

IASC MHPSS Reference Group Global Meeting

Amsterdam, 25 – 28th September 2012

Hosted by War Child Holland and War Trauma Foundation



Co-chairs IASC Reference Group: Sarah Harrison & Ruth O'Connell

Participants:

ACT Alliance; GPSI-Cairo; Terre des Hommes; War Trauma Foundation; War Child Holland; Church of Sweden; Action control la faim; Save the Children; CARE Österreich; MHPSS Network; International Medical Corps; Mercy Corps; HealthNet TPO; Handicap International; Catholic Relief Services; World Vision; The Center for Victims of Torture; UNICEF; UNHCR; World Health Organisation; Plan International; International Organization for Migration; Institute for International Health and Development; International Medical Corps.

Note-takers: Whitney Fry & Anna Slavinskaya

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Content of Day 1:

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2. Presentations of WTF and War Child Holland
3. Update on emergencies in 2012
 - West Africa/ Sahel crisis
 - Syria
 - Jordan & Lebanon
4. CCCM and MHPSS RG booklet
5. Community based services for specialized support

1. Welcoming & introduction of new members by Ruth and Sara

Registration, Housekeeping, and New Members:

Sarah and Ruth introduced the MHPSS Reference Group meeting, thanking War Trauma Foundation and WarChild for hosting. Two new members to the Group were also introduced: Merlin and Center for Victims of Torture, (CVT) Ruth presented on behalf of Merlin. If anyone is interested in contacting Merlin, Lizzy Berryman is the contact person, with contact details in the PPT presentation.

Note: All PowerPoint presentations from the meeting are available on mhps.net

The Center for Victims of Torture (CVT) was represented by the Director of International Services Neal Porter, and the International Clinical Advisor Ann Willhoite. The organization has domestic origins in the United States, specifically in clinical treatment for torture survivors. The Center for Victims of Torture is small organization with 50 employees, half of whom are clinical. The organization's domestic work has been in operation for 26 to 27 years, with international programming in 30-40 countries per year in service for just over a decade.

Regarding the Center's direct service programs, emergency services are offered for populations of large displacement. Specific operations include work in Jordan with Iraqi refugees and now Syrian, Dadaab camp in Northern Kenya, Nairobi with urban population, Ethiopia with Eritrean refugees, and this past year in DRC, Sierra Leone, and others. Typical international operations include the provision of clinical experts in global mental health who provide training and support/supervision to local staff counselors.

The Center's ongoing training and clinical supervision includes international capacity building projects, as well as partnering with existing services on the ground to provide ongoing supervision of their services. In terms of capacity building, the Center's biggest project targets 10 organizations in the following countries: Cambodia, Sri Lanka, S. Africa, Liberia, Sierra Leone, Cameroon, Moldova, Georgia, Lebanon, Bosnia, and Uganda.

2. Presentations of War Trauma Foundation and War Child Holland

2.1. War Trauma Foundation Presentation *(slides are available at mhps.net)*

Speakers:

- **Relinde Reiffers:** history of founding WTF, current activities, the Caucasus' project
- **Iris van der Mark:** projects in Burundi and Sri-Lanka
- **Leslie Snider:** project in Northern Sudan and PFA Guide Initiative

Alison Schafer of WVI asked about committee follow up in Burundi, to which WTF responded that the follow-up includes home visits, connections with local authorities on certain issues, and linking with other local CBOs to carry on the programming.

Ananda Galapatti commented the mhps.net "PFA Adaptation and Training Group" portal is a public group open to all.

Leslie mentioned that currently WTF is updating case scenarios onto mhps.net and any good cases from outside are welcome to be added at the network website. Moreover, if anybody is interested in the projects of WTF or its products (such as PFA & Intervention), please, don't hesitate to contact WTF: <http://www.wartrauma.nl/>

2.2. War Child Presentation *(slides are available at mhps.net)*

Speakers: Endry van den Berg & Manal Eid

Endry van den Berg from War Child Holland and Manal Eid from War Child Lebanon presented on the "I Deal" intervention. They began with an interactive exercise called the "Walking Billboard" to introduce themselves to the group.

"Deals" is a life skills methodology for groups, begun in 2006. The presentation generated a variety of questions about child selection, linking to existing referral networks, whether the intervention was open to other agencies and issues of translation and cultural adaptability.

Children are selected from preexisting groups, divided into 30-50 children. War Child try to include as many groups of children as possible, including vulnerable children (this requires some selection). Community volunteers work with children after the initial group sessions in order to expand the programs reach.

Regarding referral systems, this is not part of the intervention itself. When a child is identified, they are linked to existing resources (part of the facilitator training). The program is not yet open to other agencies, for War Child is still amid pilot projects and research to ensure quality of impact. Hopefully by 2014 it will be available. Digital modules can be used currently.

In terms of cultural sensitivity and translation, much testing was conducted in addition to a quality and effectiveness study in process now. The model is also open to be adapted.

Translation until now has not been an issue for War Child, but rather a literal translation in various cultures has been used for Deals. Perhaps this will change over time, if there is a need..

Capacity building is part of the program and much input is needed for facilitators to feel comfortable. Even though the modules are fairly straightforward, it can be difficult to ensure quality among facilitators. One year of three full training cycles is normally invested prior to feeling comfortable with the facilitation.

The project occurs both during and after school hours, but more needs to be done with school authorities to ensure it becomes part of the curriculum. At times, children sacrifice their lunchtime or sport time for Deals, which is not recommended. There is a need for minimum standards in this regard. In Burundi, War Child is now collaborating with the Ministry of Education to incorporate Deals in the national school curriculum, but this is a big process.

In emergencies, Deals is working in 1) safe spaces, including educational programs, and, 2) structured recreational activities. Please see the website for more details of the intervention: www.warchildlearning.org/ideal

Endry mentioned that currently War Child is working on the concept “Deals go digital” which involves developing visual-audio solutions in order to reach children that can not be reached by current programs.

At the end an ice-breaking exercise from the deals program was facilitated.

Joint WTF and WarChild Presentation: *(slides are available at mhps.net)*

WTF and WarChild shared how they are coordinating projects in various countries and projects.

3. Update on emergencies in 2012

3.1. West Africa *(slides are available at mhps.net)*

Speakers: Megan McGrath (World Vision) & Cecile Marchand (UNICEF) & Saji Thomas (UNICEF)

Megan McGrath from WV Australia, Cecile Marchand from Unicef W. Africa, and Saji Thomas from Unicef HQ presented on the integrated approach of MHPSS in nutrition programming.

Guidelines “Care for Child Development” cards are available on www.mhps.net under the ‘Nutrition’ group. In terms of challenges, along with the ppt slide (see presentation), the team found it difficult to pin down who is responsible for integrating nutrition issues- there can be confusion between protection and psychosocial sections taking responsibility (particularly within UNICEF at the field level). Currently the nutrition cluster in Chad has taken ownership and clarified leadership, which is positive. Additionally, it has been difficult to have harmonization between countries working in this approach (8 or 9 countries total in the region).

UNICEF W Africa: Nothing was done for psychosocial support and nutrition in the region, which is why it was introduced. MHPSS is now an important priority for all sectors within UNICEF. There is no UNICEF skilled psychosocial specialist who can push MHPSS development in the region. It has also proven to be very difficult to find a French-speaking consultant who specialized in psychosocial support and nutrition. It took 6 months to find such an expert, and translation was needed in the end. This is one of the challenges and one of the lessons learned.

WV Australia: Megan presented an intervention related to stimulation of a brain development in malnourished children. Specifically, she referred to the impact malnutrition has on brain development, and how it affects the relationship between child and caregiver. The mental health of the caregiver can also suffer during a food crisis. It can lead directly to an inability to care for the child and an inability to emotionally stimulate the child. She gave an example of a therapeutic feeding center in Chad where women and children were waiting passively for long time in the queue. It was recognized as a good opportunity to organize some safe spaces and activities for women and children. In addition, Megan presented UNICEF guidelines on Emotional and physical stimulation of the child in order to support child development; a UNICEF Early Childhood Development Guide for therapeutic centers or CF Spaces; ideas for making toys from locally available materials and ideas for games which can be easily organized by caregivers. If anyone is interested in these guidelines, they can be provided on request from Cecile. Megan also commented on the success of the posters at the therapeutic centers highlighting positive communication with malnourished children. Megan referred to some harmful traditional practices in Chad, which are having an impact on the psychosocial wellbeing of children, and also harmful practices specifically around the problem of malnutrition. While these issues are slowly being addressed, more education is needed.

Saji Thomas (UNICEF HQ):

Saji made the following observations:

1. Inter-sectoral integration: Most sectors don't understand the need for integration of MHPSS and don't see the link between MHPSS and other areas of intervention. Although the MHPSS guidelines exist there is a need to communicate better with other sectors.
2. We have to try to make MHPSS regulations operational in local contexts and also define how they work in a specific context.
3. The mental health component in MHPSS guidelines is lacking. Sometimes specialists say the guidelines are about social work, and others refer to mental health. There is a gap there. Saji sees the need to elaborate on "specialized care" and make it clear to people in the field.

