HANDBOOK
OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) COORDINATION
HOW WAS THIS HANDBOOK DEVELOPED?

How was this handbook developed? Beginning in November 2020, the IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (IASC MHPSS RG) would like to sincerely thank and acknowledge the valuable inputs to this handbook received from the following agencies: Action Contre la Faim (ACF), Columbia University, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), the European Commission Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO), Humanity & Inclusion (HI), the IFRC Psychosocial Centre, International Medical Corps (IMC), the International Organization for Migration (IOM), Johns Hopkins University (JHU), Médicins du Monde (MdM), Médicaes del Mundo (MdM), the MHPSS Collaborative, MHPSS.net, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the Pan American Health Organization (PAHO), Save the Children, Terre des Hommes (TDH), the World Health Organization (WHO), the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA).

Several MHPSS Coordination groups active in emergency settings also donated their valuable time to developing, reviewing and strengthening this handbook. These include groups working in Afghanistan, Jordan, Libya, Myanmar, Northeast Nigeria, Trinidad and Tobago, Ukraine, Syria, and Yemen.

The IASC MHPSS RG also thanks and acknowledges the InkLink for innovative design of the document. For communication and to provide feedback on this publication, please email the IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings at: mhpss.refgroup@gmail.com

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# ABBREVIATIONS

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

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

Why is coordination important?

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

The 2007 IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings were key to enabling this advocacy by establishing the consensus-based composite term “mental health and psychosocial support”. The global humanitarian system now uses this term to unite a broad range of actors to provide appropriate support in both mental health and psychosocial support and to demonstrate how these approaches complement one another. The inclusion of MHPS as a cross-cutting area in the most recent iteration of the Sphere Handbook (2018) further highlights the need for diverse approaches across sectors.

Mental health and psychosocial support (MHPS)

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

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

Humanitarian MHPS coordination at its best:
- brings together diverse actors, with local humanitarian leadership and knowledge at the centre
- ensures a coherent, principled and sustainable response.

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

Many factors can be a barrier to coordination and can lead to ineffective, inefficient, duplicative and potentially harmful outcomes, including:
- limited funding
- differing agendas and time constraints
- structural challenges that lead to division and competition
- narrowly defined sectors and the risk of some being forgotten or ignored entirely
- lack of coherence across coordination groups for mental health and psychosocial support
- linking MHPS to only one sector or cluster.

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

Throughout this handbook, the term MHPS Technical Working Group (TWG) is used to represent the diversity of MHPS coordination structures, while the term “co-chair” is used to refer to the persons facilitating the work of these groups.

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

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

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

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

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

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

Chapter 1

Overall goal: to reduce suffering and improve mental health and psychosocial well-being
What is the purpose of this handbook?

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

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

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

It assumes that the reader is beginning with a basic knowledge of the IASC MHPSS Guidelines (2007). It also emphasizes the central role of local actors and affected people, who must be actively engaged and included in MHPSS coordination structures in doing this. Therefore, the guidance contained in this handbook must be considered with context in mind and must be adapted accordingly. Any adaptation must be done in collaboration with affected community members and relying on national and local expertise.

Ensuring MHPSS Coordination: recommendations from the humanitarian system

A number of calls have been made to establish MHPSS TWGs to facilitate coordination. These include
- IASC (2020). Joint Inter-agency Call for Action on MHPSS
- IASC Principals Meeting, 5 December 2019

- WHO, UNICEF, UNHCR and UNFPA. Minimum Services Package for MHPSS (MHPSS MSP)

The need for contextualization and cultural adaptation

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

What about the reader?

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

How should this handbook be used?

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

What this handbook is...

- A descriptive guide, based on lessons learned
- A brief, easy-to-read handbook
- An explanation of what factors facilitate effective MHPSS coordination, including possible steps to take to achieve this
- A resource for MHPSS coordination at country or local level

What this handbook is not!

- A set of prescriptive rules on how a TWG and its members (e.g. co-chairs) should be established across settings
- An exhaustive resource on how to address all challenges in the humanitarian system or within the MHPSS field
- A handbook informed by existing guidance
- A “step-by-step” guide for MHPSS programming or coordination in every setting
- A guide to coordination across regions or at the global level

THE PRINCIPLE OF LOCAL AGENCY

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

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

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


Overview of MHPSS in the Humanitarian System

What are the common humanitarian coordination structures?

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

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

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

Cluster Coordination
Clusters are formally activated in consultation with national governments. To identify if a cluster is active in a country, please visit UNHCR’s operational webpage.

Refugee Coordination
The United Nations High Commissioner for Refugees (UNHCR) facilitates coordination in refugee settings. For a list of settings where clusters are active, please visit the UNHCR webpage.

