FIRST FACE-TO-FACE MEETING OF THE IASC REFERENCE GROUP ON MHPSS IN EMERGENCY SETTINGS

Dates: 22-26 September 2008

Place: IOM, Geneva, Switzerland

1. INTRODUCTION

On 22nd and 23rd September, 2008, the first face-to-face meeting was held of the IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. The objectives of this meeting were:

- To enhance inter-agency collaboration and collaboration with clusters to implement the Guidelines
- To review tools and activities linked to the Guidelines
- To review country initiatives in the previous 12 months and to develop a strategic plann for 2009

Participants (see Annex B) were from: Action Contre le Faim (ACF), Global Psycho-Social Initiatives (GPSI), Interaction, Christian Children's Fund (CCF), Save the Children, International Medical Corps (IMC), Interagency Network for Education in Emergencies (INEE), International Council of Voluntary Agencies (ICVA), Action by Churches Together (ACT) International, Church of Sweden, International Catholic Migration Commission (ICMC), World Vision International, MSF-H, MdM-E, ActionAid International, HealthNet-TPO, CARE International, International Federation of Red Cross and Red Crescent Societies (IFRC), International Organisation for Migration (IOM), Regional Psychosocial Support Initiative for Children (REPSSI), Terre des Hommes, United Nations Children's Fund (UNICEF), United Nations Commissioner for Refugees (UNHCR), United Nations Population Fund (UNFPA), United Nations Relief and Works Agency (UNRWA), Queen Margaret University (Edinburgh), World Health Organisation (WHO).

2. OPENING

2.1 WELCOME - ROBERT PAIVA, DIRECTOR EXTERNAL RELATIONS, IOM

On behalf of IOM, Robert Paiva welcomed the participants.

2.2 INTRODUCTION - DR. DAVIDE MOSCA, DIRECTOR MIGRATION HEALTH DEPARTMENT, IOM

Dr. Mosca outlined the ways in which IOM has incorporated MHPSS issues and the IASC Guidelines in its work, and was looking forward to being involved in the further development and implementation of the Guidelines.

2.3 UPDATE ON THE REFERENCE GROUP – MARK VAN OMMEREN, WHO

The IASC Task Force on MHPSS was formed in June 2005, and closed following the launches of the Guidelines in 2007. In its last meeting, a proposal was made to form a Reference Group. The Reference Group is the least intensive structure in the IASC world, and is relatively low profile, which can make it more difficult to influence high-level decision-makers in the IASC and the IASC Working Group.

The MPSS Reference Group has a work plan and its Terms of Reference, approved by the IASC Working Group, focus on two strands: (1) to promote the implementation of the Guidelines through orientations, capacity building, case studies, and rollout activities in diverse countries; (2) to interface systematically with the Cluster system, ensuring that MHPSS does not fall between the cracks. For

3. PRESENTATIONS BY GROUPS NOT PREVIOUSLY INVOLVED IN TASK FORCE

Eight agencies that attended a Task Force/ Reference Group meeting for the first time gave brief introductions to their work.

3.1 CHURCH OF SWEDEN: The Church of Sweden is the psychosocial focal point for the ACT alliance (a faith based alliance co-ordinating humanitarian assistance in emergencies). They have been part of a team putting together a manual on psychosocial support, which is in line with the IASC Guidelines and will shortly be available on a website. They are involved in spreading the concept of community-based psychosocial support through global regional workshops, and their next task is to develop Training of Trainers materials. They are also in the process of developing tools for psychosocial assessment in emergencies.

3.2 GLOBAL PSYCHO-SOCIAL INITIATIVES (GPSI): GPSI has been established for five years, and is based in Nairobi and Cairo (affiliated with the American University of Cairo). The organisation has worked with UNICEF, governments and various NGOs, carrying out psychosocial needs assessments, assisting with intervention strategies and conducting training. There are plans to establish a training institute in the north of Uganda, in co-ordination with TPO.

3.3 REGIONAL PSYCHOSOCIAL SUPPORT INITIATIVE FOR CHILDREN (REPSSI): REPSSI is based in South Africa and works in 13 countries. Its initial focus was to roll out and strengthen community based psychosocial interventions, but is also involved in knowledge development in the application of psychosocial support at community level, and in formal structures (e.g. schools). They work through 92 national and regional partners. Their current work includes strengthening monitoring and evaluation in the region, and one of their main objectives in training is to standardise understanding of MHPSS concepts.

3.4 TERRE DES HOMMES (TdH): TdH is a federation made up of 11 national agencies, working mainly in child protection and health. It has been working mainly in development since it was established 60 years ago, but over the last 6-7 years it has also been working in emergencies (mainly child protection). Their psychosocial work includes establishing child friendly centres, and work relating to child trafficking. TdH staff meet twice a year at regional level for training, using the IASC Guidelines as a backdrop, and good progress has been made over the last year towards institutionalising the Guidelines.

3.5 SAVE THE CHILDREN: Save the Children is an international alliance, with strengths in community-based work and an assets-based approach to psychosocial wellbeing. They work on a diverse array of psychosocial issues, focusing on strengthening community-based networks. They are looking to integrate protection into their work; to define more concretely terms what they mean by psychosocial; to build capacity and strengthen their evidence base, and take more diverse approaches to measuring change. They would like to build networks with IASC Reference Group agencies and others.

3.6 WORLD VISION INTERNATIONAL: World Vision International have only recently become involved in MHPSS and have created an informal working group. At this stage, they aim to find out about the work of other agencies and how they can work together. Their activities in the field are mainly social, focused on engaging families and communities. They are involved in conducting group interpersonal therapy in Kenya and Uganda, and hope to develop this further. They would like to partner with other organisations with more experience in this area, to move forward jointly.

3.7 UNITED NATIONS RELIEF AND WORKS AGENCY (UNRWA): UNRWA are mandated to provide basic service and humanitarian aid for Palestinians in near east. They serve 4.5 million refugees, and directly implement services including schools, health centres, women's centres and youth centres. Their MHPSS efforts have been focused on emergency situations (e.g. Gaza, West Bank, Lebanon), and have been built into schools, health centres, and community centre projects working with all refugees. Their MHPSS programme is based primarily in camps, and includes individual and group counselling, recreational activities and awareness raising. In 2005 UNRWA shifted from psychosocial support programmes to community mental health programmes addressing mild-moderate mental health problems, while continuing with psychosocial and social activities.