Sarah Harrison commented that there exists a great amount of guidance on Nutrition and MHPSS, but few people are trained globally, and, in particular, there is a need for languages other than English. We need to do more as a group to work on increasing the capacity. A

member of the Group suggested designing a training course, while another shared that language is the main problem, not the staffing capacity. We must develop a training module in French, for example, to open the door for greater capacity and dissemination. A suggestion was made to link with nutrition cluster to, encourage the incorporation of PSS into their work. **Sarah will be responsible for making this link.**

3.2. Syria *(slides are available at mhps.net)*

Speaker: Constanze Quosh (UNHCR)

Constanze Quosh from UNHCR presented on the IDP situation in Syria. She mentioned specifically 3 phases of displacement: 1. Temporary displacement from villages (and returning), 2. Urban displacement (to Aleppo and Damascus) 3. Moving out of the urban centers. It is difficult to follow up these trends in the response. Constanze briefly introduced the Syrian humanitarian response plan June 2012 (*can be found here: <http://data.unhcr.org/syrianrefugees/uploads/SyriaRRP.pdf>*).

UNHCR is developing an intensive training tool to serve as a follow-up to PFA. The situation in Syria represents a prolonged emergency, and PFA alone is not sufficient. The UNHCR team is learning that as services go mobile, more issues need to be considered (i.e. which services to mobilize, how to create safe space within mobile centers, etc.). A global mental health review is ongoing, with a methodology built on a broad literature review with eight case studies. By the end of 2012, MHPSS guidelines for refugees operations will be finalized. Constanze feels that there is a need to develop issues of best practice beyond the guidelines, and she suggested exploring how to collect and develop these practices during the meeting. She also mentioned that differences in MHPSS terminology within the MHPSS working group may be a reason why UNHCR can be perceived as paying little attention to MHPSS issues.

3.3. Jordan & Lebanon *(slides are available at mhps.net)*

Speakers: Zeinab Hijazi & Inka Weissbecker (International Medical Corps)

Inka Weissbecker and Zeinab Hijazi presented on the Syrian refugee response efforts by IMC. In Jordan, IMC is responding to the needs of Iraqi refugees, and they have increased their programme to include Syrian refugees. IMC co-chairs the MHPSS sub-working group in Jordan along with UNHCR. IMC conducted a rapid mental health and psychosocial assessment in Za'atari Camp for Syrian refugees, and results can be found on mhps.net under the Syria response/ Jordan group. This camp started with 500 people, but now there are several thousand, with the capacity to host 20,000. Zeinab briefly presented the results: 50% of camp residents experience some psychological distress. Assessment included the questions about general problems people experienced in the camp and the results indicated that problems were related to camp conditions (lack of water & electricity; sandy and dusty settings) as opposed to their situation of being displaced. A lot of anxiety and worries are about other relatives and friends in Syria. There was a question on what are camp residents doing in order to cope with stress and what they usually practiced in Syria as coping strategies. The results showed that

people can do majority of the activities they did before, but difficulties included the lack of a call to prayer to indicate the time to pray, and this was suggested as an improvement to camp management. In January, an additional assessment was conducted in host communities looking at symptoms of mental health problems. The results of the assessments can be found at mhps.net.

In Lebanon, Syrians are not yet called refugees, but are integrated into host communities. The Ministry of Social Affairs handles all incoming/outgoing services for initiatives with Syrian “guests.” Inka presented on the initiation of the MHPSS sub-working group in Lebanon.

Responses from the Group opened into a larger discussion of MHPSS terminology and potential misuse of words and concepts such as “trauma” and “traumatized.” Mark Van Ommeren from WHO commented that in his opinion the language is ideology. Ideology should not be so important, but rather the content of interventions. We have to be interested more in the indicators of the success of the intervention. Several participants were strongly opposed to this, and felt that terminology affects our actions and programmes. Therefore, we have to be clear. The discussion continued to include programming and the focus on content of interventions, specifically that ideology is reflected in the work. To outsiders, MHPSS and therapy are assumed to be the same, which is not true. We, as a working group, need to be clear about our own definition of trauma and other MHPSS terms, as it also relates to coordination.

It was also raised, however, that therapy is in fact an aspect of mental health, if only a part. Leslie Snider from WTF suggested that perhaps we’re looking at the issue from the wrong angle, that perhaps we haven’t accurately defined the word for ourselves. We need to engage with the concept and articulate it more accurately to others, so they don’t see us agitate about the term without understanding why. Ananda Galapatti from MHPSS Network shared that the term does communicate something specific, and it’s not surprising that it’s used, but we must do our best not to do false advertising. Tonka Eibs from CARE suggested that indeed we should be clearer why we have issues with the word “trauma”, but there are still larger issues at stake: organizations with no PSS background entering a response environment with a psychologist and claiming it as good practice. Another issue is with donors who just wish to tick numbers, who are not concerned about processes. There is still much more work to be done in this regard. **This issue was placed in the parking lot for further discussion.**

Another concern is that often coordination MHPSS meetings miss the main goal of coordination and pursuing best practice implementation, but rather meet just to meet and network with potential donors. Additionally, these meetings can be a vehicle for the spreading of poor language/terminology. IMC are pleased with the trajectory of coordination meetings in Jordan and Lebanon respectively, but it’s understood that work needs to be done to look at issues at a deeper level, promoting the use of existing guidelines and advocating for these among the “big players” (i.e. UNICEF, WHO, IOM). This issue may not be with the working group specifically, but rather with how the group links with other groups.

Nancy Baron from GPSI-Cairo as well as Guglielmo Schininà from International Organization for Migration raised a question regarding why the decisions of IASC MHPSS Reference group are not reaching project proposals. Kathy Angi from ACT Alliance suggested that networks of NGOs may be more interested in therapy than MHPSS because (specifically North American network of NGOs), since donor agencies are more focused on other areas such as therapy.

4. CCCM and MHPSS booklet

Speaker: Guglielmo Schininà (International Organization for Migration)

Guglielmo Schininà presented the CCCM-MHPSS booklet, which highlights what CCCM actors need to know regarding integrating MHPSS into camp management in emergencies. The writing of this manual/tool has been a two-year process with ACT preparing the first draft and IOM finalizing this current draft. The CCCM cluster and other agencies will approve the final draft in November. The presentation was to solicit recommendations and agreement on specific areas as follows:

- Political point about the booklet: by approving the booklet, the CCCM cluster agrees that there will always be a PSS focal point in the group, as part of essential support staff. The TOR of this focal point is as follows: 1) to provide advice to the Cluster in terms of site design and management; 2) to organise PFA support, adherence to “do no harm” principles, and ensure basic PSS understanding in CCCM response; and 3) to act as a liaison between CCCM and MHPSS working group.
- The document was written taking into consideration existing guidelines for all emergency response such as Sphere standards, Norwegian Refugee Council guidelines, etc. The activities were prioritized according to the pyramid of intervention in the MHPSS guidelines.
- Debatable issues:
 - We train people to do something that we think is important, rather than asking the community to decide what skills they want to contribute.
 - 3.2.3. Religious approaches which “may be unhelpful” are discouraged. Sarah Harrison suggests using a protection word there instead of the current language; the UNHCR protection manual reflects a similar issue. However, leaving out specific examples may not be clear enough. Leslie Snider suggests the spiritual section in the PFA guide. **Alison Schafer from WVI is tasked to make this suggestion to Guglielmo by Thursday.**
- The tool focuses on the immediate aftermath of a crisis; not camps after three years of existence. The best way to respond is through the mobilization of multidisciplinary PSS teams (social workers, etc)
- The tool states that only agencies with capacity to work over the mid- to long-term will be allowed in the camp. Mark Van Ommeren from WHO responded that this leaves out

MSF. Leslie Snider suggests rephrasing this statement to say, “Encourage those who can stay for the long term.”

- The booklet states that management should avoid creating parallel services based on a single diagnosis such as trauma centers, so as not to create a fragmented system. The Group requested also to rephrase this to say “encourage holistic services.” The original language may be too MHPSS specific for a camp management team to take on board.
- The tool states, “It’s recognized that most individual PSS interventions that have been studied have been seen to be effective in predominantly Western situations.” Nancy Baron from GPSI commented that most of these interventions have not been studied; this is incorrect. Mark Van Ommeren agreed, stating that current research has found PSS interventions as being effective outside the West. Top experts evaluating interventions tell us that more likely than not these interventions work just as well outside the West. Western techniques are found to be effective and positive in other settings.
- Nancy Baron suggested the point that the intervention needs to be sensitive to all cultures.
- In terms of HR, “psychosocial” and “cultural animation” was deleted. Many in the Group did not know the term “cultural animation.” “Social worker” is a possible translation. Alison Schafer recommended adding “or the equivalent” in the list, so to make it relevant in many contexts. Leslie Snider suggested adding “anthropology”, and Guglielmo translated ‘cultural animator’ as “education”. Many in the Group feel that “education” opens the door a little too much, and it’s better to keep “or the equivalent”.
- An additional training tool was presented by IOM (*RG members to contact Gulli at IOM if they require the tool*). The tool was successfully tested in Burundi and Columbia. It consists of very simple drawings that illustrate all points of guidelines with very simple actions to be taken.
- **Feedback from Mark and Alison are due to Guglielmo by Thursday morning.**

5. Community based services for (non-)specialised support *(slides are available at mhpss.net)*

Speakers: Constanze Quosh (UNHCR) and Mark Jordans (HealthNet TPO)

Mark presented on focused, non-specialized interventions (non-clinical treatment of people with moderate and severe problems), while Constanze presented on community based PSS and safe spaces outreach. Details can be found on the power point presentations. UNHCR carried out a mapping before implementation, which mapped available resources and capacities in the community. Constanze highlighted the evaluation of the project, specifically that pre- and post-evaluations are continually resulting in improved well-being, specifically on the social dimension of the intervention. Particularly those individuals accessing a combination of services (i.e. coming to the center, receiving an outreach visitor in the home, and receiving specialized care) display further benefits from participation. UNHCR is trying to link specific needs to causes,

in order to be more precise. They are trying to link the most appropriate activity to the beneficiary profile. UNHCR is developing training materials to be shared at end of the two-week intensive training, which detail the dimensions of running a PSS or safe space program. **Constanze is happy to share these modules with anyone who is interested once they are finalised.** The success of the project is because of the attention given to participatory planning, which ensures attention is given to sensitive dynamics and sustainability.