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

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

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

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

MHPSS in PHE Response

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

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

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

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

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

Humanitarian coordination / government leader

Inter-cluster Coordination Group

Health cluster

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

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

MHPSS Technical Working Groups
(with focal points in each of the clusters and with accountability in clusters, MHPSS activities to appear as relevant within Appeal chapters, rather than in a separate stand-alone Appeal chapter)
THE HUMANITARIAN PROGRAMME CYCLE (HPC):
COORDINATION OF RESPONSE IN CLUSTER SETTINGS

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

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

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

All HNOs and HRPs feed into the global humanitarian needs overview and response plans (GNHNOs, GHRRPs) produced by OCHA. These are crucial products for ensuring that MHPSS is comprehensively provided in cluster settings.

History and purpose of the IASC MHPSS Guidelines and Reference Group

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

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

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

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

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

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

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

MHPSS Surge Support

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

IASC MHPSS RESOURCES FOR COVID-19

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

1 For information on the humanitarian programme cycle, please visit: https://www.humanitarianresponse.info/en/programme-cycle/space
2 For more information on the IASC Guidelines on MHPSS, please visit: https://interagencystandingcommittee.org/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings/
documents/public/iasc-guideline-MHPSS
3 To see a full list of IASC MHPSS RG tools and guidance, please visit: https://interagencystandingcommittee.org/iasc-reference-group-on-mental-health-and-psychosocial-support-in-emergency-settings

IASC MHPSS RG members

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<th>Structure and numbers as per December 2022</th>
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<tbody>
<tr>
<td>Full members</td>
</tr>
<tr>
<td>Donor organizations</td>
</tr>
<tr>
<td>Observers</td>
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</table>

Contact: mhpss@rvo.nl
**Foundational Elements of MHPSS Coordination**

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

1. **Human rights and equity** should be promoted for all affected persons, and those at heightened risk of human rights violations should be protected.
2. **Participation** of local affected populations, national authorities and other local actors in all aspects of humanitarian response should be fully promoted.
3. **Do no harm** to affected persons through the support provided.
4. Build on available resources and capacities by engaging and working with local groups, supporting self-help and autonomy and building on existing resources.
5. **Integrate support systems** so that MHPSS is not a stand-alone programme operating outside other programming. Integrated services reach more people, are more sustainable and carry less stigma.
6. **Multi-layered supports** are crucial and acknowledge that people affected by crises respond in different ways and require different kinds of support (demonstrated in the pyramid below).

What are the foundational principles for MHPSS?

1. Competency and experience: Co-chairing requires a wide range of knowledge and competence in MHPSS. Past experience in MHPSS activities is also key for promoting buy-in from the group.
2. Operational in nature: While TWGs are ideally broadly inclusive groups, they should be co-chaired by agencies with an operational nature and focus.
3. Sharing the role: Optimally, TWGs are facilitated by two co-chairs with equal roles, responsibilities and influence.
4. Localization: Ideally, at least one TWG co-chair is a local staff member.
5. Linked with the IASC MHPSS RG: TWG co-chairs can seek support from and also contribute to the IASC MHPSS RG and its co-chairs.

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**Examples**

- Mental health care by mental health specialists (psychiatric nurses, psychologists, psychiatrists, etc.).
- Basic mental health care by primary health care doctors. Basic emotional and practical support by community workers, such as case management.
- Activating social networks. Supportive child-friendly spaces and women’s and girls’ safe spaces, and communal and traditional supports.
- Advocacy for basic services that are safe and socially appropriate and protect dignity.

---

**What are the foundations of an effective MHPSS TWG?**

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

- Promotes trust & honesty
- Inclusive & strategic leadership
- Reliable & responsive
- Open-minded / flexible
- Listens and communicates
- Builds relationships & networks
- Accountable
- Impartial & transparent
- Culturally & contextually sensitive
- Diplomatic & respectful
- Collaborative
- Welcomes diversity
- Humble

---

**WHAT MAKES AN EFFECTIVE TWG?**

**Key skills and characteristics**

- **Allocated time**: Co-chairing a TWG is a full-time position. Those appointed to the role should be prepared to fully allocate their time to the position.
- **Accountable to the TWG**: While co-chairs may be contracted by an agency, they should be accountable to the TWG.
- **Competency and experience**: Co-chairing requires a wide range of knowledge and competence in MHPSS. Past experience in MHPSS activities is also key for promoting buy-in from the group.
- **Operational in nature**: While TWGs are ideally broadly inclusive groups, they should be co-chaired by agencies with an operational nature and focus.
- **Sharing the role**: Optimally, TWGs are facilitated by two co-chairs with equal roles, responsibilities and influence.
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**Chapter 3**

**Foundational Elements of MHPSS Coordination**
### Foundational Elements of MHPSS Coordination

**Building consensus**

Understanding when it is important to build consensus around a decision is key to facilitating an effective MHPSS TWG. Consensus brings collective ownership and leads to more active engagement. However, reaching a consensus is complicated and time-consuming and can be difficult when there is a serious conflict. The IASC Guidelines (2007) can be a starting point for consensus, given their wide inter-agency endorsement.

However, in many situations, further consideration will be needed and, in some cases, it may be necessary to proceed without consensus. However, this has the potential to affect cooperation and relationships.