3.8 QUEEN MARGARET UNIVERSITY, INSTITUTE OF INTERNATIONAL HEALTH & DEVELOPMENT (IIHD): IIHD is involved in research, capacity building and higher education. Its focus is health in general, with a special interest in psychosocial. It acted as the Psychosocial Wellbeing Group (PWG) secretariat. Research interests include community based approaches to assessment of wellbeing and refugee integration issues in Europe. IIHD is involved in capacity building, particularly identifying and strengthening local capacity, and facilitating the sharing of expertise. Over the last four years, IIHD has been developing thinking around networking in the psychosocial sector, particularly looking at ways to release, strengthen and share potential at grassroots level.

4. LEARNING FROM FIELD EXPERIENCES

CHAIR: DARLA SILVA (Humanitarian Affairs Officer, IASC Secretariat)

The session was introduced by Darla Silva. Amanda Melville (UNICEF) summarised the aim of the session as the identification and documentation of key lessons learnt, to inform planning.

4.1 MYANMAR: NENETTE MOTUS (IOM)

Post-cyclone Nargis (2-3 May 2008), a MHPSS Technical Working Group (TWG) was established (2 June 2008), with good interagency, government, academic, NGO presence and participation. The IASC Guidelines are used and continually referred to in the TWG, and terms have been defined and operationalised, in conjunction with University of Yangon Psychology Department. The 2-page MHPSS flyer has been translated into Myanmar language. Challenges have included limited access for agencies to Myanmar; the need for more comprehensive assessment strategies; difficulties linking communities with MHPSS services and establishing referral mechanisms; and a lack of backing from the government for community mobilisation activities. There was a delay in implementing activities, due to funding issues, and it has been difficult to assess adherence to the Guidelines in other clusters. Finally, it has been challenging to ensure that key information and advocacy messages are culturally and socially appropriate, and shared with MOH and partners working in affected communities

4.2 KENYA: MARIE DE LA SOUDIERE (Independent consultant, worked for UNICEF in Kenya)

Post-election violence in Kenya in early 2008 led to 350,000-500,000 displaced. In the aftermath of this, a MHPSS sub-cluster was established, and a PSS Technical Working Group. National Guidelines on Emergency Post-Disaster Psychosocial Principles and Response were developed and adopted by Ministry of Health, and both these and the IASC Guidelines were disseminated, and many PSS field trainings conducted. These efforts stimulated interest in what was a new approach for many, and

some people changed their understanding of how to support people in an emergency. The introduction of the IASC Guidelines approach laid the groundwork for the preparation of Kenyan actors for future emergencies. However, the prevailing Mental Health approach in Kenya has an individual focus, and relies heavily on counselling. There was a widely held belief that counselling is a quick fix for people traumatised, and that everyone in this crisis was traumatised. There was a widespread use of volunteer counsellors, many untrained, none properly supervised, and relatively few INGOs working in this crisis. The coordination/leadership at the national level was weak, and the location of MHPSS within the Ministry of Health limited the impact that could be had on other sectors. Although the TWG made efforts to disseminate the national and IASC Guidelines, their impact was mainly in the capital.

4.3 JORDAN: REBECCA HORN (Independent consultant; conducted a mission to Jordan for the IASC Reference Group)

There are 450,000-750,000 Iraqi refugees in Jordan living in urban centres without refugee status. Considerable funding is available, and there has been great expansion of programmes over last 12 months. A Psychosocial & Mental Health Working Group has been established, the IASC Guidelines widely disseminated, and many workshops and trainings conducted. An inter-agency team is working on an Arabic translation of the IASC Guidelines appropriate to Jordan, and inter-agency technical advice has been developed. The Guidelines are well-used amongst larger INGOs and UN agencies at planning levels, less so amongst smaller NGOs and CBOs. However, the Guidelines were found to be inaccessible to some (content, organisation, language) and their target readership unclear. In addition, political factors in Jordan are a challenge, as is the urban nature of the refugee situation, which makes it difficult to work with Iraqi refugees in a participatory, community-based way. There is a lack of capacity (especially specialist services), and high levels of funding encourage agencies to enter this arena, with little attention to the needs of population or capacity of those implementing programmes.

4.4 SYRIA: PETER VENTEVOGEL (HealthNet TPO)

There are 1.2-1.4 million Iraqi refugees in Syria, mostly in urban settings. Their movements are very restricted, and there are restrictions on INGOs working with Iraqi refugees. A psychosocial coordinating group has been established, and initiatives are underway to address MHPSS needs. MHPSS has a prominent place in a joint health appeal by four UN agencies. Challenges include working with the government; a lack of common understanding of MHPSS amongst UN agencies; difficulties bringing different actors into coordination meetings. In addition, there are challenges in reaching the target group, and addressing the needs of severely symptomatic/dysfunctional individuals.

4.5 LEBANON: GUGLIELMO SCHININA (IOM)

4.6 COLOMBIA: MIKE WESSELLS (InterAction)

The situation in Colombia is one of protracted violence and war, characterised by structural violence, massive human rights violations, mass displacement and narcoterrorism. A National MHPSS Task Force helped to define a common framework, language, and reference points, and the IASC Guidelines were used to develop national guidance on Mental Health and Psychosocial Support in Emergency Settings. There has been increased awareness about potentially harmful practices, and interest and buy-in of heads of agencies, policy leaders, and different government and non-government agencies. However, the urgency of other issues overshadowed MHPSS issues, and there was very little funding available. The Guidelines needed to be contextualised to a situation of ongoing armed conflict and rights abuses. Whilst it was possible to effectively engage policy makers and government, people at grassroots level were less engaged, and there was some concern that strengthening community networks could result in communities being targeted.

4.7 PERU: MIRYAM RIVERA HOLGUIN (MdM-E)

Peru has experienced 20 years of political violence and poverty, and in August 2007 was hit by an earthquake. There has been successful implementation of Guidelines at the level of national and regional authorities and for community mobilizing at shelters and *ollas comunes*. Its impact was lower in terms of changing practices of NGOs working in the zone and in helping all the hidden populations not living in shelters or approaching *ollas comunes*. Tools and resources were developed, and the

Guidelines were included in regular disseminating activities and training processes. Multisectoral coordination systems were in place. However, to involve public institutions and local actors in the emergency work was a challenge, as was ensuring that the work of humanitarian actors did not weaken public services. Community workers tended to be overloaded with tasks so lack of time was one of the main barriers for field implementation of the guidelines. In addition, there is always a hidden population not easily accessible for MHPSS work.

