutic treatment for individ-

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6 A life-narrative interview is an interview about a person's story of their life to better understand the concepts of suffering and the role of story-telling in responding to trauma.

7 Initially, four focus groups were planned, but due to security concerns only one was possible.

8 Alissa J. Rubin, 'Flawed Justice after a Mob Killed an Afghan Woman', *New York Times*, 26 December 2015 (https://www.nytimes.com/2015/12/27/world/asia/flawed-justice-after-a-mob-killed-an-afghan-woman.html).

uals who have experienced multiple traumas, our story-telling intervention does not focus on the coherence of the narrative as a marker of recovery. Rather, the intervention mirrors the traditional form and purpose of telling stories. The Afghan adage 'sorrow makes me a story-teller' reveals the strong symbolism between suffering and the telling of stories. Given the chronic nature of the conflict and the structural violence towards women who have experienced GBV, stories of suffering are continuing; there are no closed stories of violence. This requires a shift in the aims and expectations of trauma therapeutic interventions in Afghanistan to ensure that any impact is sustained, not nullified. To achieve this, there also needs to be a shift in the way narratives are conceptualised in MHPSS programmes to take on board cultural nuances in the meaning and purpose of a story, as well as different forms of narrative. Poetry can be used to express resistance in Afghanistan, including in response to GBV and conflict,

through depicting literary representations of lived experiences and raising awareness of the human rights violations Afghan women face.[9] Traditional story-telling, then, has the potential for therapeutic benefits through enabling the participants to challenge their prescribed narratives. As our local researcher says, 'poems are our guns too'.

This research is continuing through an MRC/AHRC-funded project entitled 'Storytelling for Health: Acknowledgement, Expression and Recovery' (SHAER). The project is a collaboration with partners from high-prevalence settings across six countries.

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Reflections on a psychosocial community support programme in the West Bank
Relinde Reiffers, Kimberly Stam and Suzan Mitwalli

Humanitarian crises affect people's mental and psychosocial wellbeing and disrupt the social fabric of communities and families. Over the last decade, attention to mental health and psychosocial support (MHPSS) in the humanitarian sector has increased, and standards for MHPSS interventions have been developed.[1] Researchers in this field have identified ten fundamental questions the humanitarian sector needs to focus on.[2] One concerns the effectiveness of family-based interventions in preventing mental disorders and protecting and promoting psychosocial wellbeing. This article reflects on a community support programme – the 'Multi-Family Approach (MFA) through Community Based Rehabilitation (CBR)' – in the West Bank, involving NGOs, community-based organisations and universities from the occupied Palestinian territory, the Netherlands and the United Kingdom.

Context

There is a significant unmet need for mental health and psycho-social support in the West Bank.[3] People with physical and mental handicaps are especially vulnerable in this situation of political, social and economic hardship. For mothers of children with a disability it is very challenging to care for these children,

their families and themselves given the lack of services, socio-economic constraints, stigma and social isolation.

The MFA brings together mothers of children with a mental or physical disability to share experiences and learn from each other. The project was developed and implemented by the War Trauma Foundation and the Institute for Community and Public Health (ICPH) at Birzeit University in the West Bank, in collaboration with the Community Based Rehabilitation (CBR) programme, the Dutch national centre for psychotrauma Foundation Centrum '45 and Sioo, an inter-university centre for change management. It is based on Multi-Family Therapy, developed by the Marlborough Family Service and Education Unit in London.[4] The intervention is grounded on the premise that people in similar situations can provide each other with company, stress relief and practical problem-solving ideas; one MFA group, for instance, brings together women with autistic children from three West Bank villages, where they receive support from other mothers whose children suffer from the same condition.[5] Sessions involve enjoyment and relaxation for mothers, alongside serious conversations around shared personal, family and community experiences. A group facilitator is present, but since the MFA is a peer-support programme they are there merely to guide the process, not

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

2 W. A. Tol et al., 'Research Priorities for Mental Health and Psychosocial Support in Humanitarian Settings' *PLoS medicine* 8(9), 2011.

3 S. de val D'espaux et al., 'Strengthening Mental Health Care in the Health System in the Occupied Palestinian Territory', *Intervention* 9, 2011.

4 E. Asen and M. Scholz, *Multifamily Therapy: Concepts and Techniques* (London: Routledge, 2010).

5 S. Mitwalli and Y. Rabaia, 'Piloting the Multi-family Approach in Community-based Rehabilitation: An Observational and Interview-based Study', *The Lancet* 390, 2017.

Children playing in Hebron, West Bank.
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deliver content. The women themselves decide what topics they wish to discuss. Group facilitators are CBR employees trained by their peers, who have themselves been trained by an expert in MFA, and ICPH. Many have a background in social work. After a one-year pilot, an MFA manual drawing on experience in the West Bank has been developed, in collaboration with the MFA facilitators. The manual is illustrated with exercises that can be implemented during sessions, including getting to know one other, relationship-building and fun.[6] Since CBR is community-based and the MFA facilitators are CBR staff who run the groups as part of their work, it is likely that the programme will continue to exist even if international actors take on a more distant role.

There are currently around 40 groups, each consisting of around ten women. Sessions are usually held once a month, or every two months. Members report that the caring and trusting environment within the groups has enabled them to exchange experiences and talk freely about their children's problems. The women also report reduced stigma and feeling less stress. Not only do mothers in the MFA groups feel better, but their families also notice positive changes at home; one of

the mothers said 'my husband says I'm less irritable and more patient'. Group members are also more confident, and are now lobbying at the Ministry of Education for better educational opportunities for their children. This empowerment is expanding to other domains as well, for example involving local authorities such as the municipality.

Facilitators occasionally need to explain the purpose of the group meetings to potential participants, and how they can benefit from them. Women may have negative attitudes towards receiving mental health support because of the stigma that surrounds mental health issues in the West Bank. They may also have unrealistic expectations about the impact of MFA on their lives, and some may join a group in search of support beyond mental health, such as income-generating initiatives or medicine for their disabled children.

The CBR has struggled to provide adequate support to very vulnerable groups, such as mothers with severely disabled children who need continuous care. This is a difficult group to cater to because the children need to be looked after while the mothers are attending the MFA group. In some groups youth volunteers are available to do this, but these children typically need special care, which the volunteers are not able to provide without specific training.

6 War Trauma Foundation, *The Multi-Family Approach in Humanitarian Settings*, 2015.

One question we've grappled with is whether to work only with mothers, with fathers as well or with mixed groups. In the end we chose to work with mothers exclusively, in part because most fathers work some distance from their home, making it difficult for them to participate in training sessions, and the women are expected to share their experience and learning from the support groups at home. However, fathers could be involved at a later stage.

Staff care

A frequently asked question from field partners is how best to support the mental wellbeing of their employees and volunteers. Working with people in distress can be extremely stressful, and compassion fatigue and burn-out among mental health care workers can be a risk. One useful tool for monitoring the health status of staff is the Professional Quality of Life Scale (ProQol).[7] This 30-item questionnaire explores the positive and negative aspects of helping distressed people. Peer consultation is also provided for MFA facilitators, so that they can share with each other the difficulties they are facing and reflect on themselves and their way of working, exchange information and knowledge with other MFA facilitators and

get practical advice and learn new techniques for dealing with their own feelings and emotions.

Conclusion

This overview shows the importance of engaging MHPSS in humanitarian action on a community level. Although MHPSS is a relatively new element in the humanitarian field, an increasing number of organisations and programmes now include MHPSS. The discipline is quickly evolving, and research and sharing best practices on how to strengthen both health systems and communities are essential. There is significant strength in joint research and programming, involving universities, NGOs and governments, adding to each other's experiences and knowledge. Within these processes, attention to the wellbeing of communities and humanitarian workers is vital. Experience from our joint interventions and research programmes highlights the importance of different perspectives, and strengthening knowledge, skills and mental and psychosocial wellbeing worldwide.