Content of Day 2:

1. Advocacy & Donor engagement
2. MHPSS.net
3. Session on MH Case Management standards
4. Session on Psychological First Aid
5. Intervention journal

1. Advocacy & Donor engagement *(slides are available at mhpss.net)*

Speakers: Endry van den Berg & Eamonn Hanson (War Child Holland)

Eamonn Hanson (Global Advocacy Advisor) and Endry van den Berg from War Child presented on advocacy and donor engagement, which involves moving forward from the MHPSS advocacy campaign led previously by UNICEF. Eamonn raised the question: Are we on the right track to increase ownership, interest, and commitment to MHPSS on behalf of governments and donors? After presenting the concepts of advocacy, the Group was divided into three smaller groups to address 1) Communities, 2) Civil Society and International Organizations, and 3) Government, UN, and Donor Agencies. Within these groups, challenges and solutions were identified, and solutions prioritized in terms of urgency.

Saji Thomas (UNICEF) asked for an update from Sarah Harrison on the MHPSS RG- Donor liaison activities planned for 2012. Little was done last year, apart from individual agencies taking it on their own initiative (e.g., WV Aus with AusAid, ACF with ECHO, ACT with Sida).

Small group outcomes:

1. UN/Govt/Donors Group
 - Challenge: Continue promoting MHPSS considerations in emergency response, and then promote the guidelines. Highlight that food, shelter, and water when delivered without PS considerations can inadvertently make things worse.
 - Solutions:
 - Develop an advocacy-ready package such as a glossy brochure, a 3 minute video, and perhaps online content on mhpss.net for agencies to use
 - The co-chairs of the RG to keep up to date with what agencies are doing with what donors, and who the key contacts are,
 - Try to get people into key strategy and development meetings of their various institutions/ organisations

- We all need to be consistent in our own organizations and include guidelines and policies internally in our own proposals and in communication to donors

2. Civil Society Group

Challenge: Inclusion of MPHSS guidelines, policies and practice

- Solutions:
 - Capacity building is important
 - Show the ability (i.e. impact) of civil society staff to apply MHPSS guidelines in practice, in different contexts by different organizations.
 - Tool/guide to communicate to CBO staff in a clear way which is more than a training document, a commitment on an organizational level is needed
 - Prepare introduction materials for new staff of agencies who may not be familiar with previous initiatives or the key focus
 - Update the current advocacy package, as it needs definition.

3. Communities

Challenge: Community members, as individuals and groups, need to recognize their role as active agents in the system.

- Solutions
 - Awareness: Increased awareness on the impact of emergencies on people and how they deal with the situation.
 - Self-care ability: Increased ability to take care of oneself and others (PFA), how we can contribute to resilience, as first responders
 - Accountability: Importance of knowing the standards of communities, and holding service providers accountable to these standards
 - Integration: Integrating MHPSS issues into Emergency Preparedness Plans rather than a stand-alone plan
- Discussions stemming from this presentation focused on the knowledge of communities regarding key issues so they can hold us accountable. Many feel that communities wouldn't know these terms. It was mentioned that we, as a group, don't want to underestimate the community's ability to take in this information about MHPSS, for perhaps some communities already have a paradigm for this approach. It could be useful in this idea of them recognizing themselves as agents and holders of knowledge. Important to work with communities beforehand with key messages, allowing them to take ownership in this process of change that occurs in crisis situations, from awareness to integration.

If anyone is interested in following the area of advocacy, either taking the lead or participating in a smaller group, **please speak with Ruth**. This will also be discussed later in the week, all are welcome to join. The issue of advocacy needs to be part of the workplan for 2013.

At the conclusion, there was a presentation of a 30-second video from SEWW (Society for Emotional Wellbeing Worldwide, pronounced "sew") at SEWW.org. This was an example of how to use social media and multimedia to recruit members and advocate for mental health.

2. MHPSS.net

Speakers: Ananda Galappatti (MHPSS Network) & Alison Strang (Institute for International Health and Development, Queen Margaret University Edinburgh)

Alison Strang and Ananda Galappatti presented on mhps.net site, which launched a new version of their website in July 2011 following building on feedback from the initial website launched in early 2010. They outlined a number of new developments, including profiling resources on the home page to make them more visible. It was requested to have a directory of the resource bank, which can be continually updated. Ananda displayed statistics on how the site is being used. Much has been learned in the process of establishing the website, particularly as it relates to content flow. The site managers are also learning how to best interact with other forms of social media (FB, LinkedIn, Twitter, etc.)

The site will introduce a multiple language interface over the next few months. Cecile Marchand from Unicef West Africa mentioned that they are willing to support the translation of documents into French. It was also noted that there is a need for resources specifically in times of emergency, which requires a person at the other end to respond immediately.

A variety of discussions followed this presentation. It was felt that mhps.net is a great resource, yet it's still not well known by field personnel, and perhaps there needs to be a strategy to reach out to organizations. This is mainly an issue of resources, as there is a communication strategy defining how organizations can potentially have customized portals. It was also suggested that a peer review mechanism or section for reviewing emerging tools and guidelines etc. would be very interesting. Ananda is looking to members of the RG to provide input in this area, and also to the broader academic field. It could be a fantastic opportunity for individuals in this group to ensure the MHPSS guidelines are reflected in proposals under development.

Regarding the website usage as an internal tool for organizational use, it was stated that it may be easier to promote as public information, rather than an internal tool. At the same time, organizations would benefit from moving away from sharing materials and information with a membership of only private groups to increase exposure. It was suggested that the website could solicit fees for specific services, contributing to Master level courses. Ananda stated they are thinking about ways in which fundraising could contribute to sustainability, as long as it does not prohibit accessibility.

The presenters agreed that it is not intended for this website to grow into an empire in itself. They suggested that various groups can perform hosting functions to keep it active, thereby allowing more communities to get involved.

Ananda and Alison stated that one area of potential growth is the "Vacancies" portal, which hasn't yet fully taken off. This is a platform for the advertising of vacancies, channeling into a central database. Agencies need to send vacancies to mhps.net in order to access the service

(which is cumbersome). ReliefWeb is the usual search engine for humanitarian positions, however, it is not conducive to highlighting MHPSS positions for job seekers. Ann Willhoite suggested mhps.net could somehow be linked to reliefweb for fluidity in services and searching. Ananda responded that this would require negotiations with reliefweb, but it's a good idea. Vacancies posted on mhps.net are also currently posted on Facebook and LinkedIn.

3. Session on MH Case Management standards

Speakers: Zaineb Hijazi (IMC) & Constanze Quosh (UNHCR)

Case Management MHPSS

- Training material is currently being standardized by IMC. Staff members are trained on basic counseling, PFA, and community based mental health, and IMC conducts various refresher trainings in these areas, based on field needs.
- UNHCR has developed standard operational procedures for Case Management
- Where is the case manager sitting? Starting in UNHCR office, during emergency so many people are coming to UNHCR, directly receiving clients there. This is necessary to estimate population size and define catchment areas. Within these catchment areas, defined PHC clinics, so now integrated into the PHC setting (for sustainability and best flow of services). Also in health services, able to catch individuals who wouldn't have been identified at UNHCR.
- Interactive Session with 3 groups, on what etc. etc.

4. PFA (Psychological First Aid) Sarah

Speakers: Leslie Snider (War Trauma Foundation)

The presentation was facilitated as if it were a training course itself, experiential and interactive for TOT purposes. She began by asking, "What do you think of when you see the term Psychological First Aid?" and responses were written on the flip chart.

The group then participated in a Simulation exercise where half the group was given roles as first responders, and the other half were survivors of an earthquake.

The trainer emphasized that the simulation can often bring up emotions for those helping or for the facilitator, and this is important to know. Additionally, as facilitator you must know your audience, as the situation can change accordingly. The purpose of the simulation at the beginning of the training is to set the stage for the day of experiential learning.