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

### POSSIBLE STEPS TO BUILDING CONSENSUS

<table>
<thead>
<tr>
<th>Possible Steps</th>
<th>Details</th>
<th>Role of MHPSS TWG co-chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agree on the objectives</td>
<td>All parties must agree on the goals</td>
<td>Facilitate the development of shared goals</td>
</tr>
<tr>
<td>2. Define the problem</td>
<td>Identify the barriers that stand in the way</td>
<td>Identify shared interests and differing perspectives</td>
</tr>
<tr>
<td>3. Brainstorm solutions</td>
<td>Brainstorming involves creating a list of possible solutions</td>
<td>Facilitate the identification of problems</td>
</tr>
<tr>
<td>4. Discuss pros and cons, narrow the list</td>
<td>Evaluate the potential solutions and reduce the list to realistic options</td>
<td>Facilitate the creation of a list of solutions</td>
</tr>
<tr>
<td>5. Adjust and compromise</td>
<td>Compromise will be needed to reach a result that the group can accept</td>
<td>Remain open-minded and focus on areas or ‘zones’ of agreement</td>
</tr>
<tr>
<td>6. Decide</td>
<td>Decision-making should be a shared process and should not be dictated. It can follow a standard agreed process (e.g. majority vote)</td>
<td>Facilitate a shared decision-making process</td>
</tr>
<tr>
<td>7. Act</td>
<td>MHPSS is recognized as a cross-cutting priority for action</td>
<td>Discuss the implications</td>
</tr>
<tr>
<td>8. Monitor &amp; evaluate</td>
<td>Always assess the decision’s impact and effectiveness</td>
<td>Facilitate monitoring and evaluation (M&amp;E)</td>
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<tr>
<td></td>
<td></td>
<td>Revise the decision, if necessary</td>
</tr>
</tbody>
</table>

### Tips and strategies for building collaborative leadership

- **Build relationships among group members:** What are their strengths? What about preferences for learning and working? Remember that all collaboration is facilitated through relationships.

- **Develop clear roles and responsibilities:** Are expectations clear? To whom are the group and its members accountable? Ensuring clarity in roles and responsibilities promotes collaboration.

- **Attend to group dynamics and power relations:** Why do organizations join the group? What are the benefits? Understanding these dynamics can help clarify group dynamics and motivations.

- **Be sensitive to group norms:** What does the group expect to happen? What are the implied rules? Group norms can greatly affect the functioning of the group.

- **Understand pressures on individuals to conform:** Are group members expected to think alike or think similarly? Conformity can be helpful or problematic, depending on the situation.

- **Harness group cohesiveness:** What factors help the group work well together? Emphasize how group members benefit from working toward shared goals, including agreed terms of reference (ToR), workplans or other strategic initiatives.

- **Seek input from each stakeholder:** Do any members seem excluded, including relevant actors not yet at the table? Does a certain agency dominate? Be sensitive to those who feel overshadowed and encourage participation.

- **Share decision-making:** Do group members feel a sense of collective ownership over decisions? Collaboration is promoted when decision-making power is shared from the beginning.

- **Instil a focus on the overall response:** Do members prioritize the overall response, or the agenda of their own organization? Multiple or divergent agendas can be a major barrier to collaboration.

- **Remain impartial, use active listening skills:** Test for agreement by summarizing ideas and asking for a vote. TIP: Groups can waste time talking “around” ideas they mostly agree with. Check levels of disagreement (i.e. “I cannot agree to this “vs. “I don’t like this, but I can go along with it”).

- **While consensus is important, co-chairs should recognize when groups are clearly divided and accept that consensus may emerge later.**

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Addressing common challenges

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

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

- **There is competition rather than collaboration**
  - ● Develop clear roles and responsibilities for agencies that focus on the overall effectiveness of the collective response.
  - ● When necessary, seek support in negotiation from high-level decision-makers.
  - ● Request technical support and guidance (e.g. from the IASC MHPSS RG).

- **Global guidance requires contextualization**
  - ● Hold workshops to adapt global guidance to the local context.
  - ● Budget and plan for adaptation needs.

- **MHPSS co-chair role is not budgeted as full-time**
  - ● Advocate for inter-agency funding to support the role and promote neutrality.
  - ● Identify challenges involved in serving in dual roles and advocate with line managers.

- **The group is less cohesive than ideally it could be**
  - ● Involve stakeholders from the beginning in developing or reshaping the group.
  - ● Take a collaborative leadership approach: rotate the chairing role, venues or topics.

- **Languages used exclude certain groups**
  - ● Alternate the languages used for meetings.
  - ● Budget for translation and interpretation.
  - ● Develop agendas with space for interpretation and the clarification of terminology.

- **There is a disconnect between national authorities and the MHPSS TGW**
  - ● Organize TWG meetings together with representatives from relevant ministry offices (e.g. the ministry of health (MoH)) to build buy-in. Try to alternate the venue if multiple ministries are involved (depending on local customs).
  - ● Engage in bilateral discussions with authorities, particularly on sensitive issues, in advance of raising such issues with larger groups.