Relinde Reiffers is a senior project coordinator at the War Trauma Foundation in the Netherlands, where **Kimberly Stam** is a junior researcher. **Suzan Mitwalli** is a project coordinator and researcher at the ICPH. The authors would like to thank everyone who has worked with us, making progress in the field of MHPSS possible.

7 B. H. Stamm, *The Concise ProQOL Manual*, 2nd ed. (http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf).

Mental health research among Syrian refugees in Lebanon: challenges and solutions
Patricia Moghames, Fiona McEwen and Michael Pluess

More than 5.4 million Syrian refugees are registered in countries surrounding Syria, including an estimated 1.5m in Lebanon.[1] Psychological and social distress among refugees is common, resulting in a wide range of emotional, cognitive, physical and behavioural problems.[2] High-quality research on the mental health needs of Syrian refugees should play an important role in planning and providing services, yet conducting mental health research to a high standard in a refugee setting is particularly challenging. This article describes two research studies with Syrian refugees in the Beqaa region of Lebanon, setting out some of the challenges

faced and the lessons learned in the process of conducting the research.

The BIOPATH study

BIOPATH – Biological Pathways of Risk and Resilience in Syrian Refugee Children – aims to understand how environmental and biological factors interact to influence the extent to which children develop mental health problems or show resilience following war and displacement. This National Institutes of Health (NIH)-funded research is being led by academic partners in the UK and Lebanon (Queen Mary University of London (QMUL) and the Institute for Development, Research, Advocacy and Applied Care (IDRAAC)), with Médecins du Monde (MdM) as the fieldwork partner.

Researchers interviewed 1,600 refugee children and their primary caregivers about children's wellbeing and symptoms of common mental health problems, such as depression and PTSD. We also measured the risk and protective factors that might affect mental health, ranging from exposure to war

1 UNICEF, *Syria Crisis: 2017 Humanitarian Results* (https://www.unicef.org/appeals/files/UNICEF_Syria_Crisis_Humanitarian_Situation_Report_Year_End_2017.pdf).

2 G. Hassan et al., *Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support Staff Working with Syrians Affected by Armed Conflict* (Geneva: UNHCR, 2015); E. G. Karam et al., 'Outcome of Depression and Anxiety after War: A Prospective Epidemiologic Study of Children and Adolescents', *J Trauma Stress* 27(2), 2014.

events and the quality of their living conditions to levels of social support and access to education. Saliva and hair samples were collected to measure biological factors such as genetic variation and stress hormones. Around 1,000 of these families will be followed up after one year to study changes in children's mental health over time.

The t-CETA study

The Common Elements Treatment Approach (CETA)[3] is a psychological treatment designed for low-resource settings. It can be delivered by trained lay people under close supervision. The t-CETA study aims to adapt the approach so that it can be delivered over the telephone, and then test its effectiveness in a randomised controlled trial. Delivering CETA over the phone has the potential to reach a much greater number of children than is possible with face-to-face treatment. The study is funded by Elrha[4] and involves academic partners in the UK (QMUL), Lebanon (American University of Beirut), the United States (Johns Hopkins University) and Germany (Medical School Hamburg), working with MdM in Lebanon.

Challenges faced and lessons learned

Academic–NGO partnership

Close partnerships between researchers and practitioners in the field are key to high-quality research. They can also be challenging. NGOs' lack of experience in implementing research, and academics' lack of connection to the community and limited knowledge of operational procedures in the field, can result in significant differences in expectations and institutional culture. During the course of setting up the BIOPATH and t-CETA projects, we deepened the connections between institutions by jointly managing core research staff. Local study coordinators were employed specifically for research activities with MdM in Lebanon, with significant input in recruitment and line management from academic partners, and a joint recruitment process enabled the selection of candidates with skills relevant to both institutional settings. The study coordinator at QMUL in London is in daily contact with the Lebanon-based coordinators, facilitating joint planning and problem-solving during fieldwork and acting as the link between academic partners and NGO staff. This helps NGO staff understand the demands of the research, and academic partners understand the constraints of fieldwork.

Planning and budgeting

Planning and budgeting for both studies was done before research staff were recruited and in post. This made developing plans more difficult and necessitated revisions as new challenges emerged. For example, it only became clear when the BIOPATH fieldwork coordinator began planning field visits in preparation for the research that formal approval from the Ministry of Defence (MOD) was required in order to conduct research in refugee settlements. As a result, the preparation phase of the study had to be extended while we gained these additional approvals. Likewise, while academic staff planned staffing and timelines for the research based on estimates of how long it would take to complete assessments, these had to be recalculated to reflect the time it took for field staff to travel to areas where data collection would take place and pilot-test assessments. For future research collaborations we aim to involve staff at all levels across different departments of the partner organisations from the earliest stages of conceptualisation and planning. This should help ensure that plans are feasible, that set-up and support costs are anticipated and that research activities are planned in a way that minimises the impact on the ongoing activities of the NGO.

Approvals and support

There are many challenges inherent to working in a humanitarian setting, including ethical concerns about conducting research with a vulnerable group, ensuring that the research is beneficial to participants and securing approval for the research. Prior to the fieldwork the study was reviewed by the sponsoring UK university (QMUL), ethical approval was obtained from a local Lebanese university, government approvals were obtained from the Ministry of Public Health (in consultation with the Lebanese National Consultative Committee on Ethics) and the MOD, and clearance was sought from army intelligence units local to the settlements where the research would take place. Each municipality in the working area and each community leader in the settlements was visited by the research coordinator prior to the research to explain the study in detail, and to find out more about the community and their concerns.[5] This process took significantly longer than expected, and for future studies we will share plans with the relevant government departments at the earliest stage – before seeking funding – in order to anticipate and address ethical or security concerns in a timely manner.

Accurate measurement

Reliable and valid measures are one of the most important aspects of any research study. Measures must be adapted to the culture, educational and literacy levels of the target population, while also allowing for comparisons with other

3 L. K. Murray et al., 'Building Capacity in Mental Health Interventions in Low Resource Countries: An Apprenticeship Model for Training Local Providers', *Int J Ment Health Syst* 5(1), 2011.

5 In the Syrian refugee context in Lebanon, a community leader (also known as *chawich*) is usually selected by the members of that community to take the lead in meeting the needs of residents of the settlement, such as paying for land rental, negotiating prices with landlords, meeting with local authorities, representing the settlements and coordinating with NGOs.

An interview being conducted with a Syrian boy in an informal tented settlement in Beqaa, Lebanon.

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contexts. A review of the existing literature identified measures that seemed promising. For example, the Screen for Child Anxiety Related Emotional Disorders (SCARED)[6] and the WHO-5 Well-Being Index (WHO-5)[7] had both been translated into Arabic and validated in children or adults in Lebanon. The Lifespan Self-Esteem Scale[8] had not been used in Arab countries, but worked well with American children, uses language suitable for children, and includes pictures of sad, neutral and happy faces to help children frame their responses. Measures were independently forward and back translated by bilingual psychology students in Lebanon, and reviewed and revised by Syrian and Lebanese clinicians and mental health and public health experts. Focus group discussions with Syrian refugees (mothers, fathers and children/teenagers) from settlements in Beqaa were carried out to determine whether measures were easily understood, culturally sensitive and appropriate. Pilot work with over

250 Syrian families evaluated and refined the measures, and close monitoring during data collection and exit interviews with interviewers were used to gain information on how each measure was received and understood by participants.