4.8 IRAN: MAZIAR TALESHI (UNICEF) (through teleconference from Iran)

The Iranian Ministry of Education approved IASC Guidelines and they were rolled out in the provinces through training. 150 counsellors at MoE counselling centres were trained on the Guidelines, focusing on minimum actions plus psychosocial concepts, and state social workers have agreed to conduct similar training. Those trained have formed a network to support each other. Input has been sought from provinces on local healing practices in their areas. The next step will be to identify those local healing practices which could be beneficial, adapt them and insert into the local MHPSS manual in Farsi. It has been difficult to convince people in Iran to adopt a non-medical approach; there's a need to demonstrate that a psychosocial approach is scientifically sound. Non-UNICEF agencies have 'signed up' to IASC Guidelines, but are using different modules and commitment from UN agencies has been more personality-based than structural, with a lack of clarity about the role of MHPSS and different agencies/ institutions. There is a plan to review the IASC manual, make it user-friendly and more culturally appropriate, but this is currently on hold because the Annual Work Plan has not yet been signed, so momentum has been lost. Turnover is very high even at middle management level and there is an absence of strong NGOs in Iran.

4.9 ETHIOPIA: LYNNE JONES (IMC)

Ethiopia has increasing numbers of internally displaced people and refugees, food insecurity, poverty, poor infrastructure and telecommunications. Theirs is a chronic and continuous emergency. There is political and academic interest in the Guidelines in Ethiopia, which led to 50 copies of the Guidelines being sent, and one orientation seminar being held for university psychiatrists, WHO and Ministry. However, as yet there are no national/international coordination mechanisms, no leadership from WHO or MOH or UNDP, and no follow-up to the orientation seminar conducted. The implementation of the Guidelines is hindered by the regional power structure in Ethiopia, and a lack of resources.

4.10 CHINA: LENE CHRISTENSEN (IFRC)

Following the earthquake in China earlier this year, the IASC Guidelines were translated into a draft Chinese version. A great deal of momentum has been created, people are keen to learn and are asking for practical tools to use in the field. However, only limited psychosocial assessment have been carried out in China since the earthquake, and there is some confusion about Government policies, aid distributions etc. There is a need to interact with local authorities and adapt the Guidelines to the local context, and to find out what is already happening, and bring as many people as possible on board. The current focus is on the transition into recovery phase, maintaining funding, and keeping going what has been started.

4.11 LESSONS LEARNED

The 'lessons learned' identified by the speakers and participants are summarised below.

DISSEMINATION AND IMPLEMENTATION OF THE GUIDELINES

- **Emergency Preparedness:** Whilst coordination of UN/ INGOs seems to be good at global level, it is weaker at regional level. There is a need to engage with those already active in the regions, to build strong regional networks able to respond to situations in various parts of the world.

- **Translation:** Increased use of IASC MHPSS guidelines requires translation into local language, preferably by somebody with specialist mental health and psychosocial knowledge, and who is familiar with the use of the language in the region in which they will be used.

- **Standard messages:** it is helpful to develop standard templates on socially and culturally acceptable key advocacy and information messages that can be adapted/translated into local languages.

- **Involvement of senior managers:** The political power of senior management is very important. The focal points for MHPSS may not be very powerful, so it is important to brief the senior managers, because they are the decision makers, especially in a conflict/ emergency situation.

- **Impact of single individual/ organisation:** A considerable impact can be made by an individual or organisation committed to the Guidelines, and with the ability and resources to advocate for them.

- **Outside assistance:** There was some debate over the appropriateness of deploying somebody for a short period to help to implement the Guidelines. It was suggested that local people committed to the Guidelines could be identified and trained pre-emergency. Where this is not possible, outside support (e.g. from IASC MHPSS Reference Group members, or an interagency mission) can be valuable at an early stage, particularly in reaching government and policy leaders, to ensure common understanding and develop a common work plan. However, it was suggested that open dialogue between peers is valued and has more impact, than quick answers given by a specialist. The view was also expressed that a top-down approach, and short-term deployment, is less likely to be effective in countries where there is no buy-in from the Government.

- **Sustained follow-up support on MHPSS is essential:** There is a need to not only introduce the Guidelines, but also to have regular meetings to follow up the advances and shortcomings. This means *being part* of the process.

- **Evidence base:** The MHPSS field needs a written, 'scientific' back-up to give it credibility and authority.

- **Non-emergency situations:** To get IASC guidelines off the ground in 'non- emergency' situations (e.g. preparedness) requires a mandate from IASC ref group/ cluster system to relevant country point person asking them to promote guidelines, and an external consultant (full time, short period, funded) at MOH level to provide stimulus, guidance. It would require coordination between ministries and collaboration by local partnership of INGOs, NGOs and academic community

- **Creating ownership of Guidelines:** There is a risk of the Guidelines being seen as a burden imposed from outside, since many agencies on the ground have their own guidance.

- **Need for common understanding:** Co-ordinated approach very important; agencies need to be speaking the same language in terms of MHPSS. A MHPSS lead in every country would be very helpful.

- **Development of local guidance:** It is critical to ensure that local Guidelines, and an accompanying short orientation, are developed with local partners as soon as possible after the onset of an emergency.

- **Top-down/ bottom-up:** There is a need to bring together top-down and bottom-up approaches to implementing the Guidelines. The Colombia example shows the benefits of having 'multiple faces' of the Guidelines that combine top-down, bottom-up and middle-out.

- **Potential misuse of Guidelines by authorities:** The Guidelines can be used by Governments for their own purposes (e.g. to try to show that their country is no longer in an emergency); there is a need to think carefully about the potential dangers of using the Guidelines in conflict areas. It was also pointed out that the Guidelines had been used in Colombia to raise human rights violations with the Government.