- **Agencies do not see the benefit of the TWG**
  - ● Organize participatory evaluations, including stakeholders who do not attend TWG meetings, to find out how the TWG can improve.
  - ● Establish a clear plan with agreed and concrete objectives; re-examine if needed.
  - ● Sometimes, members do not actually benefit (e.g. from funding, from sharing data). It is essential to ensure that members do see returns from their contributions by ensuring that activities are mutually beneficial.
  - ● Organize quarterly presentations of MHPSS TWG achievements to highlight benefits.

- **High turnover among TWG representatives**
  - ● Develop a resource centre (see Core Action 2) that includes “mini-briefings” to orient new members.
  - ● Encourage agencies to delegate national staff members to the MHPSS TWG and advocate for delegates be appointed to fully represent the agency and make decisions.
**Negotiation and conflict management**

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

<table>
<thead>
<tr>
<th>Possible steps</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Recognize conflict</strong></td>
<td>Conflict is natural and can be constructive. However, conflict can also be destructive (e.g. name calling, reprisal). Sometimes, it can be obvious (e.g. yelling) and sometimes less clear (passivity, non-attendance).</td>
</tr>
<tr>
<td><strong>2 Engage stakeholders</strong></td>
<td>Certain members, or their host agencies, may be central to the conflict. <strong>TIP:</strong> Understanding participants can be a valuable first step. For example, understanding if a person tends to react to disagreement with anger can be key.</td>
</tr>
<tr>
<td><strong>3 Focus on core issues and needs</strong></td>
<td>Conflict can lead to a focus on past issues. Focusing on the issue at hand is essential.</td>
</tr>
<tr>
<td><strong>4 Draw out and consider each perspective</strong></td>
<td>It is important to ensure that each person’s view is heard and valued.</td>
</tr>
<tr>
<td><strong>5 Draw out suggestions for a path forward</strong></td>
<td>Encourage participants to share realistic solutions.</td>
</tr>
<tr>
<td><strong>6 Check for agreement or acceptance</strong></td>
<td>Sometimes not everyone will agree, but they may be willing to accept a solution.</td>
</tr>
<tr>
<td><strong>If agreement cannot be reached:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>7 Refocus on the goals of the group and on points of consensus (e.g. the IASC Guidelines)</strong></td>
<td>Disagreement can lead to real and negative outcomes for people in need.</td>
</tr>
<tr>
<td><strong>8 Review areas where there is agreement</strong></td>
<td>Identifying “zones” of agreement can lead to compromise. It can help to identify underlying values that motivate positions, and such discussions may clarify that there is more agreement than originally thought.</td>
</tr>
<tr>
<td><strong>9 Hold a majority vote</strong></td>
<td>A majority can be used to move forward.</td>
</tr>
<tr>
<td><strong>10 Act and evaluate</strong></td>
<td>Once a decision is made, evaluate it and revisit negotiations, if needed.</td>
</tr>
</tbody>
</table>

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

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

Each core action is split into four key sections:

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

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

Navigating the core actions

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

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

Core Action 1

**ESTABLISHING AND MAINTAINING A TECHNICAL WORKING GROUP**

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

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

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

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

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

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

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

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

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

**WHY IS THIS FUNCTION IMPORTANT?**

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

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

The added value of the group depends on the buy-in of its membership and the functioning of collaborative structures. From the outset, it is important that roles and responsibilities, coordination mechanisms and a shared vision for the group are developed and collectively owned. The MHPSS TWG must also be inclusive of the wide range of local, national and international MHPSS actors active in the response (see below and Core Action 3). As discussed in Chapter 2, some countries may already have functioning coordination systems.

**TIPS FOR EMPHASIZING LOCAL PARTICIPATION IN TWGs**

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


3 For further guidance related to the IASC system, please see: IASC. (2021). Strengthening Participation, Representation and Leadership of Local and National Actors in IASC Humanitarian Coordination Mechanisms
A functional MHPSS TWG is important to agree on a structure and purpose for the TWG to facilitate understanding of roles, accountabilities, objectives and timelines.

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

**TIPS**
- If developed, ToRs must be a tool for coordination and not an objective.
- Identify and address needs (e.g. accessibility, gender considerations, family responsibilities) in order to support participation.
- Facilitate regular discussions about service coordination across members.

**Develop a consensus-based way of working**
Whatever form it takes, it is important to agree on a structure and purpose for the TWG to facilitate understanding of roles, accountabilities, objectives and timelines.

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

**CO-CHAIRS’ ROLE**
Agree on meeting times and prepare agendas.

**TIPS**
- Set up and maintain a mailing list and shared drive of resources.
- Identify and address needs (e.g. accessibility, gender considerations, family responsibilities) in order to support participation.
- Facilitate regular discussions about service coordination across members.