The pilot testing revealed problems with a number of existing measures. For example, we aimed to measure two closely related aspects of coping, self-efficacy and locus of control. Self-efficacy measures the strength of a person's belief in their ability to deal with difficult situations, while locus of control relates to the extent to which a person attributes success or failure to internal or external causes. Pilot testing with Syrian refugees showed that the measure of self-efficacy worked well; the questions made sense to people and the scale showed excellent psychometric properties. However, the questions in the locus of control measure did not make sense to the study participants and the scale performed very poorly. Participants explained that success was down to God's will, rather than hard work or luck. The different cultural and religious framework used to understand why things happen means that the concept of locus of control does not help explain why some people cope better than others. Therefore, we decided to drop this measure from the research.

Qualitative approaches were used to check whether each question was understandable and appropriate to the culture of the community and the context of informal settlements.

6 N. Hariz et al., 'Reliability and Validity of the Arabic Screen for Child Anxiety Related Emotional Disorders (SCARED) in a Clinical Sample', *Psychiatry Research* 209, 2013.

7 P. Bech, *Clinical Psychometrics* (Oxford: Wiley-Blackwell, 2012); C. Winther Topp et al., 'The WHO-5 Well-Being Index: A Systematic Review of the Literature', *Psychother. Psychosom* 84, 2015.

8 M. A. Harris, M. B. Donnellan and K. H. Trzesniewski, 'The Lifespan Self-Esteem Scale: Initial Validation of a New Measure of Global Self-Esteem', *Journal of Personality Assessment* 100(1), 2018.

For example, the measure of coping strategies asked whether children would ride a bike or skateboard as a way of releasing emotions, but both are extremely rare in this context. Another measure asked how often children attended religious meetings. However, young girls do not necessarily attend mosque, so this question did not reflect religious belief among girls. In some cases translation into Arabic unavoidably changed the meaning of a question. For example, a question that asked about having a 'rich, complex inner life' was conveyed as a 'rich, complicated inner life', which did not make sense to participants. We removed or rephrased any questions that caused problems in the pilot study. We also used quantitative data analysis to reduce the length of longer questionnaires. Where there were no existing measures we developed new ones, including a measure of the quality of the refugee environment (Perceived Refugee Environment Index (PREI)), a measure of children's aspirations and expectations about the future (Future Aspirations and Plans (FAP)) and a measure of access to mental health services (Mental health Service Use and Needs (MhSUN)).

Fieldwork challenges

Challenges involved in the actual conduct of the research included adverse weather, security concerns and transport issues, as well as pressure to address staff and refugees' concerns, needs and requests. Conditions in the refugee settlements vary dramatically: some are muddy while others are well-constructed and designed; some have a clear division between shelters and roads, while in others shelters are randomly scattered and there may not be passage for cars; some have proper waste management and sanitation while others do not. Almost all refugees expected basic needs assistance when first introduced to the research project, and the team had to balance attending to these needs and taking details for referrals with collecting data for the research. We tried to anticipate the challenges that might be faced, developing a contingency plan and creating and managing a reporting system for fieldworkers. A WhatsApp group was created for communication about security issues, including MdM's security focal point, the logistics officer, the fieldwork team leaders and the fieldwork coordinator. On the rare occasions when security issues arose, this was immediately communicated to the group and feedback provided.

Data management and quality assurance

Finally, monitoring and maintaining the quality of the data being collected is of utmost importance. When data collection is taking place in remote locations, and when many interviews are being collected by a large team each day, this can be extremely challenging, and there is a risk that substantial amounts of data are collected before problems become apparent. We took a number of steps to ensure high-quality data collection. Before the field research began, intensive technical training was conducted with field team members covering data and sample collection and storage, as well as generic skills such as communication with adults and children, ethics and personal conduct and security. Training was conducted in Arabic, and all documentation was translated. Interview data was collected through tablets and uploaded to a secure website every day. Data processing was automated so that data could be exported, processed and evaluated quickly by the academic team in London. This made it possible to detect errors in data entry and provide feedback promptly to the fieldwork coordinator.

Conclusion

Achieving high-quality research in Beqaa has proved challenging, but it is possible when academic and NGO partners work closely together and develop systematic and innovative approaches to data collection. One of the most important planning recommendations is to closely communicate day-to-day with fieldworkers and logistics and security staff at the NGO, as well as with the community. While it might be burdensome, time-consuming and complicated, having the feedback of field team members and the community while drafting research plans is likely to save a great deal of time and effort later. It is also crucial to keep in mind that challenges and obstacles, especially during the data collection phase, are inevitable. As such, having a dedicated, well-trained team and good communication between academic and NGO partners will build a solid foundation that will increase the chances of success.

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Improving humanitarian crisis response policy and practice: mental health and psychosocial support coordination in Lebanon

Nour Kik and Rabih Chammay

International responses to humanitarian and refugee crises bring together a multitude of actors and a plethora of missions, agendas and capacities. This diversity holds great potential, but also considerable risk. The potential is that the involvement of such a diverse set of players can result in a comprehensive and effective humanitarian response. The risk is that the response is fragmented, with duplication and wasted resources; is inconsistent with actual needs; and has unintended and adverse consequences. The multiplicity of actors also increases competition for resources, and upward accountability to donors compromises and eclipses downward accountability to the people the response is supposed to help. This lack of downward accountability is aggravated by the fact that, in countries affected by crisis, government accountability mechanisms usually relate to legal (registration) and financial (reporting) matters, not the quality of operations.

To address these concerns coordination is essential, and is a core function of humanitarian governance. Effective co-ordination can optimise available resources and increase accountability, minimising duplication, preventing overlaps and ensuring complementarity and the synchronisation of humanitarian work. How should coordination mechanisms be designed to maximise benefits and avoid pitfalls? In an attempt to answer this question, this article explores the mental health and psychosocial support (MHPSS) response to the Syrian refugee crisis in Lebanon.

The MHPSS response in Lebanon

Lebanon is a small, middle-income country, with a history of civil war and political unrest. Its population is around 6 million, including 180,000 Palestine refugees and around 1.5 million people displaced from Syria. Displacement has had a significant impact on the economy, employment and basic services, including health services. Even before the current crisis, the mental health system was inadequate: availability, accessibility and affordability of services were limited, both for Lebanese and non-Lebanese, with services mainly provided in the private sector and skewed towards specialised care. Hospitals had occupancy rates of 97%, and outpatient care, mainly provided in the private sector, was affordable for only a few. Mental health was poorly integrated into primary care.

Gaps in services and a lack of coordination between providers were highlighted by a 2013 UN High Commissioner for Refugees (UNHCR) assessment of MHPSS services for displaced people.[1] Building on this report, and recognising that humanitarian crises can be an opportunity to 'build back better', the Ministry of Public Health (MoPH) has committed to a long-term vision for sustainable mental health reform, and has taken major strategic steps in that direction, including establishing and leading a national MHPSS coordination mechanism, the MHPSS task force (TF), and launching a National Mental Health Programme to lead reform of the mental health system. The first national strategy for mental health, launched in 2015 and covering the period to 2020,[2] is intended to build a sustainable mental health system. The strategy aims to move towards the vision that 'All people living in Lebanon … will have the opportunity to enjoy the best possible mental health and well-being'. Displaced people are one of the vulnerable groups identified in the strategy as needing particular attention. The key objective of the strategy in addressing the needs of these populations is to sustain the MHPSS TF and ensure the development and implementation of an annual action plan for addressing gaps and challenges in responding to these needs. The MHPSS response to the Syrian crisis is anchored within this national policy framework.