A series of questions were asked to encourage people to think about PFA and where it is appropriate. Who can benefit from PFA? Who may need more support than PFA alone? When would you provide PFA? Where would you provide PFA? For example, what if someone had been raped; where would you provide PFA? (When facilitating, be aware that some discussions may take a long time (i.e. gender issues, privacy issues, etc)).

Following a group activity, the group was reminded that what is seen as “good” communication is different depending on the context, and it is important to define what is “good” and “bad” communication as it may vary.

Recap: Facilitation guide is a four-hour training. Leslie walked through the remaining slides where there wasn't time to address the remaining principles of PFA. If the facilitator encourages role-plays early on in the training, much of the issues in the remaining slides from the training are already addressed. See PPT for more details of the training, and note that there is a PFA group on MHPSS.net.

5. Intervention journal

Speakers: Peter Ventevogel (HealthNet TPO and WTF) & Simon van den Berg (War Trauma Foundation)

Marieke Schouten, president of WTF introduced this session by reminding the Group why we get involved in this work, linking to the purpose of the Intervention Journal, which is celebrating 10 years, as well as War Trauma Foundation, 15 years, and the MHPSS Guidelines, 5 years. Marieke thanked Peter and Simon for their work with Intervention Journal.

Peter (editor-in-chief of Intervention Journal) introduced the journal and explained the rationale behind it. Workers in the field did not have a platform to share and learn: this was the initial purpose of the Journal. Targeted groups include policy makers, researchers, and practitioners. Peter shared the organizations who have supported the Journal in the past, requesting others to consider supporting. With more funding, the Journal can develop further and continue to fill the need in both the academic and practical fields. Simon shared what has been accomplished in the past 10 years.

Discussion following the presentation started with Saji Thomas, stating that UNICEF would be willing to discuss partnership with special issue in 2013, specifically on the theme of the integration of mental health in existing systems of care. Financially, a special issue costs between 30,000 and 40,000 Euros, and UNHCR supports with small grants of 10,000 Euros annually- this is a great help to the journal, enabling Intervention to routinely publish special issues.

The group expressed gratitude to Peter for the journal on an academic level and suggested a continued focus on impact. Neal Porter asked if Intervention would be open to articles highlighting services from higher-income nations, for example, highlighting treatment of individuals coming from areas of armed conflict and who have resettled. Peter stated that this work has been less present in the last decade and he would not necessarily encourage it because these cases can be published in the general psychological journals. He continued, by saying that while it is appropriate to publish articles on treatment in high-income settings, the content should be relevant for low-income settings. Peter wants to ensure that voices who are not always heard have a voice. Nancy Baron suggested the use of voice for the website, in order

to capture stories from the field. This would allow people to share their story. **Ananda commented that he will think about this idea and respond after speaking with technical individuals.** He further stated that it would need to be simple enough visually, with contributions by MHPSS members who would serve as vehicles to promote the voice of others.

An audience member commented that often field persons have interesting content to share with Intervention, but don't have the time or knowledge to share properly. He encouraged the Group to target people like this, helping them to write or encouraging these people to share. Work from such individuals would be welcome (**please send to info@intervention.com**).

Content of Day 3:

1. Publications & Products update
2. MHPSS in Urban environments – update on Cairo conference
3. MHPSS Update
4. Workplan 2012 and Planning for 2013

1. Publications & Products Update

Ruth O'Connell shared that funding has been an issue over this past year, and the Group is currently looking for €2,500 Euros to fund the MHPSS reference group's rapid assessment tool (formatting, and editing) Additionally, she's delighted that ISBN numbers have been identified, thanks to IMC Lebanon who facilitated acquiring these numbers from the Ministry of Culture. This will enable us to publish our documents on the WHO website.

Mark Van Ommeren (WHO) presented on the past year's publications (*slides are available at mhps.net*):

- *Mental health and psychosocial support for conflict-related sexual violence: principles and interventions*. This is the result of a meeting organized by a multiple UN agencies (WHO, UNFPA, and UNICEF) on behalf of United Nations Action against Sexual Violence in Conflict (UNAction) on 28-30 November 2011. The article exists in both English and French.
- *Mental health and psychosocial support for conflict-related sexual violence: 10 myths*. (available in English and French)
- *Do's and don'ts in community-based psychosocial support for sexual violence survivors in conflict-affected settings*. (available in English and French)
- *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings* (pre-publication version). A few years ago the WHO decided to collaborate with UNHCR to create an assessment toolkit. The 4Ws are included, as well as sectorial qualitative toolkits.
- *Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes* (same guide, new cover photo). There are no plans for printing the tool, but it will be accessible on the WHO website as soon as an ISBN number is acquired. A version of this document is currently on mhps.net with examples of how it's used in other countries (**All are encouraged to join the group to access this document**). The tool has been used in Jordan, Syria, Libya, and Kenya (in Dadaab camp). There is great value in this tool, not just as an exercise in itself, as it can

produce outcomes to improve coordination. In Jordan, for example, agencies use results to strategize, usually a few months before the CAP appeal to truly inform planning. The tool is also helpful to assess to establish if it is appropriate to intervene.

Mark also touched on the HESPER (The Humanitarian Emergency Settings Perceived Needs Scale) Scale, used by the IASC Taskforce and Needs Assessment reference group as a base for MIRA (Multi-Cluster Initial Rapid Needs Assessment). It is the only assessment at this time concerned with reliability. The HESPER Scale was created to determine the role of trauma and perceived needs. A newly published paper in the British Journal of Psychiatry addressed this issue, titled, "Role of current perceived needs in explaining the association between past trauma exposure and distress in humanitarian settings in Jordan and Nepal," written by Mark Jordans from HealthNet TPO. **This paper will be circulated among the reference group.**

Inka Weissbecker (IMC) presented on the mhGAP tool, specific to stress (SPE-STRESS). See ppt presentation for more details (*slides are available at mhps.net*). Within this stress response model, the majority of the recommendations were for adults, while recommendations for children are limited by research. Discussions arose about how to present this information weighted so to balance the recommendations. Indeed, as Inka shared, there is a base for recommendation (either strong or standard) with a table of criteria outlining rationale for these criteria, including risk benefit rationale. More information on mhGAP exists on mhps.net including strength indicators. This presentation is not yet ready for dissemination, for it is too easy for misinterpretation. With regard to the limited recommendations for dissociation, a question arose about how to move forward with this issue. Mark responded that no one has completed a trial on conversion disorder until now, so a lack of quality evidence exists; there is some guidance, but no formal recommendations. WHO will make a humanitarian version of mhGAP that will be for clinicians, but the agency is looking in the direction of how to address community workers who can possibly be trained in mhGAP. Developing materials in this regard is part of the agency's vision.

Saji Thomas presented on the UNICEF-led evaluation tool, developed in conjunction with Columbia University: *Inter-Agency Guideline to the Evaluation of Psychosocial Programming in Humanitarian Crises*. Development of this tool began two years ago, but it was never formally launched. Although approved by many agencies individually within the RG, the tool was not formally endorsed by the IASC reference group, mainly because it was heavily focused on children and adolescents. Saji wanted to gather information from the Group about the tool's accessibility and usage, and how to best move forward with the tool, if there's interest. Generally speaking, the group was aware of the tool, but it wasn't being widely used, most likely because it initially came out around the time of the Haiti earthquake. The Group expressed interest in further dissemination, feeling that it will possibly be more relevant now than when first distributed. UNICEF is willing to print and distribute, but the Group felt it would be time and money better spent to first translate, and then disseminate in soft copy (printing isn't as desirable). **Action Point: Saji will focus on translation in Arabic, French, and Spanish (initially), while distributing it in soft copy to all UNICEF offices (as a smaller file). If there is**

still desire and funding later, printing will be considered. Additionally, Saji presented on specific tools in development by UNICEF:

- Unicef is working on three main projects regarding child friendly spaces:
 1. Revision of interagency guidelines on CFS. This is online (“field testing version”);
 2. CFS training package: This is a work on behalf of the Child Protection Working Group to incorporate “all that is out there on CFS” together into one place. Although focused on CFS, it can apply to all safe space programming. It is not clear whether it will include mobile safe spaces. Recommendations will be made to the child protection working group regarding involvement of agencies who may be interested in joining (it is an open group);
 3. Checklist for field workers in CFS in the process of being developed;
- Unicef project (over 4 years) on peace building, led by the Education Cluster. This project released an ad yesterday for agency involvement, specifically requesting input in PSS. This project will be initiated in 14 countries.
- Unicef is developing a manual on Child Protection for Religious Leaders. It is not currently at a stage to share,
- Unicef Child and Adolescent Kit is being developed at the headquarters level for use in all emergency settings, with a focus in psychosocial interventions such as arts, recreation, and activities. This is different from the recreation kits and others; it contains more guidance on implementation. **If anyone is using other kits in emergencies, please share with Saji** This project is led by the Child Protection Working Group.