- **Potential misuse of Guidelines by institutions/ organisations:** The Guidelines can also be used by individuals/ agencies to justify what they are doing. There are examples of agencies and academic institutions making superficial reference to the Guidelines in proposals and publicity, but their actual activities are not, in fact, in line with the Guidelines. This can be confusing for those making decisions, who are not familiar with the Guidelines

- **Allow time:** It will take time for people to change their understanding of MHPSS, since their current understanding is based on years of training and learning.

CONTENT OF GUIDELINES

- **Guidance on timelines:** Guidance on how long after an event each action point should be implemented would help with monitoring progress and prioritisation of activities.

- **Guidance on use by different actors:** There is a need for direction regarding how the Guidelines should be used by those in different roles, and to produce adapted versions of the Guidelines for different purposes.

- **Contextualisation:** there is a need to operationalise the Guidelines to specific contexts (urban refugee crisis; protracted, complex emergency; restrictive governmental environment). This requires ongoing analysis of specific areas such as education and how to support the most severely affected people, developing specific action plans.

- **Accessibility:** the Guidelines could be made more accessible in terms of context, layout and language.

TRAINING

- **Pre-emergency training:** There is a need for training and orientations to be conducted for government agencies and partners (coordinators, decision makers), including those in other clusters, before emergencies occur. It takes at least one day's training for everybody to be 'on the same page' and it is difficult to engage institutions in the midst of an emergency.

- **Context-specific training:** There is a need to adapt MHPSS IASC Guidelines training to the context - cannot assume that we are all starting from the same place. Training on IASC Guidelines is overwhelming to those who have little understanding of PSS. In situations where there is resistance to the IASC Guidelines, it has been found to be helpful to focus on the basics, using the pyramid to conduct a mapping exercise and help people to gradually see the relevance of the Guideline

- **Focus on attitude change:** Design training with more room for discussions, participatory and experiential learning , as there will often be a need for a change in perception, understanding, attitudes and behaviour.

- **Bottom-up training:** Training on Guidelines should be 'bottom up' rather than 'top down', and should focus on the practical implementation of the Guidelines.

- **Training the right people:** Examples were given of agencies and field staff not being aware of the Guidelines, despite great efforts being made to disseminate them, and to conduct trainings and orientations. It can be difficult to know whether training is reaching the 'right people'.

COMMUNITY INVOLVEMENT

- **Involvement in co-ordination groups:** There is often little involvement of affected populations in co-ordination groups. In some countries (e.g. Colombia) it can be difficult to engage affected groups doe to Government resistance, or because local communities have other priorities following a natural disaster, or during a conflict. It may be easier to mobilise affected communities in post-conflict situations.

- **Slower implementation:** There is a need for a slower, more community-engaged approach

- **Discussion of Guidelines with affected populations:** There is an need to talk to affected populations about whether the Guidelines are useful to them.

- **Coordinated, integrated community based training** on IASC Guidelines

- **Involvement of communities** to scale up MHPSS activities, using existing structures

- **Local relationships are crucial.**

- **Consider engaging with business community:** It was noted that the business community have an interest in putting people back on their feet, so they can be engaged in the economy.

INTEGRATION

- **Include public institutions:** Empowering public institutions requires lots of energy, and it is often easier for NGOs to ignore public institutions and act 'independently', which does not lead to effective services.

- **Integration of MHPSS with other clusters:** There is a need for better integration of MHPSS activities with other Clusters

- **Link MH and PSS:** Crucial to link psychosocial support and mental health interventions

- **Referral mechanisms:** In many settings, there is a need to strengthen referral mechanisms

- **Government involvement:** Advocacy and closer involvement of the Government in MHPSS co-ordination would be helpful, although this is difficult in some countries.

- **Cluster system:** There is a lack of clarity regarding the cluster system in general and psychosocial support specifically in the UN system. This has been identified as a particular problem in Iran.

5. ROLE OF REFERENCE GROUP IN SUPPORTING MHPSS IN SUDDEN EMERGENCIES

Amanda Melville (UNICEF) introduced this session by providing an overview of the role of Reference Group members in rapid onset emergencies. There are two main aspects to their role:
- Remote or in the field
- Individual agency/interagency

Three types of work are carried out by Reference Group members in these situations:

1) Dissemination; advocacy and mainstreaming: including supporting translation, printing and dissemination; advocating internally for use of guidelines and for the establishment of MHPSS coordination group; staffing and conference calls. This has been done in an ad hoc way, and the question is how to continue offering this ongoing support in the most effective way.

2) Utilization of Guidelines to develop country based policies and planning: including providing support for development of policies and the development of linkages between global actors and local coordination groups/actors. Also includes technical support on how to use the guidelines in the planning process.

3) Capacity Building on the Guidelines and Community implementation: including conducting orientations/ training on the guidelines in the country, providing tools and reviews of planning based on guidelines. The more emergency prepared a country is, the easier it will be to use the Guidelines when the need arises - even a short orientation can give an entry point.

DISCUSSION

Dissemination, Advocacy & Mainstreaming

- There's a need for an evidence base, and expectation that this should come from hard science. How can we give legitimacy in ways which satisfy people, but also legitimise other types of evidence (e.g. qualitative work, solidarity, local perspectives)?

- We can all reference the Guidelines in our everyday work, through what we write and say. This can have a big impact in term of dissemination.

- We can reference the Guidelines in our interactions with the media. The media tend to focus on trauma, and it can be difficult to engage with them; it might be helpful to bring journalists together for a seminar on MHPSS.

- The lexicon (language used to describe the stress of people in emergencies) is helpful, but it was noted that the current lexicon has not been agreed by everyone (it has only been used in the Lebanon inter-agency statement).

- The challenge is not to talk about the Guidelines, but about the content of the Guidelines. This will help minimise lip-service and help dissemination.

- For some action sheets (e.g. health services ones), specific tools are needed. This would help in sectors such as education.

- Proactive networking and planning before an emergency is important. It is helpful to undertake some kind of regional training, and identify key people in different countries, creating small networks of people who already know the Guidelines and can respond quickly in the event of an emergency.

- We can enhance links with academic institutions, since they have been found to be strong advocates for the Guidelines in some settings (e.g. Myanmar). Very often the Guidelines can be incorporated into courses. The point was also made that we need to be aware of the risk of academic institutions referring to the Guidelines to advertise their courses, and give them credibility, when the curriculum is not based on the Guidelines. There is a danger of the Guidelines being misused as a promotional tool.