The MHPSS TF, chaired by the MoPH, the World Health Organisation (WHO) and the UN Children's Fund (UNICEF), has 50 members from UN agencies, local and international NGOs and government ministries working in MHPSS. It meets each month at central level in the capital and in three of the country's governorates. The task force has achieved much in various areas, from key coordination functions to capacity-building, service development and the development of national normative documents, including a harmonised list of psychotropic and neurologic medication for prescription in humanitarian settings and standard minimum recruitment criteria for mental health in the humanitarian field. MHPSS indicators have been developed to gather data about the utilisation and quality of services and to inform service planning and policy development. The TF has facilitated service mapping using the WHO '4Ws' tool, and an online mapping platform is being finalised. Capacity-building interventions have been rolled out in evidence-based psychotherapy approaches and to improve the safe identification and referral of people with mental disorders. The TF has also contributed to the implementation of the

1 R. El Chammay, W. Kheir and H. Alaouie, *UNHCR Assessment of Mental Health and Psychosocial Services for Syrian Refugees in Lebanon*, 2013 (http://data.unhcr.org/syrianrefugees/download. php?id=4575 Accessed) 23 July 2014).

2 Ministry of Public Health, Mental Health and Substance Use – Prevention, Promotion, and Treatment – Situation Analysis and Strategy for Lebanon 2015–2020, Version 1.1, 2015 (https://www.moph.gov.lb/userfiles/files/ Mental%20Health%20and%20Substance%20Use%20Strategy%20for%20 Lebanon%202015-2020-V1_1-English.pdf).

Elham, a Syrian refugee, holds her son Ahmad in their home in Kafar Kahel informal settlement in Koura District, Lebanon.
© Dominic Chavez/World Bank

national mental health strategy, and supports its goal of expanding and reorganising mental health services in line with the WHO service organisation pyramid.[3]

Strengths and challenges of the task force

An action plan for the task force is developed annually through a participatory process that identifies gaps and challenges in the MHPSS response through feedback from implementing actors, triangulated with the results of assessments and service maps. The action plan defines a common vision and priorities and sets out a roadmap for action. The strength of the plan is its alignment with Lebanon's national mental health strategy, which ensures that actions undertaken fit within the bigger picture and contribute to the building of a national system catering to the needs of Lebanese and non-Lebanese alike. Another major strength of the TF relates to its role as a meeting

point for partners, facilitating links and strengthening relations between government and non-government actors involved in mental health. The collaborative governance model adopted by the MOPH, its commitment to engage with all actors and the participatory processes adopted for the development and implementation of the action plan ensure that all actors are engaged and increase the perceived legitimacy of the MOPH as a leading and governing body. Actors acknowledge that there are system-level challenges in responding to people's needs that cannot be addressed without the leadership and engagement of the government.

The task force was initially set up at central level and then expanded regionally. This presence at field level ensures that gaps and challenges can be identified more easily and maximises the participation of local NGOs. Participation at regional level is lower than centrally, because of the smaller number of actors active in the regions and because actors attending regional meetings are mostly frontline workers heavily engaged in fieldwork. Around 40 actors take part regularly in meetings. Initially no specific commitments were attached to membership, limiting accountability and the level of commitment of some actors to the work of the TF. Steps have been taken to address this, including:

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3 In line with the WHO mental health service organisation pyramid, mental health services start with self-care and informal care, generally provided by oneself or one's network and peers, and are cross-cutting across all levels of care. Formal mental health care services should be offered through primary healthcare services and should be easily accessible and affordable. Specialised psychiatric care is at the tip of the pyramid.

- Ensuring that meeting agendas cover issues of interest to participants, and efforts to promote interactivity. Discussions around key issues related to service provision are essential, in addition to presentations of new projects and activities, assessments and updates on the implementation of the national strategy.
- Revising the task force's terms of reference to include defined membership commitments, such as regular attendance and proactive participation in meetings, regular and timely reporting on MHPSS indicators and service mapping and contributions to the implementation of the TF action plan. The new terms of reference will be finalised and implemented later this year.
- An MoPH Director-General circular was issued on 12 July 2017 (number 64) related to projects in MHPSS and substance use in Lebanon. This asked all actors (including local and international humanitarian and non-governmental organisations, UN agencies, local and international universities, associations and donors) to coordinate with the Ministry on new projects, to ensure that the efforts of all actors complement each other and contribute to building the national mental health system in line with the national strategy, and to avoid any duplication of activities. This is proving effective as actors are increasingly engaged and motivated to coordinate and collaborate with the MoPH.

Lessons

Three major operational lessons emerge from the MHPSS humanitarian response coordination in Lebanon. The first is the importance of an annual action plan, developed in a participatory manner, that can contribute to building the national mental health system. This is essential to ensure consensus on priorities, enhance coordination and ensure that resources are optimised and allocated towards priority areas. The second is the importance of clear terms of reference and membership criteria to increase the accountability and engagement of MHPSS actors. The governance model for coordination must increase commitments to joint action by promoting the move from coordination to collaboration, in line with the national plan. Third is the importance of developing and enforcing normative, contextualised technical documents, such as guidelines and standards, in addition to 'soft' governance tools. Such documents constitute the basis for accountability mechanisms that are quality-led. Governance tools can enhance coordination, as exemplified by the circular issued by the MoPH.

Key considerations for coordination in humanitarian emergencies

Building on the lessons from the Lebanon experience, key considerations for the effective coordination of humanitarian response include:

- Engaging actors around one action plan to increase effectiveness and responsiveness to people's needs. Setting a roadmap in line with a national strategy reduces haphazard and fragmentary action.
- Recognising that humanitarian response strategies should contribute to and be integrated in national development strategies. Not doing this can hinder or delay the execution of sustainable solutions and continued reliance on humanitarian assistance.[4] Emergencies are unparalleled opportunities to build better systems for everyone in need.[5] Government-led humanitarian governance can anchor coordination mechanisms in the national policy framework, creating synergies between short-term humanitarian relief and longer-term development strategies.

This leads to a third consideration:

- Promoting government ownership of the humanitarian response. Government leadership is key to ensuring the effective implementation of all functions of coordination: the coherence of humanitarian action with long-term development, increased accountability, efficiency and effectiveness and improved inter-sectoral coordination. It is increasingly recognised that government-led coordination mechanisms, unlike cluster-based approaches, have the authority and sovereignty to legitimately set up mechanisms to ensure accountability – downward to populations and upward, not to donors but to the government – for effectively contributing to responding to people's needs. It is also recognised that a more thorough form of coordination is likely in situations where the government of the affected state sets a single national plan as a standard.[6] Government agencies have a unique understanding of the local context, including service provision systems and their building-blocks, and have the primary responsibility for responding to humanitarian crises, as highlighted by UN General Assembly Resolution 46/182 on 'Strengthening of the coordination of humanitarian emergency assistance of the UN', which provides the basic framework for humanitarian assistance. The resolution emphasises among its guiding principles that governments are

4 UNDP and UNHCR, 'UNDP/UNHCR Transitional Solutions Initiative (TSI) Joint Programme Phase I (2012–14)', *2013 Annual Report*, http://mptf.undp.org/document/download/12914.

5 World Health Organisation *Building Back Better: Sustainable Mental Health Care after Emergencies*, 2013 (http://www.who.int/mental_health/emergencies/building_back_better/en/).