Ananda Galappatti shared that CEDAW (Convention for the Elimination of all forms of Discrimination against Women) is considering funding a general recommendation around conflict. **The MHPSS Reference Group may want to consider making a submission of proposal to this appeal, or perhaps agencies would consider making a contribution through DAWN.**

Leslie Snider added to yesterday’s PFA presentation that it’s possible to do a two hour training course, including simulation and group work. Additionally, a facilitator’s guide has been developed for PFA, yet it needs feedback from the Reference Group. Included in the guide is how to set things up, tips for facilitation, tips for participatory learning, etc. with step-by-step facilitation with optional exercises if time exists. Additionally, all supporting material is at the end of the guide. **Leslie requests feedback from the Reference Group. If willing to provide feedback, request a soft copy from Ruth and responses can go to Leslie.**

2. MHPSS in Urban environments – update on Cairo conference

Speaker: Nancy Baron (GPSI-Cairo) (*slides are available at mhpss.net*)

Nancy’ presentation was about her own work with urban refugees and migrants in Cairo and the content of this year’s conference on MHPSS in urban settings which was organized in April in Cairo.

A special focus of presentation was on the analysis of relevance of the existing MHPSS in emergencies guidelines in an urban context.

UNHCR developed a policy on refugee protection and solutions in urban areas (available here: <http://www.unhcr.org/refworld/docid/4ab8e7f72.html>). The policy promotes a rights-based approach and includes two principal objectives:

- to ensure that cities are recognized as legitimate places for refugees to reside and exercise the rights to which they are entitled
- to maximize the protection space available to urban refugees and the humanitarian organizations that support them.

Nancy has underlined that more protection space of refugees leads to their rights and needs being met.

Nancy began with a simulation exercise aimed at encouraging the participants to feel what it is like to have to flee. Nancy emphasised that many urban refugees experience long journeys often accompanied by violent incidents, torture, rape, and other human rights abuses.

Life as a refugee begins as an acute situation but rarely is short term. In 2010, 197,600 refugees were able to return home. It is the lowest number since 1990. Therefore, the refugee population is basically a long-term population.

Urban Refugees: Cairo

More and more people are moving to urban settings, which includes refugees also. Among 10,5 million global refugee population 50% live in urban cities and 33% are living in camps.

The population of Cairo is 20 million people. One year ago there was a revolution in Cairo, which changed political and ideological trajectory of the society. The demonstrations are on going everywhere in the country.

Egypt is very poor country; therefore national people don't welcome refugees. Cairo has a refugee population of 35000 people (excluding Palestinians). Often children of refugees are not welcome at school, which leads to their living on the streets.

Nancy runs the Psychosocial Services and Training Institute in Cairo, designed to train specialists from different organizations and sent them back with a new knowledge and expertise. Now there is a functioning network and people are connected. There is a Case management system in place in the PSTI.

Nancy's target audience are the poorest of the refugee community, who face problems such as lack of housing, food; protection & security issues; growing crime problem on the streets, etc.

One of the biggest challenges is the relationship with the Government, which denies the existence of refugees. There are no services for refugee population on behalf of the government. The situation of the refugee population leads to violence, risk-taking behavior,

and community conflict, etc. More information on the target groups of the Nancy's Institute can be accessed on mhps.net.

Cairo Conference

Nancy presented the Cairo conference in April 2012 "A Growing Challenge: Psychosocial and Mental Health Support for Refugees and Migrants living in urban settings". The goal of the conference was to create a space where field experts could share their experiences Nancy has presented the programme of the conference, which dealt with MHPSS in the urban environment. More information can be found on MHPSS.net

The conference participants explored a wide range of published research relating to urban refugees (for example, research of the American University in Cairo Center for Migration and Refugee Studies), existing guidelines, and the results of conducted assessments (specifically in Libya and Egypt). The issues of integration between national and refugee populations, as well as problems of refugee generation born in a host country were reviewed. Special attention was given to the topic of managing community conflicts in urban refugee populations, which is an emerging issue due to the political character of displacement. Nancy mentioned that common language, culture or religion do not guarantee support within refugee community. She also mentioned that in camps, populations often move as a group and live together, but in urban settings different languages and cultures may be all together in overcrowded situations.

Nancy asked the members of Reference group who attended the conference in April to give their feedback to highlight the most important issues. This included that it was interesting to see different models from different regions of the world. Also, the idea of necessity of differentiation in programming for populations moved from traumatic settings to safer areas, and those who continue to live in areas affected by protracted crisis was questioned. Other participants added that it was useful to visit some work locations and have the possibility to talk to psychosocial workers to know better their experiences and problems. It was commented that the majority of these workers were in fact good humanitarian workers, and not necessarily with MHPSS background, and that mainstreaming MHPSS considerations within educational programmes for humanitarian workers is an important issue. For UNHCR, it was interesting to see what perception people have about UNHCR and its role as well as applicability of Middle East experience to the situation of urban refugees in other parts of the world.

Best Practices' Guide

One of the most important issues raised by Nancy was her desire to collect best practices for MHPSS for emergency response for refugees in urban settings. She asked the Reference Group for assistance with approving documents in order to answer the following questions:: What to include? Who is interested in participating? Should it be a published guide/ manual? How to fund publication?

In response, members of Reference groups gave their suggestions as follows:

Nancy has suggested the option of publishing a collection of good case studies in a special edition of Intervention. Leslie (WTF) on behalf of Peter and WTF has replied that they are happy to offer Intervention as a platform.

Mark from WHO brought an example of a WHO guide which included the collection of 10 case studies, selected on the basis that the "best" cases should include some numerical data in order to quantify the results of interventions ("not just a good story"). One of participants has suggested that generalization can be a good criterion for selection, as it means that the proposed cases can be used in other settings. Guglielmo commented that before developing guidelines, it is important to give a definition of the notion "urban refugee" (viz-a-viz mixed migration patterns). In addition, he said that refugees in most of countries are entitled to certain services and each country has different system of mental services provision for migrants. So it is important to take into consideration the legal system of the specific country. Leslie commented that when you are choosing case studies you already think that some issues are important and have to be addressed in case studies. **Nancy has summarized that the "best" practices have to include definitions, legal considerations, and structured format with indicators and given analysis.**

Other comments were related to the offer to cooperate with UNICEF and UN Habitat and their initiative to disseminate knowledge on good examples of interventions for refugees in urban settings, UNHCR's interest to compare case management systems in urban settings in different regions, inclusion of urban focus in other clusters, and gender perspectives in the provision of PSS for urban refugee population (which is specifically interesting for UNICEF).

Saji stated that the use of the term "best practices" can be quite dangerous and suggested to use "promising practices" or "guiding notes".

Regarding the question of a decision making body and participating actors, should it be agencies, NGOs, IASC, etc.? Guglielmo commented that a lot of the issues of assistance of refugees in urban settings are not only emergency related, and this may cause difficulties if a broader group of humanitarian actors are invited to participate. It was reiterated that guidelines are meant to be a product of IASC, it must be linked to the IASC guidelines.

Nancy announced that she will lead a group to work further on this idea of guidelines. There is also a plan to organize the second conference in 2013 in Cairo. In the meantime, she is planning to have a draft version of discussed issues and some articles.

3. MHPSS Update *(slides are available at mhpss.net)*

Mark van Ommeren: WHO/ICD definitions of PTSD, complex PTSD, prolonged grief disorder and acute stress reaction; Disorders Specifically related to Stress: Developments for ICD-11

The presentation by Mark has yet to be approved. WHO uses the International Classification of Diseases (ICD) as a diagnostic tool, as opposed to the Diagnostic and Statistical Manual for Mental Disorders, (DSM – originating in the USA) for all mental health diagnoses. As we all know, this is a very hot discussion in psychiatry. Both the DSM and the ICD are under revision. Forthcoming editions are DSM-V and ICD-11. WHO—and Mark specifically—has been pushing quite hard to change the terminology from “stress-related disorders,” to “disorders specifically associate with stress.” Clinical utility is the deciding factor of what goes into the ICD or DSM, for complexity is not always useful. From his presentation arose comments about ICD and its utility, specifically, how an agency should decide which method to choose (i.e. ICD or DSM). Mark shared that each agency can choose for itself, but WHO uses ICD if the agency is interested in coordinating best with WHO. The problem is that different countries use different methods, but IOM shared that national laws will not necessarily deter an agency from a desired method, for all in that agency will join the broader method, regardless of national laws in this regard. It was also asked about the role of helplessness, and Mark shared that it has no effect on PTSD, so it was dropped from the diagnosis.

Cecile Bizouerne ACF, World Association of Infant Mental Health (WAIMH)

Cecile presented on WAIMH (see ppt for more details) and concluded by asking the group if they would like to get involved in WAIMH in the future. Megan McGrath (WVI) has been in discussion with WAIMH, and WVI is interested in coordinating in this regard. Inka (IMC) commented that IMC does a lot of early childhood development initiatives in emergencies, and the agency would also be interested in coordinating. **Action Point: If individuals/agencies are interested, contact Ruth.**

In terms of behavior change and sensitization in the field, Cecile presented on this topic and mentioned that it has become an issue of concern. Unfortunately, this issue of behaviour change is often pushed in certain ways by donors, specifically encouraging poor behaviour change communication methods that may counter psychosocial wellbeing. While an agency can move forward with these methods and perhaps gain a large number of beneficiaries (e.g. radio messaging), there is a problem in the ideology of behavior change itself. ACF has begun creating a manual (one section theoretical and one section practical) to look at barriers and psychosocial issues in behavioral change approaches (this is not only on awareness campaigns). Cecile is interested to know if others have experienced similar situations and are interested in addressing problematic issues in behavior change programming. Tonka Eibs (CARE) expressed interest in this discussion, also advocating for a handbook released by Food for the Hungry International entitled “Barriers Analysis,” which outlines factors that could impede the process. The ACF manual being developed is not just for emergencies, but it is certainly humanitarian in nature. Neal Porter (CVT) recommended ACF to request suggestions from the many NGOs working in BCC in terms of sexual behavior and HIV; their experience may be informative. Sarah Harrison suggested linking with those working in HIV, such as REPSSI.