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

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

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

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

**Case Study 1**
In Yemen, MHPSS coordination has been challenging due to issues with access to certain areas and the barriers these present for effectively organizing the response. An MHPSS TWG had previously been established in Aden, but due to practical and logistical challenges it became inactive for some time after its creation. In 2020, an MHPSS expert with prior experience of facilitating MHPSS TWGs was deployed to reestablish the group. In the initial days and weeks of re-engaging with partners, it became clear that the previous workplan and ToRs, though expertly written and developed, were too ambitious and had become impractical in dealing with the evolving situation on the ground. The members of the newly reformed MHPSS TWG set about revising the documents to emphasize more practical, and concrete and more simplified objectives and to clearly define roles and responsibilities. The group held a one-day brainstorming workshop where members identified needs, resources and priorities, all of which facilitated the development of a workplan and revision of the ToRs. Since this time, the MHPSS TWG has remained active through regular coordination meetings and has begun to carry out its workplan, facilitated by a clear sense of roles among members and a direction set out by these foundational efforts.

**Reducing power differences and facilitating participation**
Work to reduce competition for resources among TWG members and instead promote equitable participation.

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

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

**Resources**
For additional resources to support implementation of this core action, please see Annex 14.
Information management (IM) includes the collection, analysis and dissemination of information to guide decisions. IM supports MHPSS actors in developing a shared understanding of the situation and what is needed in response. MHPSS IM does not simply mean performing an activity, such as producing a 4Ws mapping or assessment report. Rather, it is an ongoing process to inform priority setting. A wide range of methods can be used for effective and systematic MHPSS IM. Deciding the scope, what tools to use and how frequently activities are performed will depend upon contextual needs and resources. Ideally, MHPSS TWGs should have the resources and capacity for a dedicated MHPSS IM officer or team with the requisite skill set. However, in reality is that MHPSS TWGs do not often have dedicated IM officers and tend to rely on member agencies or on overburdened and under-resourced co-chairs for IM. Therefore, it is crucial that only essential information is collected and managed. Information should also be assessed for quality, rather than assumed to be useful.

MHPSS.net is a key resource for MHPSS IM, and regularly publishes emergency briefings in an effort to help fill the information gap.

WHY IS THIS FUNCTION IMPORTANT?

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

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

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

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

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

MHPSS expert deployed in Gaza emergency response

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

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

- **CO-CHAIRS’ ROLE**
  - Facilitate discussion to build consensus on the scope of IM needs.
- **TIP**
  - Facilitate identification of an MHPPS IM focal point within the TWC. In ideal situations, the TWC should have a dedicated IM officer to liaise with other IM teams.

**STEP 2. IDENTIFY EXISTING INFORMATION**

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

- **CO-CHAIRS’ ROLE**
  - Liaise with stakeholders to identify existing information.
- **TIP**
  - Review, or support reviewing, the existing sources of data.

**STEP 3. DEVELOP AND MAINTAIN A RESOURCE CENTRE**

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

- **CO-CHAIRS’ ROLE**
  - Support the collation, sharing and regular updating of information held by the resource centre.
- **TIP**
  - Use mapping/gap analysis results to inform service coordination meetings.

**STEP 4. COORDINATE MAPPING AND ANALYSIS OF GAPS**

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

- **CO-CHAIRS’ ROLE**
  - Advocate for the inclusion of MHPS in multi-sectoral needs assessments and work planning.
- **TIP**
  - Avoid asking too many questions; less is always more.

**STEP 5. COORDINATE NEEDS ASSESSMENTS**

Incorporating MHPPS considerations into single or multi-sectoral assessments is key to informing the response and promoting the cross-sectoral integration of MHPPS. The WHO/UNHCR MHPPS Tool can be used to identify key MHPPS questions (see Annex 10 for further guidance).

- **CO-CHAIRS’ ROLE**
  - Facilitate regular discussion of information needs and gathering.

**STEP 6. DISSEMINATE INFORMATION AND LESSONS LEARNED**

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

- **CO-CHAIRS’ ROLE**
  - Disseminate results to inform the response and advocate for the inclusion of MHPPS.

**STEP 7. REGULARLY DISCUSS INFORMATION GATHERING**

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

- **CO-CHAIRS’ ROLE**
  - Facilitate regular discussion of information needs and gathering.

**CASE STUDY 2:**

**MAPPING AGENCIES AND ACTORS IN SOUTH SUDAN**

In June 2016, an MHPPS coordination structure was formed in South Sudan. However, the group initially struggled to engage many key stakeholders. To facilitate mapping, a four-day workshop was organized in Juba to bring together MHPPS stakeholders. On day one, all member organizations of the health cluster, protection cluster, education cluster, child protection sub-cluster and CBV sub-cluster were invited to a refresher training on MHPPS basic principles and on the 4Ws mapping process. Thereafter, each cluster and its member agencies were invited to a half-day session to complete a 4Ws Excel sheet. Five people who had received in-depth training on mapping were present to assist participants, as well as two computer technicians, and computers were made available for all. In addition, the MHPPS TWC co-chair worked with IM officers within each cluster to incorporate MHPPS data that had previously been reported to the cluster. Partners who were not cluster members but who were crucial to the MHPPS system in the country were also engaged. After data were compiled and analysed, a one-page brief was presented to MHPPS TWC members and clusters with a set of practical key recommendations. The MHPPS TWC co-chair also presented the results of the exercise at the Inter-Cluster Working Group to facilitate inclusion in the HNO and HRP for South Sudan during that cycle. A larger report was also compiled and published in an online resource centre.