- The capacity of academic institutions can be strengthened by building their library resources.

- We need to institutionalise the Guidelines in our agencies, with each agency needing a champion.

- There is a need for guidance on how to bring in different sectors. Steps have been made towards this already; the health sector co-ordinator guidance was said to be very helpful, and will be disseminated to all countries.

- While developing the Guidelines, feedback was received that the Guidelines were too big and too complex to use. The Task Force nonetheless decided to keep it big ("to have the baby born in full health"), and to subsequently translate it into formats where it can actually be used. We now need multiple tools, for different purposes.

- There is a lot of work to do with donors, using the Guidelines as a checklist to evaluate proposals. This is inherently inter-agency advocacy.

- There's a need to look at the dissemination of the Guidelines in situations where there's no Cluster approach. Development agencies, especially high level people, need to be oriented to the Guidelines. The key agency is UNDP. It was noted that the Reference Group has the opportunity to send the Guidelines to Humanitarian Co-ordinators, who in the past have said they receive too many documents and are unlikely to read lengthy guidelines. There is a need for a brief document with action points.

Community-Level Implementation

- Community-level implementation has been one of the weakest areas up to now.

- A need was identified for tools to help people implement the Guidelines at field level. However, it was suggested that it may be more appropriate to focus on developing a process to assist communities to develop their own tools.

- One of the hindrances to community-level implementation in Peru was the big agencies which came with a lot of resources, began their activities without co-ordination, and started giving assistance individually. This broke down community mechanisms, and only when they could be convinced to stop doing this was it easier to work with communities.

- It was noted that it can be easy to assume that there is no community of affected persons in some settings, but working with local organisations can reveal that assumption to be false. Participatory assessments are helpful.

- Community mobilisation is possible, even in a short time. It can be facilitated by:

  i.   Brief guidance on how to implement the Guidelines. This would assist communities, and stop Governments using just parts of the Guidelines.

  ii. The indicators are the least developed part of the Guidelines. A consultant could set up some indicators to help assess how the Guidelines have been used in a particular context. They would need to be locally adapted, but this would give a starting point.

  iii. When implementing the Guidelines, it's important to have people on the team who are devoted to working with community organisations (down-top approach).

  iv. There's a need for popular education materials – five or six models which can be adapted in different contexts.

v.   Key messages for different stakeholders – community, donors, regional authorities.

6. IASC MHPSS GUIDELINES AND THE CLUSTER SYSTEM

6.1 DRAFT COORDINATION TOOL (Mike Wessells, CCF/ InterAction)

[See Annex D for copy of document]

Mike introduced the document as a tool to assist protection and health cluster co-ordinators to use the Guidelines.   It guides co-ordinators through the process by asking four questions, and outlining actions to be taken depending on their response. Mike led the group through the document.

The group generally felt that the draft document would be extremely helpful. During the following discussion, some suggestions were made:

- A final section should be added for situations where there is nothing in place. If this is the case, the cluster leads should be approached and asked to form a single MHPSS group.

- The document could include a question about whether other clusters are working on MHPSS (e.g. education).

- Co-ordination isn't an end in itself; a final question could be – do you have an action plan to address priority gaps?

- This document could be combined with a planning tool (e.g. one-page sheet used in Myanmar listing what cluster leads need to do to address MHPSS in a co-ordinated way).

- There's a fear of creating another cluster but if MHPSS is seen as a sub-group of existing clusters, there is unlikely to be resistance.

- MHPSS is formally not a cross-cutting issue within the IASC at the moment, but if the Reference Group feels it is important, we could try to advocate for MHPSS as a cross-cutting issue.

- Once the document is finalised, there will be a need for conversations with health and protection clusters to get buy-in at global level, and then see how to disseminate it.

6.2 HEALTH CLUSTER (Mark van Ommeren, WHO)

[See Annex E for copy of document].

This 8-page document is intended as a summary of the Guidelines for health cluster co-ordinators. It is currently in draft form because there are proposals to create similar documents for education and protection cluster co-ordinators, and they should be finalised together to ensure the messages are consistent. The draft has been reviewed by health experts in this Reference Group, and health cluster, and the health cluster has shown early indications that they may be willing to publish it. In addition, there will be a Health Cluster Guide, in which we can include key MHPSS messages.

Erin Kenny (WHO) noted that there should be a focus on best practices and service provision, rather than co-ordination processes, so the clusters and related documents should be seen as a means to provide services to people in need. The global health cluster guidance tools have gone through Mark, to ensure MHPSS are integrated in our documents.

6.3. PROTECTION CLUSTER (Atle Solberg, IASC Protection Cluster Secretariat, UNHCR)

One of the biggest challenges for the Protection cluster is that there is no mandated cluster lead for natural disasters, so UNHCR can't lead in all situations. The protection cluster consists of five areas, each is the responsibility of different agencies. It is important that the cluster is tasked with standards and policies; building capacity; operational support.

Achievements include creating the Handbook on IDPs and developing an assessment framework. MHPSS is taken seriously in the cluster, and will be a key part of protection cluster co-ordination training.

Amanda Melville added that there is the possibility of including MHPSS in a co-ordination training module that's being developed by child protection cluster, and there's an opportunity to link MHPSS documentation more closely to child protection documentation.

6.4. EDUCATION CLUSTER (Marian Hodgkin, INEE)

The education cluster was only approved late 2006 and is co-led by UNICEF and Save the Children. It is currently working on four areas: a capacity mapping exercise; surge capacity; capacity building – MHPSS Guidelines are circulated in INEE minimum standards training; needs assessment is in early stages. The INEE minimum standards is the guiding document for the education cluster and will be revised next year, so this would be a good opportunity to reference and include MHPSS Guidelines.

6.3.3 NUTRITION CLUSTER (Lynn Jones, IMC)

The global nutrition cluster seems quite unwilling to include MHPSS in their work; they see it as low priority and the main donors in nutrition (except UNICEF) are not willing to fund MHPSS integration. There is a lack of MHPSS knowledge amongst nutritionists, and they are already overwhelmed with guidelines and manuals. Amanda Melville noted that progress would require a coalition of people to push MHPSS issues. A task for the next work plan is to identify priority clusters, and who will be responsible for pushing MHPSS issues in each. IMC and ACF have indicated interest in taking the issue forward with the nutrition cluster next year.