6 W. Ammar et al. 'Health System Resilience: Lebanon and the Syrian Refugee Crisis', *Journal of Global Health* 6(2), 2016; P. Knox Clarke and A. Obrecht, *Good Humanitarian Action Is Led by the State and Builds on Local Response Capacities Wherever Possible*. Global Forum Briefing Papers. London: ALNAP/ODI; A. Clarke Santoro and M. McKee, 'Governing the Lebanese Health System: Strengthening the National Response to the Burden of Syrian Refugees', *Eastern Mediterranean Health Journal* 23(6), 2017.

responsible for initiating, leading and coordinating humanitarian assistance; and that actors in the international system must direct their contributions to supplementing and supporting national efforts.[7]

This last consideration has implications for international guidelines for humanitarian action, including the Inter-Agency Standing Committee (IASC) guidelines for humanitarian response. Despite the recommendation in the guidelines to include representatives from key government ministries, UN agencies and NGOs in the MHPSS coordination group, there is no mention of a more active and engaged role for governments in the leadership and coordination of the response. The guidelines call for the development of 'inter-agency national policies and plans for MHPSS emergency response'.[8] But can plans be qualified as 'national' if no government entity is involved in setting them and officially endorsing them? And how can the recommendation in the guidelines to link emergency response with development activities be applied if the critical role of governments in this process is not well articulated?

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7 UN, 78th Plenary Meeting, Resolution 46/182, 1991 (http://www.un.org/documents/ga/res/46/a46r182.htm).

8 Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, 2007 (http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf).

Supporting mental health care provision in Lebanon and Iraq
Marie Darmayan and Dia Abou Mosleh

Health systems in many countries, including in the Middle East, have largely overlooked mental health. Despite the fact that mental disorders are found everywhere, affecting women, men and children, at all stages of life and all levels of society, people with mental disorders fail to receive the treatment and care they need and risk becoming marginalised from society.[1]

Mental health care provision is a complex issue. The fact that only a small number of people use mental health services is often related to a lack of understanding of mental health issues, the stigma surrounding mental ill-health or because it is a relatively new element in the international development arena. It is also a direct consequence of a lack of political support, inadequate management, overburdened health services and, at times, resistance from policy-makers. In conflict-affected countries such as Iraq and Lebanon, government systems are unable to meet the mental health needs of their own people, let alone those of refugees and the internally displaced (IDPs). Médecins du Monde (MdM)'s extensive experience in Iraq and Lebanon demonstrates that, while conflict negatively affects already weak health systems, it can also provide opportunities for humanitarian actors to encourage and support stronger and more sustainable government mental health and psychosocial support (MHPSS) systems.

Challenges …

Despite the differences in context, both Iraq and Lebanon face challenges affecting the quality, availability, appropriateness and timely delivery of mental health services, exacerbated by unrest and conflict. In both countries, the few resources that are dedicated to mental health and psychosocial support are often inappropriately deployed. A severe lack of human resources, lack of trained staff able to identify disorders and a shortage of hospitals and beds all undermine the quality and effectiveness of care. Even when services are available, the high costs of psychotropic medication[2] hinders proper care. There is also no integration of effective treatment through primary healthcare, community-based care and short-term hospital care. According to the World Health Organisation (WHO), Iraq has fewer than four psychiatrists for every million people (0.37 per 100,000), and fewer than two nurses working in mental health per 100,000 population.[3] WHO also found that mental ill-health was the fourth leading cause of mortality amongst Iraqis over the age of five. In Lebanon prior to 2013, the mental health system was mostly led by the private sector and by local and international non-governmental organisations (NGOs) working in the humanitarian sector. According to WHO, in 2013 Lebanon had just 1.5 beds per 100,000 people for community mental health services in eight psychiatric wards at general hospitals and five specialised mental health hospitals with a capacity of 28 beds per 100,000 people. Psychiatric hospitals have a 97% occupancy rate.[4]

The presence of large numbers of Syrian refugees has placed a huge strain on the Lebanese healthcare system. Only 10%

1 World Health Organisation, *Improving Health Systems and Services for Mental Health*, 2009, p. 9.

2 Psychotropic drugs are '[a]ny medication capable of affecting the mind, emotions, and behavior'. *Farlex Partner Medical Dictionary*, 2012.

3 WHO, 'Global Health Observatory Data Repository' (http://apps.who.int/gho/data/node.main.MHHR?lang=en).

4 WHO, 'WHO-AIMS Report on Mental Health System in Lebanon' (www.who.int/mental_health/who_aims_report_lebanon.pdf).

Médecins du Monde's Iraq mission provides care for IDPs in Dohuk and Kirkuk governorates in Kurdistan.
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of people in need of MHPSS services receive proper care and support.[5] In Iraq, the population has lived under extremely difficult conditions for many years, including physical deprivation, political repression and prolonged conflict. An estimated 18% of the population in Lebanon and Iraq suffer from mental illness.[6, 7] According to a survey conducted in Iraq in 2009, almost 20% of the population will suffer from a mental health disorder at some point in their life. The most common disorders were anxiety and depression. The survey also found that only 6% of people with mental disorders could access treatment.[8] In an MdM assessment of the mental health and psychosocial needs of Syrian refugees in Lebanon conducted in 2013, 58% of interviewees exhibited fear, 64% anger, 62%

lack of interest and 56% feelings of hopelessness; 65% were unable to conduct essential activities for daily living.

… and opportunities

Despite the critical context in both countries, recognition and awareness of mental health and the availability of international funds provide an excellent opportunity to lay the foundations for sustainable national mental health systems. Beginning in 2004 in Iraq and 2014 in Lebanon, significant efforts are being made by both governments to integrate mental health into primary healthcare in order to improve the prevention and detection of mental disorders, provide access to services and adequate treatment and reduce stigma.

In Iraq, efforts by the Ministry of Health (MoH) with the support of WHO have been directed towards establishing and launching a national mental health policy and legislation and increasing efforts to integrate mental health into primary care services, schools and other community services. While supporting mechanisms and funding are not yet in place, the MoH still views mental health as a priority area in its overall health agenda. The integration of MHPSS within primary care was included in the Basic Health Services Package for Iraq, developed and launched by the MoH in 2010, and piloted in

5 E. Karam et al. 'Prevalence and Treatment of Mental Disorders in Lebanon: A National Epidemiological Survey', *The Lancet*, 367, 2006.

6 Education for Peace in Iraq Centre (EPIC), 'Mental Health in Iraq: Misunderstood and Marginalized', 7 July 2014 (https://www.epic-usa.org/mental-illness).

7 Colin Lee, 'Addressing Mental Health Needs in Lebanon', *Humanitarian Exchange*, 51, 2011 (available at https://odihpn.org/magazine/addressing-mental-health-needs-in-lebanon/).

8 S. Alhasnawi et al., 'The Prevalence and Correlates of DSM-IV Disorders in the Iraq Mental Health Survey (IMHS)', *World Psychiatry*, 8, 2009.

some primary health care centres (PHCCs), but lack of funding has meant that no appropriate follow-up work has been done.

In Lebanon, MdM is working with the Ministry of Public Health (MoPH) on the integration of mental health services into primary healthcare at the PHCC level, as well as directly providing mental health support and treatment, both at the community level and through outreach activities in the Bekaa region and Beirut. Social workers have been providing psychosocial support sessions for men, women and children in need, home-based follow-up and access to other services (cash assistance, food vouchers, non-food items, shelter, legal protection, education, resettlement, etc.), as well as referrals to specialised mental health services provided by psychotherapists and psychiatrists. Since 2015, MdM has also been involved in a strategic partnership with the MoPH's National Mental Health Program (NMHP). The NMHP aims to reform mental health care in Lebanon and provide services beyond medical treatment at the community level, in line with human rights provisions and the latest evidence on best practice.[9] The National Mental Health Strategy that emerged in 2015 integrates mental health services into primary health care and reinforces a community-based approach, whereby care and treatment are delivered first at primary level within the community, before 'stepping up' to more intensive and specialist services when clinically required.[10]

MdM adopted this approach in a pilot intervention with partners in an MHPSS unit at Rafik Hariri University Hospital, the largest public hospital in Lebanon. The pilot includes the integration of mental health into primary care, the establishment of a community mental health centre, the integration of mental health within different departments of the hospital and the establishment of a psychiatric ward. The ultimate intention is to provide comprehensive, accessible, high-quality and evidence-based mental health and substance use services, with a continuum of care, and offered regardless of nationality, age or gender.