Maria Bray Tdh:

Capacity Building and Personal Competencies; Working with Children and their Environment

Maria presented on the approach of Tdh and the organizational process to establish systems and frameworks for psychosocial *approaches* and *interventions*. The Tdh manual covers: 1) personal and social skills, and 2) methodological and technical skills (e.g. games and sports with children). The purpose is to reflect upon the core skills gained from practice, specifically to link skills with practice from the field, and to develop specialists in each Tdh delegation. She facilitated the Reference Group in two interactive exercises. Tdh is now trying to incorporate protection and psychosocial as an integrated approach. The manual ([Working with Children and their Environment](#)) is on the Tdh website, in addition to a small handbook called [Traditional Games for Child Protection](#).

Cecile Marchand (UNICEF) made an announcement: for all NGOs in the room working in West and Central Africa (emergency and non-emergency), to please send a brief email to Cecile at cmarchand@unicef.org with details of their projects, including exact location. Next week there will be a large child protection meeting in the region and it will be important to link people. This information will also be useful for mapping.

4. Workplan 2012 and planning for 2013: Ruth

Ruth presented the workplan for 2012 and went through the activities in order to determine which have been achieved. (See 2012 workplan for more details, on mhpss.net). Ruth mentioned that we are dropping the focal points activity, as there has been no interest. Alison Schafer commented that this has been a challenge for the past three years. The issue of advocating with donors was also unmet, and takes time. The success with WV Australia and AusAID this year was a result of two years of effort to incorporate PSS into their framework. In terms of donor funding from ECHO, Guglie asked the Group if anyone had received funding from them in the past two years, specifically in PSS. It seems they have shifted their approach to MH and away from PSS for the time being. Others in the Group comment that they have received funding from ECHO, and perhaps it depends on the region.

Action Point: If an agency has money allocated to coordination at the field level, email the chairs of the respective MHPSS WGs at field level and copy Sarah who will follow up.

Discussion about the role of the Reference Group in 2013

The current co chairs have been in position for two years, Ruth O'Connell funded by UNICEF, WV Australia and IFRC, and Sarah Harrison, supported by ACT Alliance. Both UNICEF and ACT are no longer in a position to support a co chair position for 2013, and it was acknowledged that they, as well as WVI and IFRC have been very supportive and engaged so far, and that the group could not have continued without their support.

Saji Thomas (UNICEF) spoke about the specific changes that will take place in 2013 and had some proposals for the group. Unicef is committed and very happy with the work of the Reference Group over the past years. He gave much credit to Ruth and Sarah in this regard. UNICEF feels that rather than supporting one person in the role of chair, perhaps the time of one of the chairs could be spent on achieving specific deliverables (which fit in with UNICEF

work plans), which could be funded by UNICEF through consultancies. If it is done at an interagency level and if there's commitment from other agencies, UNICEF can find funding on a deliverable by deliverable basis, with Saji taking on the role of co chair in addition to his other work. UNICEF is not washing its hands of responsibility, but there should be another way to take things forward. Funds are shrinking; the RG is relatively small in the global picture, and it does not have cluster status, which would make it easier to fund. Saji reminded the group that other RGs operate in the manner that Saji proposed. UNICEF sees this as an opportunity to test the commitment of agencies in this RG, and encourage creative solutions. The following discussion ensued:

- The current positions are funded until the end of December
- Based on the co-chairs' experience over the past 2 years, what is the exact role of the position and needs of the members? What often comes up from the field that requires someone to respond? This should require the type of support you give (not the budget driving the support). Sarah and Ruth responded that it has been a full time job which has required the co chair to deploy to support emergencies on occasion (funded by ACT), Lots of phone call support, liaison and work with clusters, lobbying work for MHPSS, bureaucracy as well as hands-on support, and the normal important work based on continuity/ development of relationships.
- WVI raised the concern that it would be difficult to track existing networks if there is no chair of the group. People here are connected who may not be otherwise. Also as an NGO, the facilitation between NGO and UN may not be fostered. People coming and going will not support the network. During a rapid onset emergency, this network is functional quickly. Without such support, at the field level this will take too long. Without a focal point person, there's a lack of continuity and limited communication
- WTF: This past week produced an interesting and fruitful dialogue on the application of guidelines and what it means when you translate this into practice. It's as critical now as it was a few years ago to have this kind of presence and leadership in the group
- MHPSS Network: The MHPSS RG is a powerful and unique forum for agencies to come together and discuss a variety of issues. The level of cooperation is remarkable, thanks to the trust and efforts of the co-chairs
- IMC: as co-chair of the WG in Lebanon, Sarah (based in the region at the time) was very supportive. Having this is very important for people in the field
- IOM: There are still things that have been missing in the structure of the RG/leadership. The relationship with higher coordination bodies (e.g. OCHA) needs improvement. The possibility of the person to be deployed quickly may be risked if an inexperienced person is deployed. There may be a risk of coordination that's perhaps driven by an organization's interest (rather than the RG) if a single agency or organization funds the position. Having an independent person who can be deployed to validate the system with the higher coordination mechanisms is important. That's what nice about the co-chairs is that no one is prioritized over another. The best way to solve is to have an NGO appointed to do only coordination all over the world. An NGO rep in itself cannot prioritize coordination over the NGO's agenda

- MHPSS.net: Much of the responsibility of the co-chairs is challenging the global powers. Having a UN agency responsible would perhaps be better than an NGO
- ACF: Regarding the functioning of other clusters, it is useful to have a senior person who can be deployed immediately. The advantage of a cluster is that it is backed by a UN agency. It is different with the MHPSS.RG because there is no lead agency responsible
- CARE: Wonderful looking at what this workshop has produced and enabled us to share together, and congratulations. We need to plan for the longer term for advocacy and perhaps accountability
- IOM: if MHPSS is included in cross cutting issues, perhaps some funding can come from the humanitarian coordinator himself? WHO: perhaps, not sure. Also remember the battle of MHPSS to be a crosscutting issue has been very difficult. Probably won't go from 4 to 10...we're not the only group contending for this
- The possibility of each organization contributing to the overall cost of the co chair was discussed, either on a sliding scale or divide by 30. Some agencies felt this would be prohibitive, while others felt it might make a "hierarchy" of membership- ie, if one organization does not contribute, would they still have a voice?
- The discussion moved to writing proposals to secure funding. The group were reminded that in order to seek institutional funding, an agency is needed to act as "host" for the funds, and also to submit the proposal. The RG is not able to manage funds or submit proposals. This also rules out private foundations, as the RG is not an "entity" as such, but rather a collection of organisations with an independent chair
- Option: 1. Divide the cost of the co-chairs among the agencies, 2. Find private donor, or 3. Ask UNICEF to take on 10% and try to fund the rest through specific individuals contributing deliverables to the work plan
- ACT/ Church of Sweden: We risk losing the whole thing with the 3rd option. It is useful to have one UN and one INGO affiliated co-chair leading this group. Perhaps it is possible for others to help co-fund, and it is not only a matter of finance, but finding suitable co-chairs. Perhaps an organisation cannot afford to pay, but may have a person suitable to do the work. It is helpful to have two people in this position
- UNICEF suggested two solutions: solution 1) agencies to step in with funds and personnel, and 2) pool of people who could represent the RG in emergency responses. Must be creative in solutions.
- Ruth O'Connell: Last year we started shifting to deploying co-chairs in emergency in response to requests from RG members. The co chair position takes time, and it is difficult to release existing staff for this
- UNICEF: It's a funding issue, can't set aside resources for something that *might* happen, and MHPSS.net commented that emergencies are inevitable. WTF felt that there are many crises brewing and now would be the time to justify setting aside money for responding
- IOM asked what the budget was and suggested that there must be an agency that can take the role. Ruth O'Connell reminded the group that before looking at the budget, the role of the co chair needs to be established as it has been evolving