DAY 2: Tuesday 23rd September

7. NETWORKING: follow up on 2007 meeting with PWG

7.1 SUMMARY OF WORK BY 'G7' NO FORMING A PSYCHOSOCIAL NETWORK(Alison Strang, Queen Margaret University)

(Powerpoint slides are available from speaker)

Alison described the progress made since the Sept 2007 Task Force/ PWG meeting in exploring networking as mechanism for improving policy and practice. She outlined a proposal to establish a network consisting of an interactive web platform (http://psychosocialnetwork.net), a web of local networkers, and a stewarding group to provide a form of leadership.

7.2 OVERVIEW OF GLOBAL LEARNING NETWORK (Mike Wessells, CCF/ InterAction)

(Powerpoint slides are available from speaker)

Mike gave an introduction to the Care and Protection of Children (CPC) Agency Learning Network, which aims to strengthen child care and protection in emergency settings through the collaborative action of humanitarian organizations, local institutions, and academic partners from both South and North.

7.3 DISCUSSION

Issues raised during the discussion of the networking proposals were:

- The possibility of overlap with the work of the Global Mental Health Network (GMHN), to be launched on October 10th. This group may do some of the same things, but with a focus on mental health care and development. There was a suggestion that once the MHPSS network is established, formal links can be established with the GMHN. It was noted that the GMHN and MHPSS networks have different strengths, with the GMHN having significant academic capacity and focusing on the 'top of the pyramid', and the MHPSS being closer to service delivery on the ground, and includes all levels of the pyramid.

- Once the CPC network has been launched in November, there will be various ways people can become involved, although there is a concern not to have more northern than southern partners.

- Mike Wessells said in his presentation that the CPC does not focus on the top of the pyramid because there are others focusing on the 'top of the pyramid.' Two people disagreed with Mike on this - stating there are many agencies working on children's wellbeing, but very few agencies are working to support children with severe mental disorders in emergencies.

- There was some discussion about the feasibility of employing local networkers, as suggested in the MHPSS networking proposal. There would be challenges around their terms of reference, their recruitment and selection, and evaluation of their performance. It may involve finding people already good at networking and employing them part-time as networkers, which is the opposite of the normal recruitment process. Alison described that this has been done successfully in Sri Lanka, and noted that there is a great deal of knowledge around about what makes an effective networker.

- The issue of access to the internet was discussed. The need for internet access to be improved in some locations was recognised, and the positive impact of this on bringing people together. Whilst this would undoubtedly have benefits, some members of the group felt that it was beyond the capacity of the MHPSS Reference Group to undertake this task themselves, but links could be made with those NGOs involved in telecommunications.

- The challenges of managing a website documentation centre were raised. It involves a great deal of work to digitalise paper documentation, and classify it to help people find what they need. The importance of ensuring that the website contains documents in languages other than English was also emphasised. Alison referred to the 'Wikipedia' style of the website, which means that the responsibility for classifying documents will be shared amongst members. Networkers would

manage this process and teach people how to classify documents. This shared 'hosting' would also facilitate translation of key documents by members, and the development of different language-group sections of the website.

- The issue of 'quality control' of the website content was discussed. There is a tension between the desire to have an open-access site, and the desire to have some quality control. Some members of the group expressed concerns about quality control, and suggested processes by which this could be managed. Alison noted that it would be possible to see who has uploaded each document, which would indicate whether it was endorsed by an organisation. She also highlighted the need to be careful about the question of who the site belongs to; it has been designed to be an open space, and is not about controlling content, although hosts will remove anything offensive.

8. INSTITUTIONALISATION OF IASC MHPSS GUIDELINES

8.1 Marian Hodgkin (INEE) gave a presentation on the institutionalisation of the INEE Minimum Standards in Education in Emergencies. These were launched in 2004, and a INEE working group has been looking to implement and institutionalise them. They developed four adoption strategy checklists for donors and governments, NGOs, UN agencies and interagency co-ordination. These offer strategies for the use of the Minimum Standards at a number of levels within an organisation, ranging from easy, immediate actions (e.g. downloading MSs onto all agency laptops), to others that are longer-term (e.g. references to MSs in strategic planning docs).

Working group members have individually developed institutionalisation plans for their own organisations, and share these at bi-annual meetings.

A key challenge has been decentralisation; those at headquarters may be working on institutionalisation plans, but that may not connect well to the field, and vice versa. Another challenge is staff turnover. Once the Minimum Standards are institutionalised, this will be less of an issue, because their use will not depend on individuals.

Lesson learned are to grab opportunities to institutionalise, take all opportunities to reference guidelines in written and verbal work. INEE's work with donors has been very effective and they have developed case studies on how donors have used the guidelines.

8.2 INSTITUTIONALISATION OF MHPSS GUIDELINES IN AGENCIES

Representatives of organisations described their experiences of trying to institutionalise the Guidelines. Strategies include:

- Incorporating knowledge of the Guidelines into Terms of Reference for relevant posts.
- Issuing instructions relating to the Guidelines from senior management
- Incorporating the Guidelines into organisational capacity building and tool development
- Integrating the Guidelines into work plans
- Taking opportunities to refer to the Guidelines in meetings and presentations
- Distributing the Guidelines to all offices.

9. REVIEW OF EXISTING TRAINING AND ORIENTING TOOLS

9.1 Nancy Baron (GPSI) gave a presentation in which she reviewed the training documents she had been sent by group members. The reviewed materials fell into nine categories:
- Orientation: Presentations
- Orientation: Seminars
- Orientation: Handouts
- Curriculum design: Assessment of training needs
- Training Courses: Directed by IASC MHPSS
- Training Courses: Including IASC MHPSS

- Experiential training techniques: Discussion, Role Play/Simulation
- Evaluation of: Training courses
- Follow-up through: Action planning

The materials in each category were described, and examples given.

9.2 DISCUSSION

There was a general consensus that the review carried out by Nancy was extremely useful, and that ways to take this work forward should be considered during the work planning session.

There is an issue about making training materials public; getting permission to share materials can be a challenge and would need to be discussed further with those who created them.

The training materials as they are may need to be annotated or expanded upon by their creators before being shared. The costs and benefits of everyone doing that individually, versus employing one person to review and develop the training materials, should be considered.