When the project started, the hospital was unable to care for people with mental disorders, partly because hospital staff had little or no knowledge of how to assess, diagnose and address disorders. To address this, a mental health team

comprising case managers, psychologists and psychiatrists was set up in the primary healthcare centre. Training on mhGAP – an evidence-based guideline to facilitate the scaling up of care for mental and neurological disorders and substance abuse – was given to care providers from the hospital and primary healthcare centres. A referral system was established in 2017 between the primary health level, the specialist community mental health centre and in-ward intensive psychiatric care in the hospital. Individuals identified as having a disorder are cared for by a multidisciplinary team, including MHPSS case management, psychosocial support services, psychotherapeutic and psychiatric interventions at individual and group levels and awareness sessions on mental health issues. The observed positive impact on mental health has encouraged the MoPH to extend the model to ten other regions in Lebanon in coming years.

In Iraq, MdM provides curative and preventative care for IDPs in Dohuk and Kirkuk governorates in Kurdistan, designed to reduce the risk of emotional numbing, breakdown and self-damaging coping strategies. A team of mental health and social workers implemented psychosocial support and psychological first aid (PFA) activities. MdM then developed a pathway of care, including a strong network and referral and coordination arrangements, mainly with other international humanitarian agencies. Several challenges emerged during implementation, including having to deal with two different government systems in Iraq and Kurdistan. Unlike Lebanon, this meant that, instead of working within and supporting a national mental health care framework and structure, which would enable the sustainable provision of all levels of care, MdM and other international and local NGOs were only able to deliver short-term MHPSS services.

Mental health disorders and the burden they create are a public health problem. As a humanitarian health actor, MdM's first priority was to respond to people's immediate mental health needs. However, advocating and working closely with all stakeholders including the government health sector to build a national framework should be the next step to ensure positive impact and sustainability. MdM's experience in these two crisis-affected countries is an explicit example of this. In both cases, the start-up intervention was intended to provide direct psychosocial support and mental health services. However, in Lebanon, with the existence of a national strategy and attempts to build a national framework, MdM was able to develop a more rigorous model that is both comprehensive and hopefully more sustainable.

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9 Ministry of Public Health, Republic of Lebanon, 'The National Mental Health Program' (https://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program).

10 Ministry of Public Health, Republic of Lebanon, 'Mental Health and Substance Use, Prevention, Promotion and Treatment', Situation Analysis and Strategy for Lebanon 2015-2020 (https://www.moph.gov.lb/userfiles/files/Mental%20Health%20and%20Substance%20Use%20Strategy%20for%20Lebanon%202015-2020-V1_1-English.pdf).

Applications of Psychological First Aid around the world: summary of a five-year retrospective

Leslie Snider, Alison Schafer and Carina Hjelmstam Winberg

When terrible things happen, we want to reach out a helping hand to those who have been affected. Psychological First Aid is … an approach to help people recover by responding to their basic needs and showing them concern and care, in a way that respects their wishes, culture, dignity and capabilities.

Psychological First Aid Brief, WHO for World Mental Health Day, 2016

In 2011, on World Humanitarian Day, the World Health Organisation (WHO) and partners launched guidance in Psychological First Aid (PFA) in a simply worded format designed for professionals and non-professionals alike.[1] To be as accessible as possible, the guidance was made freely available online, with content that was easy to translate and adapt for different languages and cultures. Sixty international peer reviewers from various countries, cultures and crisis contexts provided input into the guidance over the two-year period of its development, and 24 UN and NGO agencies endorsed the final product. A facilitation manual followed in 2013, and in 2014 revisions to both documents were developed to meet the particular needs of field staff working in the Ebola virus disease outbreak in West Africa.

PFA is not new: the concept and term were coined in the 1940s as a way to help Merchant Marines suffering from 'war stress'. Today, several formulations of PFA exist, but the WHO guide appeared to fill an unmet need for practical guidance in non-technical language for people meeting or working with individuals in distress. This includes, but is not limited to, people affected by humanitarian emergencies, or in lower-resource settings. PFA has become a widely used, frontline approach to mental health and psychosocial support (MHPSS) for people affected by crisis events large and small. As part of humanitarian emergency preparedness and response, large-scale national and regional PFA capacity-building efforts have been undertaken by various entities, including the Japanese government, the Pan American Health Organization (PAHO) and NGO consortia in Asia, the Middle East and Africa. Many aid organisations orient staff and volunteers as standard practice in humanitarian emergencies, including the Nepal earthquake and the European refugee influx.

The guidance quickly became the second-highest selling publication in the WHO bookstore, and there are now over 20 language translations around the world. That the guidance was so rapidly taken up is likely due to its simplicity. Illustrated with engaging cartoons depicting different cultural contexts, it promotes concrete skills that anyone can learn in order to assist in practical, humane ways. Helpers – from firefighters, police and community volunteers to health and mental health staff – could grasp the guidance and apply it to their particular roles in helping distressed people, and often to their daily lives. It appeared to make abstract concepts, such as psychosocial support, more practical, defined and understandable for non-mental health humanitarian responders.

As the MHPSS field evolved, with a growing evidence base and a variety of innovative intervention strategies undergoing field testing, the time was right to critically reflect on PFA and its place within the spectrum of MHPSS approaches. The Church of Sweden, with advisory support from World Vision International (both Reference Group members), commissioned a five-year retrospective (2011–16) to understand how the WHO PFA guidance has been perceived and applied since its launch.[2] Utilising a desk review, online survey, case studies and interviews, the retrospective looked at:

- translation and adaptation processes;
- applications (and misapplications) in different crisis contexts;
- use by different types of helpers, from lay people to professionals;
- the place of PFA in the larger field of MHPSS in emergency response; and
- recommendations for the future.

The retrospective provides a rich overview of respondents' experiences with the materials (including adaptation and translation), with PFA orientation and training-of-trainers, and their perceptions of PFA, including the name itself, how it is understood and its key strengths and risks. The case studies provide further analysis on how PFA has been applied, from large capacity-building efforts to applications in particular settings such as the Ebola crisis, in staff and team care and in emergency response coordination and advocacy for MHPSS in general.

Five key recommendations summarise the priorities that emerged from these varied perspectives, and provide a roadmap for next steps for practitioners, the authors of the guide and stakeholders in the global MHPSS community:

1 World Health Organisation, War Trauma Foundation and World Vision International, *Psychological First Aid: Guide for Field Workers* (Geneva: WHO, 2011).

2 Church of Sweden, Peace in Practice and World Vision International, *Psychological First Aid: Five Year Retrospective (2011–2016)*, Church of Sweden, 2018 (https://www.svenskakyrkan.se/internationelltarbete/reports-policy-documents--and-positions-on-church-of-swedens-international-work)

Ebola survivor Abdul Rahman Sanu counsels a patient at a health centre in Sierra Leone.

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1. Provide an updated overview of the MHPSS field that clarifies the place of PFA within the broader spectrum of support

According to respondents, the simplicity and accessibility of PFA was both its greatest strength and its greatest potential danger. In the experience of some practitioners and donors, 'PFA' became synonymous with 'MHPSS', and so the full range of multi-layered, integrated MHPSS support and interventions in emergencies tended to be overlooked (and sometimes under-funded) in favour of this one, useful yet insufficient approach. Asking respondents to locate PFA on the Inter-Agency Standing Committee (IASC)'s MHPSS intervention pyramid also high-lighted the lack of clarity and consensus about where PFA fits on the spectrum of MHPSS actions and interventions.