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1. For more information about IASC’s Who is Where, When, doing What in MHPPS: 4Ws Tool, please visit https://www.iascglobal.org/mental-health-and-psychosocial-support
discussion
tips to support implementa-
tion of this core action, please see Annex 14.

2. For more information, please visit https://www.humanitarianresponse.info/en/operations/ukraine/mental-health-and-psychosocial-support

3. For example, see mapping dashboards from the MHPPS TWC in Ukraine: https://www.humanitarianresponse.info/en/operations/ukraine/mental-health-and-psychosocial-support
A key role of an MHPSS TWG is to facilitate the coordination of integrated MHPSS activities among local actors (including those not affiliated with a formal group or humanitarian agency), national actors (e.g. community-based organizations (CBOs), government ministries) and international actors (e.g. INGOs, UN agencies) and across and within sectors.

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

**WHY IS THIS FUNCTION IMPORTANT?**

[Image]
OUTCOME
MHPPS is integrated within the work of relevant stakeholders.

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

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

CASE STUDY 3: LINKING MHPPS ACROSS AND WITHIN SECTORS IN JORDAN

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

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

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


STEP 1. IDENTIFY RELEVANT STAKEHOLDERS
It is crucial that this process is inclusive. In many settings, essential local stakeholders are overlooked or excluded.

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

- TIP
  Keep an open mind and cast a wide net.

STEP 2. ADDRESS BARRIERS PREVENTING PARTICIPATION IN THE TWG
In some settings, local actors may be hesitant about joining coordination efforts because of language barriers, access barriers or other practical challenges.

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

- TIP
  Avoid using unnecessary jargon in TWG meetings.

STEP 3. LINK WITH OTHER COORDINATION PLATFORMS
In order to coordinate with relevant sectors, cluster coordination groups, government actors and civil society organizations (CSOs), MHPPS TWGs should aim for mutual representation, participation and contribution in all coordination meetings.

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

- TIP
  Brainstorm solutions or other practical coordination efforts because of language barriers, access barriers or other obstacles.

STEP 4. HOLD MHPPS ORIENTATION SESSIONS
Holding sessions to introduce stakeholders to each other’s work is key to linking initiatives. Holding orientation sessions on MHPPS (e.g. the IASC (2007) Guidelines) for non-MHPPS actors is also useful for mainstreaming MHPPS within and across sectors.

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

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

STEP 5. DEVELOP AND IMPLEMENT JOINT REFERRAL PATHWAYS
Joint referral pathways facilitate access to the full range of MHPPS services and additional supports (e.g. protection, health, education, GBV, education, livelihoods).

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

STEP 6. SUPPORT SECTOR RESPONSE PLANNING
As sectors begin to integrate MHPPS within response plans, the MHPPS TWG can provide technical support. In cluster settings, the HPC, including the drafting of HNOs and HRP, can provide important entry points (see Annex 12 for tips on integrating MHPPS into the HPC). Identifying MHPPS indicators (Core Action 5) can also support sectors with the integration of MHPPS and the coordination of service delivery.

- CO-CHAIRS’ ROLE
  Encourage TWG focal points to advocate for a decision-making role in the planning and coordination of service delivery.

- TIP
  Keep an open mind and cast a wide net.

STEP 7. ENGAGE IN JOINT ACTIVITIES
Joint activities build relationships and conserve resources. They may include inter-agency workshops or trainings, advocacy campaigns or other joint response activities. Encourage TWG focal points to advocate for a decision-making role in the planning and coordination of service delivery.

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

HOW CAN THIS FUNCTION BE MEASURED?

IN THE TWG

- # of sectors, clusters or AoRs represented in the TWG
- Establishment of a functioning referral system.

HOW ARE POSSIBLE STEPS?

STEP 1.
- IDENTIFY RELEVANT STAKEHOLDERS
- CO-CHAIRS’ ROLE
- TIP

STEP 2.
- ADDRESS BARRIERS PREVENTING PARTICIPATION IN THE TWG
- CO-CHAIRS’ ROLE
- TIP

STEP 3.
- LINK WITH OTHER COORDINATION PLATFORMS
- CO-CHAIRS’ ROLE
- TIP

STEP 4.
- HOLD MHPPS ORIENTATION SESSIONS
- CO-CHAIRS’ ROLE
- TIP

STEP 5.
- DEVELOP AND IMPLEMENT JOINT REFERRAL PATHWAYS
- CO-CHAIRS’ ROLE
- TIP

STEP 6.
- SUPPORT SECTOR RESPONSE PLANNING
- CO-CHAIRS’ ROLE
- TIP

STEP 7.
- ENGAGE IN JOINT ACTIVITIES
- CO-CHAIRS’ ROLE
- TIP
In northwest Syria, the MHPSS TWG identified the need to build capacity among health workers to provide MHPSS services.