Some group members felt that a smaller number of model packages might be most useful, whilst there was a feeling amongst others that there is value in having all these resource materials available. Both would be possible, and part of a training package could be a series of examples of doing certain things (e.g. introducing the pyramid). It would also be possible to put out a call to meet certain needs (e.g. experiential exercise to change attitudes).

A distinction was made between orientation/ training on IASC Guidelines, and training on a more general field which incorporates IASC Guidelines. It was suggested that there is a need for a discrete module on how to train in the Guidelines, but there is also a need for a wider set of resources, to meet various needs.

Areas in which group members identified a lack of training materials were:

- Evaluation: including evaluating participants or what they produce after training, and whether programmes really follow the Guidelines (impact of training).

- Training for clinicians, who may be resistant to the materials and need non-confrontational training.

- Experiential information on psychological and social consequences of disasters. Experiential exercises are best way of shifting attitudes.

10. IASC REFERENCE GROUP WORKPLAN FOR 2009

Before this part of the meeting began, Lynn Jones (IMC) infomed the meeting about the Harvard Humanitarian Initiative, which has a mental health working group, co-chaired by Lynn. They aim to develop a framework of ethics for research/ evaluations in emergencies and would welcome group members' ideas and documents.

This part of the meeting aimed to begin the process of work planning for 2009, although it would not be possible to finalise the work plan at this stage. The meeting divided into four groups to discuss different aspects of work. The outcomes of each group's discussions are summarised below. This is the beginning of the work planning process. The next stage is for it to be written up, priorities to be set, and for people to commit themselves to certain tasks. The co-chairs will organise that. The idea of reviewing training materials was felt by some to be sensitive, and would need to be proceeded with carefully. It was proposed that a sub-group be established to discuss this further.

The issue of selecting a co-chair for 2009 was raised. Mark van Ommeren will write down what co-chairing involves and circulate to group, but it involves 20% of a full-time job. There is no funding for the post, it is an in-kind donation from an agency to the IASC, but it brings significant benefits to the agency.

IDEAS FOR WORK PLAN
1. DISSEMINATION
• Liaise with research groups
• Create a checklist for institutionalisation (task to be undertaken by a sub-group)
• Provide peer review of any SPHERE text written and be involved in consulting on the draft in the field. This will take place from mid-2009-2010
• Dialogue with donors, Governments and senior management (task to be undertaken by a sub-group).
• Obtain funding to print the Guidelines, and organising for the printing to be done and the copies to be shipped to an agency which will act as a central point for distribution. NGOs are much better placed to undertake this take than UN agencies. Copies could be printed and sold at cost. (Issue to be explored further by a sub-group with specifically Action Aid)
• Communication and advocacy: media and different stakeholders. (Issue to be explored further by a sub-group).
2. INTEGRATION of MHPSS INTO THE CLUSTER SYSTEM
• Continue to strengthen integrating MHPSS within Protection and Health Clusters (documents, workplans etc.).   - Develop MHPSS guidance for protection coordinators and finalize MHPSS guidance for health coordinators   - Meeting between health and protection Cluster focal points to agree on roles and responsibilities to finalize the 1-pager on coordination   - Child Protection: Protection maybe UNICEF, TdH, UNHCR? Finalise co-ordination
• Consider integrating MHPSS within Education and Nutrition Clusters through use of focal point and technical committee system. INEE for education? IMC and ACF for Nutrition?
• Coordination toolkit on MHPSS (Co-chairs, IOM, ACT Interational CCF)   - Finalise generic coordination tool and steps that such a coordination group could do   • - Develop Toolkit with key tools that co-ordinator would need to do coordination work   - Systematically send out joint letter every time there's an emergency: Suggestion that reference group members who are leading protection and health cluster in countries where the cluster system is to engage with their staff. Maybe send joint email from reference group plus reference group members who are coordinating health and protection with cluster guidance. Noting that the reference group members who could participate and possibly lead. Should choose the agency that has the closest capacity to the government appointed agency (if there is one). Copy humanitarian coordinator. Give them co-ordination documents and toolkit. Initial letter with reference to online documents – should be done systematically (already done informally). Include names of reference grouup members in that area, and maybe they could take lead role. Also something about government and importance of building on exisiting mechanisms.
• Funding within cluster system and linking to MHPSS   - Funding for activities to come out of appeal by different agencies   - Funding for coordination would have to be included in the appeal by lead agency. Some organisations may be able to include this in their global discretionary funding.   - Advocacy with donors with coordination costs for MHPSS in large scale emergencies. Also advocacy within cluster system.   - Co-Chairs and organisations who are within discussions on funding for cluster system should include advocacy on funding for MHPSS
3. COUNTRY IMPLEMENTATION
Two models were identified: 1/ global to regional, trickle down to countries OR 2/ pick a few 'target countries' where we will implement Guidelines. It was proposed to use both strategies.
• important to have a 'regional champion' who will take process further within that region.
• develop regional toolkits, adapted to regional context. Find materials and translate.
• Continue with regional trainings.Train people to translate Guidelines into context as part of emergency preparedness. Issue of turnover of staff. Need external support/ funding for this.
• There are some countries where things are happening, but in other places things are still not in place. Identify a few countries to target, start to advocate within their own agencies.

Formatted: Bullets and Numbering

• Have someone working on issue of indicators, making proposal for more concrete indicators. A consultant needed for this – funding.
• 1-2 sheets of things to think about when developing case studies/ implementing the Guidelines.
4. TRAINING AND ORIENTATION
• create a quality, standardised package for orientation and training on IASC Guidelines (not on general MHPSS).
• Specific orientation packages for donor group – future of quality control.
• Specific orientation packages for media group. Could be rolled out around the world. It benefits all of us if the media report correctly.
• Can we set up 'gold seal'/ stamp of approval for training packages? Reference Group could have review committees, maybe meet twice a year that has a list of standards. People producing training materials could submit them to the review board, which would review them against the standards and decide whether to give a 'IASC stamp' stating it's in compliance. Otherwise, there are lots of materials saying they're IASC-compliant, and they're not.
• Website – open forum, anybody can put training materials. How do we have quality control? Didn't like idea of censoring or screening, but did like idea that everything that came in could go into one of three categories: open forum; not yet reviewed; reviewed and given 'stamp of approval'. Also a section for those not given 'stamp of approval'.
• Regarding the issue of the website, it was noted that the MHPSS website is designed to be open access, so have to make clear that material isn't reviewed.
• The issue of logos would need to be discussed with the IASC secretariat. They might allow their logo to be used on materials created by the Reference Group, but on reviewed materials we could put a 'statement' instead.