The MHPSS field is evolving rapidly as new, accessible resources are developed and tested and the evidence base expands. It would be timely to update the MHPSS field with an overview of the range of resources in the repertoire of MHPSS practitioners, when and how they should be used, and how they complement each other in a coordinated system of support. PFA can then be situated more appropriately within the larger sphere of psychosocial approaches and mental health interventions.

2. Keep attention to PFA as a foundational component of MHPSS approaches and tend to its applications in practice

Respondents recognised the value of ensuring that PFA guidance is widely accessible and freely available, and recom-mended promoting it further within disaster preparedness

initiatives. Many noted that PFA helped to raise the profile of MHPSS in emergencies, reached across cultures and contexts through the translations and opened the door to mainstreaming MHPSS within other sectors. However, despite guidance on facilitating orientations little is known about how PFA has actually been applied or orientations have been conducted, and the ethical principles of safety, dignity and rights that underpin PFA sometimes got lost. One concrete recommendation was to acknowledge that PFA provides core guidance on basic psychosocial support skills, and to focus attention on how it is incorporated within ongoing and new initiatives – including as an integral component of new scalable mental health care interventions.

3. Continue to develop innovative PFA resources and technologies

Few respondents in the survey were aware that an e-learning course for PFA exists on the website of one international NGO, Plan International,[4] or that there is an online forum linking practitioners on MHPSS.net.[5] Respondents were very interested in these types of resources and technologies, as a complement to face-to-face orientations, to broaden the reach of PFA in lower-resource settings and to help clarify its use. Apps, online forums and e-learning utilising video clips and simulation demonstrations would be highly valued and would help in future applications of PFA.

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4 See Plan International Plan Academy website: http://www.plan-academy.org/enrol/index.php?id=31.

5 See the PFA Adaptation and Training Group on MHPSS.net.

4. Promote fidelity to the model with support to capacity-building initiatives and dialogue among communities of practice

Respondents generally felt the content of the PFA guidance had held up over time, and asked that the original guidance be kept intact. What they felt would be helpful at this stage is more information on how best to adapt and apply PFA in different contexts, including a compilation of case scenarios and orientation approaches from crisis situations. There are successful examples of national and regional capacity-building efforts that have led to the formation of communities of practice offering peer support for the application of PFA, improved attention to the care of staff and other helpers in crisis response, more coordinated advocacy for MHPSS in general and improved preparedness. A reinvigoration of existing online forums (e.g. the MHPSS.net PFA group) could be a good place to start, along with innovative technologies that could further develop communities of practice.

5. Develop common approaches and tools for monitoring and evaluation of and research on PFA

One question that has come increasingly to the fore as PFA has gained popularity is: what is the evidence that it works? PFA as articulated in the WHO guide is purportedly 'evidence-informed' and 'consensus-based'.[6] The evidence informing PFA comes from disaster research focused on risk and the resilience of individuals and communities and, in particular, findings around the importance of social support in recovery from crisis events. Through the Look, Listen, Link actions of PFA, it is designed to improve the ability of responders to appropriately make contact with survivors, listen supportively and help affected people connect with services and their natural sources of support. PFA is also consistent with the literature promoting the factors known to support individuals in their recovery from crisis events, namely hope, safety, calming, self and community efficacy and (again) social support.[7]

However, 'evidence-informed' is not 'evidence-based', and calls to evaluate the efficacy of PFA have increasingly revealed challenges and diverging points of view. PFA is not a discrete 'intervention' with one, agreed definition, and it is used flexibly according to the needs of affected people and the skills and roles of different helpers. Some liken PFA to a set of good communication and helping skills or a good bedside manner, and do not see it as an intervention at all. Indeed, as PFA has been increasingly utilised by helpers outside of the MHPSS field, it more clearly emerges as guidance for any helper to communicate better, be aware of safety considerations and other support and services, and minimise further harm to a survivor by poorly chosen words or actions. Furthermore, the WHO PFA guidance explicitly distances itself from the notion that offering PFA as a brief, supportive approach can prevent later mental disorder or distress, or that it can be used to reliably identify people at risk of developing longer-term mental health problems. Thus, clinical evaluation methods and outcomes defined by mental health symptoms would not be appropriate for evaluating the efficacy of PFA.

Opinions on the importance of establishing an evidence base for PFA varied widely among respondents in the retrospective study. Some emphasised that it was critical to evaluate PFA, while others believed an evidence base for common-sense, basic helping skills is unnecessary. However, respondents generally agreed on the need to develop a common, practical approach to monitoring and evaluating PFA – including developing relevant indicators and simple tools that could be used to collect data on its application during crisis response. Focus areas recommended for evaluation and research included fidelity to the model described in the guidance and the impact of orientation on helpers themselves. In addition, based on the influence of PFA in general MHPSS approaches, a systems-level perspective for evaluation and research may be warranted.

In conclusion, the PFA retrospective study allowed us the chance to Look at the progression of the WHO PFA guidance, Listen carefully to people's experiences and perceptions and hopefully now Link PFA within holistic, comprehensive MHPSS responses in emergencies. Just as medical first aid does not constitute a comprehensive health response, so PFA is not a panacea for all the mental health needs of people affected by crisis events – it must be integrated as a component of wider MHPSS frameworks and services to most effectively 'reach out a helping hand'. It is the hope of the authors of the retrospective study that these findings can help to guide future applications of this widely used resource in ways that will benefit the larger MHPSS field, and to provide a clear picture of the wealth of MHPSS resources and knowledge now available to field practitioners.

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2 Church of Sweden, Peace in Practice and World Vision International, *Psychological First Aid: Five Year Retrospective (2011–2016)*, Church of Sweden, 2018 (https://www.svenskakyrkan.se/internationelltarbete/reports-policy-documents--and-positions-on-church-of-swedens-international-work).

Mental health and psychosocial support: who cares for the volunteers?

Cecilie Dinesen

Every day, volunteers around the world respond to humanitarian emergencies. In Syria, volunteers deliver food, water and medical supplies to families fleeing Eastern Ghouta. In Bangladesh, volunteers provide shelter, food and psychosocial support to unaccompanied children separated from their families as they fled Myanmar. During the Ebola response in West Africa, volunteers ensured safe and dignified burials and conducted contact tracing in affected villages.

The central role of volunteers in humanitarian responses is increasingly recognised. The 2015 UN Resolution 'Integrating volunteering into peace and development: the plan of action for the next decade and beyond' (Resolution 70/129) underlines the role that volunteers can and should play in the implementation of the 2030 Sustainable Development Goals, including in humanitarian action, peace-building and conflict prevention. The Resolution also requests Member States and the United Nations system to work together with volunteer-based organisations to enhance the protection, security and well-being of volunteers. Although this indicates an increasing recognition of the duty of care towards humanitarian volunteers, their mental health and psychosocial needs are all too often neglected. Simple and cost-effective initiatives and interventions can be put in place before, during and after humanitarian responses to promote the well-being of volunteers and reduce symptoms of distress and burnout.

What do we know about volunteer well-being?