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

Building as a regular capacity from local experts.

Practices and systems context, indigenous about the local cultural discussions should be very useful.

CO-CHAIRS’ ROLE can provide (e.g. facilitators, finances, venues).

TWG meeting(s) asking members to discuss resources to support trainings.

Step 3. Identify resources for capacity-building. Identify resources that MHPSS TWG members or cluster or sector partners can provide (e.g. facilitators, finances, venues).

Step 4. Develop and implement a capacity-building plan. It is essential to facilitate trainings based on needs and on available resources in order to maximize impact. A plan that addresses training needs helps to facilitate effective use of resources.

Step 5. Disseminate information on training or workshop opportunities. Disseminate information on events organized through the MHPSS TWG or capacity-building offered by different clusters or sectors, national authorities and local resources (e.g. universities).

Step 6. Arrange for appropriate supervision and follow-up. Capacity-building initiatives are not sustainable without on-the-job training, mentoring and supervision to trainees. One-off trainings are not recommended.

Step 8. Optional. Create a standard inter-agency competency framework of MHPSS positions in protracted emergency settings, some MHPSS inter-agency training needs assessment reports.

Step 7. Develop a repository of training materials and/or trainers. Create a shared drive containing training materials and a list of trainers as part of the resource centre (Core Action 2).

Case Study 5: Building among Members of the Afghanistan MHPSS TWG

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

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

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

WHY IS THIS FUNCTION IMPORTANT?

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

WHAT ARE POSSIBLE STEPS?

STEP 1. ORIENT AGENCIES ON THE IASC COMMON M&E FRAMEWORK FOR MHPSS
Jointly funded or organized orientation workshops on the IASC Common M&E Framework can support agencies in designing M&E plans and promoting a collective approach to assessing the response.

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

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

STEP 2. ALIGN AND IMPLEMENT M&E APPROACHES
Aligning M&E approaches for similar areas of work (e.g. case management services, children’s clubs, mental health in primary care) can improve quality, support collaboration and build evidence.

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

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

TIP
This could happen in an annual one-day workshop or during regular MHPSS TWG meetings under an M&E theme.

Because actors have varying reporting requirements, advocacy to align M&E requirements by donors is also essential.

OUTCOME
Improved monitoring and evaluation of MHPSS programming.

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

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

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

CO-CHAIRS’ ROLE
Collaborate with sector focal points to identify 2-3 suggested indicators and MoVs for each sector.

Support focal points to advocate with sectors to integrate these indicators into response plans.

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

STEP 3. IDENTIFY MHPSS INDICATORS AND MOV FOR EACH SECTOR
Developing a list of this sort can support sectors to integrate MHPSS into response planning and ultimately into their response activities.

CO-CHAIRS’ ROLE
Facilitate the process of developing agreed approaches to M&E among MHPSS TWG members.

TIP
This could happen in an annual one-day workshop or during regular MHPSS TWG meetings under an M&E theme.

Because actors have varying reporting requirements, advocacy to align M&E requirements by donors is also essential.

STEP 4. SHARE INFORMATION ON LESSONS LEARNED
Information sharing is key to raising the quality of MHPSS services and promoting accountability to affected persons.

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

TIP
Workshops can be organized around key areas of work.

CASE STUDY 6
INTER-AGENCY WORKSHOPS ON MHPSS M&E
Joint inter-agency orientation workshops on the IASC M&E Common Framework have taken place in Afghanistan, the Caribbean, Cox’s Bazar in Bangladesh, Iraq, Sri Lanka, Syria, Turkey and Ukraine.

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

1 For more information on operationalization accountability to affected populations, please see IASC Accountability to Affected Populations (AAP): A Brief overview, https://interagencystandingcommittee.org/system/files/iocw_nw_20134678_0.pdf

Resources
For additional resources to support implementation of this core action, please see Annex 14.
Despite the challenges, humanitarian emergencies also present significant opportunities to build back better. Many emergencies draw attention to MHPSS, often for the first time in affected areas, through media coverage, policy-maker awareness and donor interest. Thus, the actions taken during the immediate and medium-term response to emergencies can either support or limit the potential to create sustainable and durable systems. Therefore, a key consideration of an MHPSS TWG, and an outcome of better MHPSS coordination, is long-term sustainability. However, during crises, rapid and pragmatic solutions can seem like the only options, even if they are not sustainable in the long term. Even in settings where strong leadership, collaboration or support exists, securing long-term commitments for MHPSS after the emergency phase can be challenging. Still, in any setting, sustainability can be enhanced when it is identified as a foundation of the approach, from the beginning, and considered throughout.

WHY IS THIS FUNCTION IMPORTANT?