11. AOB

11.1 Roster

There were differing opinions about the feasibility creating a functional roster. It was suggested that it may perhaps be easier to strengthen existing rosters than start a new one. The possibility of establishing a sub-group to discuss the issue of a roster was put forward, as was the idea of hiring a consultant to explore the issue by talking to stakeholders.

11.2 Early recovery cluster situations

There was some interest in engaging UNDP and early recovery cluster situations, looking at how to make early recovery psychosocially sensitive. It was suggested that this could be added to potential work plan ideas, and renewed attempts could be made again to involve UNDP in the Reference Group.

12. CLOSING REMARKS

The meeting was brought to a close by Amanda Melville, who thanked the outgoing co-chairs, Sabine Rakotomalala and Mark van Ommeren for their commitment and support.

DAY 5: Friday 26th September

<ins>Training/orientation tasks to be potentially included in Work Plan for 2009</ins>

After reviewing earlier small group work on the same topic (see notes Tuesday 23 September), a range of ideas for expanding orientation, training, and to some extent, dissemination of the IASC Guidelines was explored. Key ideas (some already mentioned by the working group) included:

Processes
- Develop a peer review and editorial group for reviewing orientation/ training materials by IASC agencies, including how this could be organised/sectioned on the (non-IASC) network website (http://psychosocialnetwork.net)
- Facilitate field-level inter-agencies co-ordination of trainings, orientations and follow-up activities, so agencies can better collaborate and share resources (the idea of organizing this at the regional level was emphasized)
- More regular Reference Group meetings (eg 3-4 times per year)– whether face-to-face and/or via regular teleconferencing;
- Outreach to key organisations not presently represented in the reference group. (establish strategy for reaching out to other specific NGOs currently undertaking significant psychosocial activities (e.g. War Child, Plan International, and others). Some of these may be invited to the Reference Group is they meet Reference Group membership criteria)
- Begin orientation and trainings at regional levels, where existing networks are active through Reference Group contacts – e.g. Southern Africa, East Africa, Asia, South-East Asia, South America, Middle-East-Northern Africa.
- Need to begin focusing more on assessment and evaluation of trainings over the next 12 months, given considerable training activities have already occurred. Assessment and evaluation needs to play a more significant role in forthcoming trainings and training packages, as well as a continued focus and development of case studies with related impact evaluations (incorporating more stringent measures). Training packages also need to include follow-up activities.

Products
- Compilation of existing orientation, training and ToT materials and work completed during the current weeks meetings. (Permission from NGOs to be sought and arrangements for uploading to website to be made.)
- Developing a quality standard model orientation & training package – including modules covering orientation to (a) donors, (b) media (c) senior management orientations (d) new NGOs (NGOs not currently represented in the IASC Reference Group to consider their collaboration and commitment to the guidelines) (e) staff of specific sectors (health, WASH, shelter etc) and orientations on specific action sheets.
- Develop a ToT package to scale up implementation of the aforementioned orientation & training package.

<ins>Setting priorities</ins>
Priority of actions were identified as follows. Agreed that current co-chairs would be responsible for incorporating these into the overall draft work plan for 2009 and engaging implementers for tasks:

1. Compilation of existing resources to be finalised (including those presented during meetings and those developed during training exercises)*
2. Resources compiled to be uploaded to website**.
3. Co-ordination efforts for reference group to be enhanced (via meetings & web)
4. First model training and orientation packages to be developed (drawing upon compiled materials)
5. Implementation of these packages to be ongoing within individual organisations' training and orientation activities
6. Develop a ToT on IASC Guidelines

7. Regional ToT meetings to maximise opportunities for delivering orientation and training materials

*Establishing a committee to review options for organizing peer review and editorial content to be considered throughout the process of developing training materials
**The idea of sectioning the networking web site for materials consistent with the Do's and Don't's of the IASC Guidelines to be discussed further.

Exploration of existing resources
Organisation representatives identified potential to support activities of the reference group in the following areas. *This is not an exhaustive list and excludes representatives not present at the meeting

Activity	Possible contributors
Peer reviews & circulation of key documents to network	WHO, SAVE, IMC
Field level training & capacity building (with program-based funding)	IOM, UNHCR, Act, WV, UNFPA, UNICEF
Regional level networking & training	IOM, UNHCR, Act, IMC (no funding), UNFPA, GPSI, UNICEF
Support for development of training packages (model packages & ToT)	CARE, Act, Church of Sweden (including funding for personnel), GPSI (esp. Human resource), UNFPA
Building capacity for organisational staff	SAVE, UNHCR, Act, WV, ACF
Pilot projects (Asia & Africa)	UNHCR, WV, UNICEF
Health Cluster dissemination	WHO
Nutrition Cluster dissemination	ACF
Focal point for training in acute emergencies	Act, IMC,
Contribution for fundraising & outreach strategies	UNICEF, GPSI, Act
Compiling existing training resources; developing training and coordination packages	GPSI
Co-Chair/Reference Group Coordination	UNICEF

Any other business
- Reconfirmed that checklist for institutionalisation of guidelines should be in work plan. Other ideas represented in previous reference group meeting to be incorporated into work plan, along with those around training, as documented above.
- Co-chairs for 2009. Two of three co-chairs are stepping down. UNICEF is likely to continue co-chairing the reference group for another 12 months but another representative (preferably NGO) as co-chair needs to be sought. Noted that CARE and WV are considering an offer of services for this role, but further confirmation is required to ensure agencies make a strategic commitment (top-level) for representatives to undertake this role.

ANNEX A: Agenda

ANNEX B: List of participants

ANNEX C: IASC Reference group work plan 2007

ANNEX D: Draft Assessment and Action Tool on how to support

ANNEX E: Draft Advice on MHPSS for Health Cluster Co-Ordinators

ANNEX F: ToT Days 3 and 4 - Notes from Nancy Baron