Millions of people volunteer in humanitarian emergencies. They work in difficult, complex and sometimes dangerous environments. They help people during and after crises, providing them with practical help, understanding and social and emotional support. They may find themselves comforting survivors in the initial phases of shock and grief, and they often work long hours in challenging conditions. Volunteers are also likely to be members of affected communities; they often work close to home, and may experience the same loss and grief as the people they are supporting. Operational experience shows that, in addition to direct exposure to traumatic events, organisational issues and working conditions have a large impact on the stress levels and well-being of volunteers. This includes unclear or non-existent job descriptions, poor preparation and briefing and inconsistent or inadequate supervision.[1]

There is limited research available on the mental health and psychosocial well-being of disaster volunteers, but what research does exist backs up operational experiences. A review of the literature shows that humanitarian volunteers tend to have higher levels of mental health complaints than professional workers, but may be more resilient than other members of affected communities.[2] Research conducted after a large earthquake in Indonesia indicated that mental health issues for volunteers may persist for many months following the event.[3] The research also showed that volunteers providing psychosocial support, distributing goods and handling administrative and logistical tasks were particularly affected. This is backed up by findings from the West Africa Ebola response, where volunteers providing psychosocial support and contact tracing and drivers reported more mental health distress than, for example, burial teams.[4] This suggests that it is not necessarily frontline volunteers who are most vulnerable, and that efforts to support and care for volunteers should target the broader group of volunteers.

Organisations should consider, not only the mental health and psychosocial needs of their core volunteers, but also the needs of the spontaneous volunteers who often join humanitarian responses. Volunteers with a long organisational affiliation are usually trained and prepared for their tasks, but spontaneous volunteers often have little or no prior experience and training before joining the response. This make them more vulnerable to mental health issues after the response.[5]

How do we support and care for volunteers?

Many of the challenges facing volunteers can be managed by addressing organisational and structural issues before, during and after a response, and through the provision of basic psychosocial support. Relevant psychosocial support for

1 IFRC Reference Centre for Psychosocial Support, *Caring for Volunteers: A Psychosocial Support Toolkit* (http://pscentre.org/wp-content/uploads/volunteers_EN.pdf).

2 Sigridur B. Thormar et al., 'The Mental Health Impact of Volunteering in a Disaster Setting: A Review', *Journal of Nervous and Mental Disease* 198(8), 2010; Sigridur B. Thormar et al., 'The Impact of Disaster Work on Community Volunteers: The Role of Peri-Traumatic Distress, Level of Personal Affectedness, Sleep Quality and Resource Loss, on Post-Traumatic Stress Disorder Symptoms and Subjective Health', *Journal of Anxiety Disorders* 28(8), 2014.

3 Sigridur B. Thormar et al., 'The Impact of Disaster Work on Community Volunteers: The Role of Peri-Traumatic Distress, Level of Personal Affectedness, Sleep Quality and Resource Loss, on Post-Traumatic Stress Disorder Symptoms and Subjective Health', *Journal of Anxiety Disorders* 28(8), 2014.

4 IFRC, *The Psychological Strain of Responding to West Africa's Ebola Outbreak: Findings from Guinea, Liberia and Sierra Leone* (Geneva: IFRC, 2015).

5 Sigridur B. Thormar et al., 'PTSD Symptom Trajectories in Disaster Volunteers: The Role of Self-Efficacy, Social Acknowledgement, and Tasks Carried Out', *Journal of Traumatic Stress* 29(1), 2016; IFRC, *The Psychological Strain of Responding to West Africa's Ebola Outbreak*.

The international committee of the Red Cross delivered an emergency relief convoy through the Syrian Arab Red Crescent to Barzeh city.
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Box 1: Toolkit on caring for volunteers

More information on how to implement caring for staff and volunteer practices can be found in *Caring for Volunteers: A Psychosocial Support Toolkit*, from the Psychosocial Centre at the International Federation of Red Cross and Red Crescent Societies (IFRC). The toolkit describes in detail the support system that organisations can set up before, during and after a crisis, and steps for implementing policies, structures and practices within a two-day training curriculum. The toolkit and the accompanying training material are available in French, English, Russian and Arabic at www.pscentre.org.

Box 2: Peer support for volunteers: an example from Lebanon

The Lebanese Red Cross (LRC) runs a country-wide ambulance and first aid service, the Emergency Medical Service (EMS). A volunteer team leader runs a 12-hour weekly shift with a group of volunteers, and they also all do a 24-hour shift every fifth weekend. The LRC has established a peer support initiative with the support of the Danish Red Cross and the Spanish Red Cross. Nour Ghaddar, an EMS team leader in Beirut and a member of the national volunteering working group, explains: 'When planning a caring for volunteers initiative, it is highly important to look at all aspects of volunteering to get everyone on board. It was a new concept and we approached it in a systematic way involving managers, team leaders and volunteers. We began by training EMS volunteers on self-care, then team leaders were trained in basic skills such as listening, providing feedback and ensuring close follow-up with volunteers who are facing specific challenges'.

All units will soon have a trained peer supporter to keep an eye on their peers' well-being and discuss issues related to the tasks or work of the team. Nour: 'We are passionate about what we do, and we aim to develop volunteers so that they can achieve their objectives in the Red Cross but also gain skills that will serve them professionally and personally'. Volunteers realise that they not only render services, but also develop their own skills and talents. They learn to work in teams, provide vital services such as pre-hospital emergency care and psychological first aid and deal with a variety of challenging situations. Upcoming initiatives include expanding the scope of volunteering within the LRC, training local volunteer coordinators on conducting exit interviews and helping team leaders and heads of stations delegate tasks more effectively.

volunteers ranges from small acts of recognition and informal gatherings to more structured peer support systems and psychological first aid for volunteers – either individually or in groups. These are all simple and cost-effective interventions and initiatives that can be implemented with no or limited resources. However, there is currently very limited research on the effectiveness of these interventions, and this is urgently needed in order to support and scale up these interventions. An added benefit of providing support and recognition to volunteers is that it often leads to increased recruitment and retention. Better care inspires and motivates, and ultimately leads to better performance.

Before a response, it is important to address the known organisational factors that can cause distress later on, and to ensure

that volunteers are properly recruited and trained and have clear job descriptions. Contingency planning can help prepare the volunteers for a response.

During a response, the well-being of volunteers should be monitored and supported. A simple yet powerful way of supporting a team is to show appreciation and recognition of their efforts and hard work. This can be done through informal gatherings, where the manager calls volunteers together for refreshments and makes a short speech of appreciation and gives others the opportunity to say a few words. This can be combined with more formal components, such as handing out letters of appreciation. As indicated by the research from Indonesia and West Africa, it is important to include the broader group of volunteers in such events,

not just those involved in the frontline response. Another way of supporting volunteers during a response is through a peer support system. This provides a network of support and strengthens the resilience of volunteers.

After a response, it is important to follow up with the volunteers and provide support to those who need it. If the team has been involved in a very stressful or dramatic response, or if some team members show signs or symptoms of distress, the manager may decide to arrange a psychological first aid session for the entire group. This is a safe space where participants can talk about their experiences in a supportive environment, where others listen without judgement and where reactions to crisis events are normalised through the provision of psychoeducation, peer support is encouraged and information about available support systems is shared.

Managers should follow up with their volunteers in the weeks and months after a response to check if anyone is in need of additional support or referral to more specialised mental health and psychosocial services. This is particularly challenging with spontaneous volunteers, but it is an important part of the duty of care.

Conclusion: what next for volunteer care?

There is increasing recognition of the importance of ensuring safety and well-being of humanitarian volunteers at the global level, but too often support and care systems for volunteers are not in place on the ground. Barriers include limited understanding of the issue, lack of acknowledgement from management and organisational and structural barriers. In order to address these gaps, simple, cost-effective initiatives and interventions can be put in place before, during and after humanitarian responses to reduce symptoms of stress and burnout and promote the well-being of volunteers. This includes addressing organisational and structural issues and the provision of basic psychosocial support to volunteers. Volunteer care initiatives should be included in strategic plans and budgets, and managers at all levels should recognise the role of volunteers and support initiatives for their protection and well-being. Research on the effectiveness of interventions and initiatives for volunteer care is urgently needed in order to support activities on the ground and promote wider advocacy efforts to put volunteer care on the agenda of volunteer managers, organisations, stakeholders, donors and policy-makers.

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