- WVI: asked for clarification on the feelings of the group, and their wish to continue to have the group chaired by an independent representative?
- WHO: One year RG was led by WHO and UNICEF, and both co chairs went to Gaza with their own agencies. It was difficult to both work for the RG and their respective agencies, but as a way of resolving the issue of lack of co chair, it functioned. The co chair does not have to be independent
- UNICEF: There is a need to make the activities of the group operational, and UNICEF would be able to support this as opposed to what it sees as solely HR costs. (Currently.) Is it possible to combine all agencies' implementation operations?
- ACF: In response to the suggestion to contribute \$5,000, ACF cannot, (Neither can CARE) and feel that it is unrealistic to expect agencies to be able to do so. The co chair role is also important for advocacy; is not just about tools, but to have someone who is representing many organizations is important
- IOM: Role of the co-chair is 1) advocacy, 2) relationships/linking NGOs and UN, higher agencies, and 3) able to deploy quickly to start up and validate coordination systems;
- MHPSS.net: MHPSS.net networking platform will have a funded post for an emergencies host for the next three years and may be able to play a role in the issue of quick deployment
- UNICEF: Raised the option of a steering committee of 7-9 people who could meet regularly through conference calls instead of the whole group meeting every year, as is currently the case. Two agencies could chair with the support of the steering committee and would be a test of the commitment to the RG. Some members felt that the annual meeting was too important to discard, and others felt that a steering committee would possibly create a hierarchical situation. The question was raised on how to ensure commitment of the steering committee
- IOM: if WHO is already working 20% on this issue, perhaps other people can negotiate with agencies to take on 5% of time for the RG;
- Plan International suggested piggy backing on one of the clusters, but it was pointed out that all other clusters are either not interested or don't have funding. There was also a political decision not to link with other clusters in order to maintain neutrality
- UNICEF: reiterated that they (Saji) will take on the role of chair in conjunction with another agency, although he was unable to say how much time he could commit on top of his already heavy workload
- MHPSS.net: may be best to specify the options in terms of functions, time allocation, and funding. Then we can decide which functions to drop
- Ruth O'Connell: membership should be by agency, not person. Must get institutional buy-in in this regard
- IMC: IMC would have no funds to contribute since we don't have unrestricted funds. We are open to looking at other possibilities of assisting, such as writing and submitting proposals to donors. We are committed and also overworked, but if there is a committee, we'd be happy to be part of this. We take on quite a bit of coordination in the field, any way we can assist, we'd be willing

- IOM: can provide working space for a person in Geneva, can be embedded. No problem to be involved in steering committee. 5,000 also won't be a problem.
- **Action points: Sarah and Ruth will draft up details of options, an approx budget for the Co-Chair position and outline Co-Chair tasks for dissemination to the group**

Content of Day 4:

1. Priority Deliverables for MHPSS in the coming two years
2. Small Group Discussions about top three priority areas for 2013-2014
3. Discussion on the involvement in Emergency response
4. Co-Chair Discussion, Options

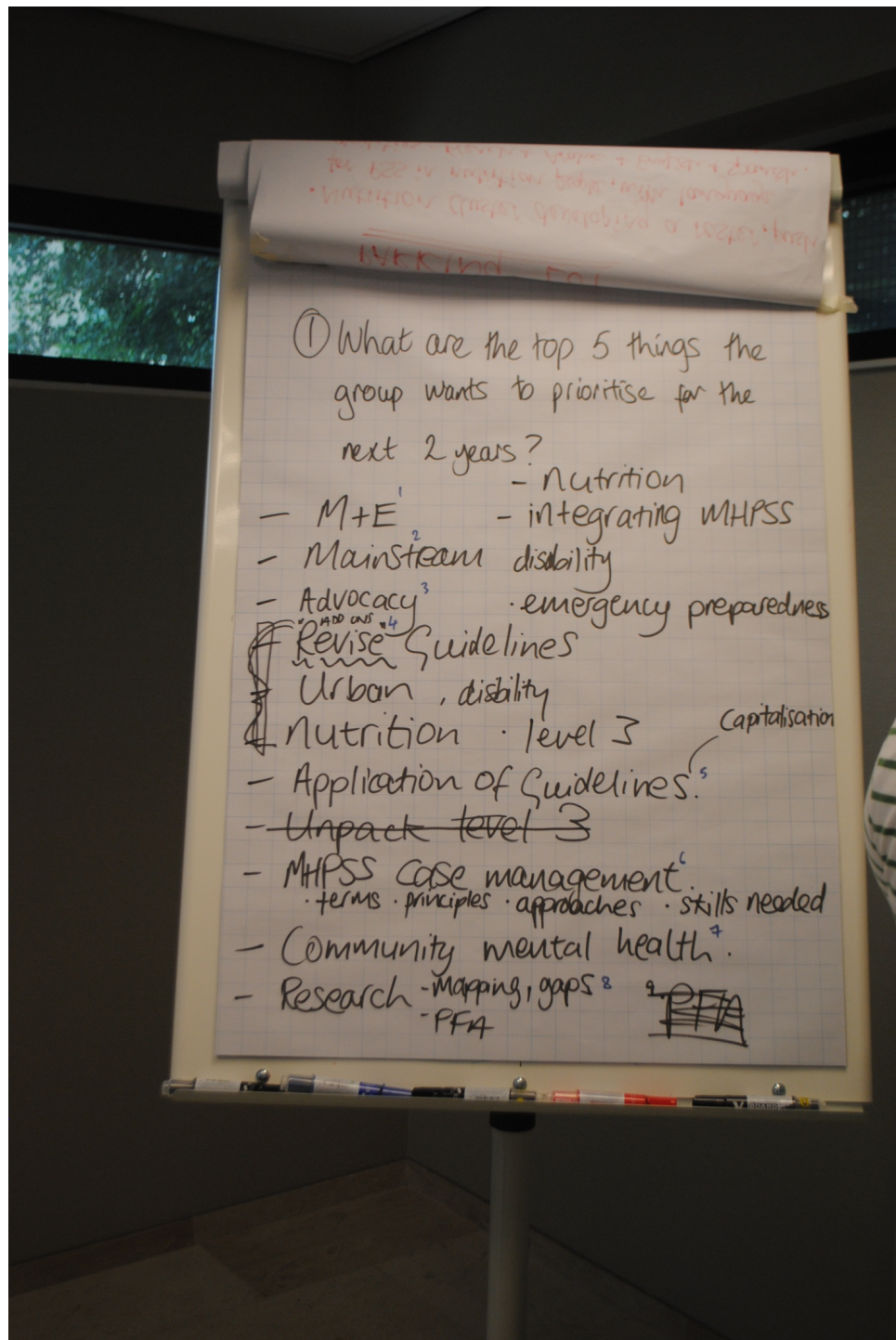
1. Priority Deliverables for MHPSS in the coming two years

The top 5 priorities for 2013 were discussed in light of the funding situation; normally the workplan for the coming year would be planned activity by activity. The morning was spent looking at key deliverables that the RG would like to achieve in the coming two years, eventually prioritizing the top three. The group took an initial look at the items in the Parking Lot that had accumulated from the week:

- Nutrition cluster developing a roster, push for PSS in nutrition people, with language abilities – French, Arabic, English, and Spanish
- Training programmes for MHPSS in nutrition to disseminate the guidelines and manuals
- Coordination mechanism as a vehicle to advocate for best practice (standards/language/etc). How to liaise with management/higher levels. Need to stop repeating mistakes
- Trauma as a concept. Need to explain, explore, publish activities
- Roster of camp manager and PSS people that can be deployed in rapid onset emergencies
- Myanmar: an emergency that nobody cares about (i.e. what is the role of the RG and the co-chairs in some of those emergencies where only one person is working, what responsibilities should the chair take on? To push people to go into certain roles?)
- Level 3 pyramid Gap. How can we as a RG clarify what should fit into this gap and document it (use/map/evaluated programs)
- MHPSS in Urban settings documentation
- Revising guidelines
- PFA

Brainstorming session on deliverables for the coming two years, in no particular order of priority:

- Revision of guidelines, specifically the development of an accompanying guidance document to include 1) integration of urban issues, disability, and nutrition; and 2) lessons learned or review of how the guidelines have been implemented over the past five years. This will be delegated to the co-chair as a 6-month deliverable. (It was noted that if this is added to the workplan, it will become a consultancy).
- In-depth look at how agencies apply MHPSS guidelines in practice, and gather best practices and/or field application procedures.
- It was suggested to prioritize M&E, specifically impact assessment on MHPSS programming, to look at what we already have and not develop new tools.
- Development of a common terminology to describe case management and then define principles and approaches, develop a document on required skills
- An accompanying document to further unpack Level Three in the intervention pyramid
- Explore issues around community mental health, specifically to address mechanisms, approaches, and how can we support communities where no access to primary health care exists. Perhaps this area can be combined with the conversation of urban spaces, or even Level Three
- Emergency preparedness
- The need for deliverables was again reiterated in light of the need to source funding from donors and UNICEF. If we create an action plan with very specific deliverables, this will enable us to find support for “programming” as opposed to “coordination.”



Priority Deliverables for MHPSS in the coming two years based on the initial brainstorm above:

1. **Research; also M&E in terms of application:** 21 votes
2. **“Add on” or mainstream into guidelines (nutrition, urban settings, disability, level 3):** 15 votes
3. **Advocacy: donors, clusters, OCHA/CERF:** 13 votes
4. **MHPSS case management:** 11 votes

5. Community Mental Health: 5 votes
6. "Taking stock": 5-year review of guideline applications: 1 vote

Continuing discussion following this vote

- Nancy Baron stated that the case management people are going to move forward in delivering this anyway, so it's not necessary to have it as a RG activity. It will be done and we'll report back to the group.

2. Small Group Discussions to further break down top three priority areas for 2013-2014

1. Research/M&E/Impact Deliverables

Plan of actions:

- To establish a steering/working group (including people with research experience + those who are interested) -> create a relevant group on www.mhpss.net.
- To create a special learning space and a data base at www.mhpss.net to collect updates on on-going research and M&E materials (according to specific regions) -> the group asked participants to discuss with their agencies publishing/ sharing rights in order to be able to share and disseminate information. There is also an option at www.mhpss.net to publish materials with restricted access. The data for data base will be collected by workers hired to support www.mhpss.net platform (info form Ananda), however, it is necessary to do follow up and decide how this information is going to be used after being collected.
- Mapping of research and M&E processes (as well as gaps) among the agencies of the reference group. To map area of interests and plan future research, reinforce existing linkages with academic institutions. It was suggested to map the relationships, co-operation and engagement with academic & research institutions. This mapping can be simply done as an excel sheet. Else has suggested doing this mapping on the different levels of the pyramid.
- To develop practical impact indicators which people can routinely use to look particularly at the different levels. The group has asked if anybody has even 1 indicator which seems to be good measuring tool, send it to Leslie (WTF)/Mark (WHO)/Ananda (MHPSS.net) and it can be published.
- Looking for specific operational funding for research and new linkages with research/academic institutions & universities;
- Coordination function of co-chairs remains key issue: co-chairs are responsible for contacting reference group' actors and monitor what is being done in this respect

Guidelines Integration/Additions Deliverables

1. Produce fact sheets on disability, working in urban contexts, pyramid level 3 interventions linked to IASC guidelines; Fact sheets need to link to best practice, translate into application
2. Emergency preparedness: include section on disaster risk management, include MHPSS elements into emergency preparedness
3. Key agencies doing these types of work (urban, nutrition, etc) need to present what they need from the guidelines and what is missing from them, in order to ensure relevance
4. **** (Regarding Level 3, it frequently overlaps with levels 2 or 4; the conversation started in terms of what to do after PFA, for example. **The consensus is that this group will not focus on Level 3, in terms of developing a fact sheet and application deliverables.**)**

Advocacy Deliverables

1. Advocacy towards donors – the chair coordinates this process, asking respective agencies for help when necessary.
2. Advocacy towards humanitarian response system – the chair monitors what is happening
3. Internal Advocacy, while mainstreaming towards professional, academic, and civil society communities – role of different agencies, with co-chair collecting this data
4. Fundraising and advocating on behalf of RG – facilitated by a steering committee or group

Deliverables for advocacy include the following

- a. Mapping relevant contacts
- b. Newsletter to target these people with key facts, reader-friendly
- c. Relevant meetings

The chair's role is to pool all information together, to give other agencies information about practices; not a monitoring role.

This group also discussed RG membership in terms of advocating for the guidelines, and centered on how to encourage people to follow the guidelines, deciding that the RG cannot police member organizations. MHPSS RG can only be inclusive. It is hoped that it will be a self-selective process

3. Discussion on the involvement of the MHPSS RG Co Chairs in Emergency response

The group was asked what level of support should be provided by the co chairs in an emergency- remote support, deployment, technical support in what manner?

The following points were made:

- Coordination is very important, and can be overlooked or subsumed by an agency's own mandate. (Coordination is not a deliverable) It is important to have someone who is aware of the key issues and concerns, and who is impartial and able to coordinate from a neutral position. But should this be the co chair?
- WHO: Operationally, it is necessary to create a structured list of what is to be achieved on the ground. Coordination is important in these contexts, but the outputs do not clarify if it's actually helpful. If the purpose is to go and set up coordination and leave again, then is too thin- where is the sustainability?
- IMC: What is the function of a coordination group? Disseminating guidelines to donors and agencies on the ground? Or the enforcement of IASC principles and practice.

The idea of a roster was discussed, and a solution was suggested where a donor pre funds a number of emergencies. The co chair is responsible for deploying or supporting someone who is already there to coordinate. We have a large network of people who can respond. This would also move beyond an individual approach and make the group responsible for decisions on what emergency to support etc. The co chairs are not expected to be consultants to groups in the field. Regarding a roster, who can deploy? It needs to be set up in advance to save time. Clear guidelines need to be developed by the group.

- ACF: When there is an emergency, we're all fighting for resources. It's not easy to work with a roster because of interagency agendas. It's better to have one person from each agency delegated to deploy, rather than calling up everyone on the roster in an emergency. This is an issue of capacity for NGOs who will lose a person.
- Sarah Harrison explained the classification of emergencies currently used under the IASC Transformative agenda to dictate response time etc. Emergencies are classified in 3 levels. Level 3 is a mass scale like Haiti where senior level cluster leads deploy in 24 hours. UN country teams and the Humanitarian Coordinator have a lot more responsibility and power in first 3 months to take decisions on behalf of humanitarian community. In a Level 2 emergency of a lesser scale, the Humanitarian Coordinator has less control and decision-making power early on. This authority and decision of deployment can stay within agencies. Level 1 emergencies are protracted crises. In a Level 3 emergency, a chair would be deployed. Levels 2 and 1 would be open for using a roster and working out the mechanics of this. The main challenge is if a level 3 emergency occurs, there will always be a RG representative on the ground since many agencies will be present. Sarah is more concerned about a Level 2 emergency (e.g., Horn of Africa and Sahel drought based crises) when it's not so clear who will be present. This is perhaps a bigger issue.
- Nancy Baron: Level 3 is essentially quality control. It is clear that someone will get sent in these emergencies, but it may not be the best person. Can we ask these agencies with funding that when the decision is made to send, that the decision is vetted within the RG?

- UNICEF: The roster for the RG is about people meeting certain qualifications, and who goes on the roster is our decision. We can train individuals, as well.
- Sarah Harrison: The difference with GBV and CP rosters, the co-chair manages who's on the roster, deciding when they deploy, etc. We don't have that in this group (management). The rapid response team positions are also funded by specific agencies e.g., SAVE, RedR and DRC.
- IOM: This becomes an administrative issue for the RG; we are not a cluster. Perhaps a solution is to include in the guidance of the different clusters that there should be a person from MHPSS involved.
- Mark Van Ommeren: The clusters would agree with you, specifically that they are the ones in charge. At the same time, MHPSS is not of very high importance within the cluster system- we are a cross cutting issue. In practice, this is difficult
- Mark Van Ommeren: If you allow that, all advocacy as a cross-cutting issue will be undermined.
- Alison Schafer: Let's remember that the role of the co-chair isn't just in times of emergency. We identified many other roles this morning.

4. Co-Chair Discussion, Options: Discussion on the role of co-chairs in the work of Reference group

General tasks of co-chairs besides coordination were outlined- a document will be sent to the group outlining the tasks in full.

Therefore, an impact will be different. Nancy has suggested making it as a plan B if there is no money for co-chairs available after 2 month.

Three options have been decided upon, and members have been asked to consider which are possible.

1. Divide the cost of the co chair position/ positions among agencies
2. Find a private donor
3. UNICEF to contribute 10% of the costs, the rest to be achieved through individuals contributing to the workplan deliverables

A steering committee is necessary for options 1 and 3. There are still 3 months of funding remaining.

- IOM: possible for IOM to assist with funding the first option, while also provide a location/desk in Geneva, which IOM feel is important- Geneva is a central location for liaising with clusters etc.

WTF: Marieke Schouten: War Trauma Foundation would be interested in looking further at the possibility of supporting a co chair, perhaps through matching funds or hosting. This was seen as a very positive development. The larger network group part of WTF could also benefit. They will consult with other agencies in The Netherlands.

Funding as discussed, including the timeframe of potential donors. WTF suggested that funding could be perhaps sourced in April more easily if the co chair position could be funded for the first quarter of 2013.

Action: Within one week from now, Ruth and Sarah will come up with a budget for the co-chair position. Everyone in the RG will go back to their agencies with this budget and determine how much/ if they can contribute. A conference call will be arranged to see how much funding is available.

A **steering committee** for the short term has been established, including the following agencies: **IOM, Unicef, IMC, WVAus, WTF**

Action: Steering committee needs to convene and discuss approaching proposal writing for key donors/foundations. Co-Chairs will then arrange a conference call for RG in November to discuss progress. Sarah will call IFRC to determine their position in this matter.

- IMC: Regarding donors, the RG proposal would be difficult to sell currently, but IMC would be willing to assist in looking at how can we make it more fundable, such as connecting this work to emergency response, building capacity in MHPSS, distributing guidelines, etc. Funding for a co-chair could come out of this broader proposal.
- WV Australia: The research component may have some selling points, as well.
- MHPSS.net: We must look at our track record. Considering the co-chairs have been involved in some high emergencies over these past years proves there is need for this role.
- WHO: If there were money around for the co-chairs, I can think of a few agencies that would be interested in the co-chair position. It would mean high visibility for the organization, an interesting job, etc. Mark suggested IMC to take on the co-chair role, should funding surface.
- Nancy Baron: IMC already does the response and field level MHPSS coordination in many contexts. The problem is whether or not this can be considered, if they are the primary responders. Would the person be a neutral person who works for the whole group?
- WHO: This is a problem, but it's how it works in every cluster situation

Closing

Thanks to War Trauma Foundation and War Child for hosting, and ensuring the meeting was so successful. Thanks was also given to Ruth and Sarah for their work as co-chairs over these past two years.