Case Study 7: Building Sustainable Mental Health Systems: 15 Years of Progress

In 2004, Sri Lanka was devastated by the worst natural disaster ever recorded in the country’s history. Prior to the tsunami, the country had endured three decades of civil war. Mental health and psychosocial well-being had not been a priority in the country, but in the aftermath of the tsunami massive international attention led to an influx of resources and actors focusing on MHPSS. However, their capacities varied and activities were at times inefficient and in some cases potentially harmful. Sri Lanka’s head of state recognized the challenges, and the importance of MHPSS, early on, and established a presidential taskforce to coordinate the response. From the outset, stakeholders also took a long-term view. The MoH and WHO collaborated with the Sri Lanka College of Psychiatrists and relevant national mental health professionals to develop a 10-year (2005–2015) National Mental Health Policy, which was approved just 10 months after the tsunami and served as a coordinating guide. The policy emphasized community-based systems and services and also placed an emphasis on national leadership and local professionals. Over time, MHPSS stakeholders worked together to ensure that the immediate response actions also effectively helped to reform the mental health system. In 2008, consistent with the national mental health policy, a National Mental Health Advisory Council (NMHAC), chaired by the Secretary of the MoH and including representatives from other relevant ministries, professional bodies, UN agencies, NGOs and service users’ and carers’ organizations, was formed to oversee implementation of the mental health policy. In 2015, revisions of the policy began and in 2020 a final policy was completed. As of 2021, the number of districts with acute inpatient units in general hospitals had increased from 10 in 2005 to 25. Outreach clinics now exist in almost all health divisions of the country, representing a total of 291 clinics offering community-based mental health care. Building on these successes, MHPSS was also recently included in the “COVID-19 Sri Lanka Strategic Preparedness & Response Plan 2021.”

For in-depth discussion and case examples of building back better mental health systems in emergencies, please see: WHO (2014). Building back better: sustainable mental health care after emergencies. https://apps.who.int/iris/bitstream/handle/10665/83577/9789241545371_eng.pdf?sequence=1
The MHPSS response leads to sustainable systems and services. **How can this function be measured?**

**Outcome**
The MHPSS response leads to sustainable systems and services.

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

**Means of Verification**
- Participatory evaluation
- Sustainability checklist (see Annex 13)
- Localization assessment

**STEP 1. IDENTIFY AND BUILD ON LOCAL RESOURCES AND CAPACITIES**

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

**CO-CHAIRS’ ROLE**
- Advocate with MHPSS
- WG members to ensure that programming builds local capacity, supports self-help and strengthens local resources.

WHERE INTERNATIONAL ACTORS ARE INVOLVED, CO-CHAIRS HAVE A ROLE IN:
- Co-ordinate regular discussions on sustainability and plan for transition and handover from very early on.
- If the TWG is co-chaired by a representative of an international agency, identify a local counterpart as co-chair, ideally early in the emergency.

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

**STEP 2. ALIGN WITH NATIONAL POLICIES OR PLANS**

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

**CO-CHAIRS’ ROLE**
- List alignment with national policies and plans as a regular agenda item and monitor for opportunities to support the strengthening of these.
- Where plans do not exist, engage stakeholders to support their development, or the development of minimum standards for MHPSS.

**STEP 3. PLAN FOR LONG-TERM SUSTAINABILITY**

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

**CO-CHAIRS’ ROLE**
- Facilitate regular review of service sustainability among MHPSS TWG members (see Annex 13 sustainability checklist).
- Develop a sub-working group to focus on sustainable resource mobilization.

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

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

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

**CO-CHAIRS’ ROLE**
- Engage in or support advocacy with key stakeholders (e.g., ministries of health, finance, social services, education, emergency response).
- Consider organizing a workshop on cases for investment in MHPSS services.

**STEP 5. PROMOTE CARE AND SUPPORT FOR STAFF AND VOLUNTEERS**

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

**CO-CHAIRS’ ROLE**
- Facilitate self-care within the TWG (e.g., retreats, discussions on self-care).
- Develop a sub-group to identify and promote strategies for staff care.

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

**CASE STUDY 8: BUILDING SUSTAINABLE MENTAL HEALTH SYSTEMS IN LEBANON DURING AND AFTER HUMANITARIAN CRISIS**

Lebanon has experienced a long history of political unrest and conflict. It is also home to several large refugee communities fleeing adversity in neighbouring countries. As the current emergency has progressed in Syria, Lebanon has received a massive influx of displaced persons, leaving many community and social services overwhelmed, including an already underfunded mental health system. In response, the Ministry of Public Health (MoPH) partnered with many stakeholders, including WHO, UNICEF and International Medical Corps, to launch the National Mental Health Programme (NMHP), a collaboration aimed at national mental health reform and building sustainable systems to address the challenges posed by the current emergency and beyond. In 2015, because of the NMHP and through a widely inclusive process involving key stakeholders in the country, the Mental Health and Substance Use Strategy for Lebanon 2015–2020 was created. This guiding strategy was key to ensuring that programmes and services were aligned from the outset, and contributed to a longer-term vision that guaranteed universal access, including for refugees, and emphasized a shift in focus towards a more continuum of care.

In 2016, due to the strengthening of national and inter-sectoral referral systems was prioritized and led to the establishment of strong links between MHPSS, protection, shelter and other sector partners. The NMHP Task Force has also played a key role in coordinating responses to the COVID-19 pandemic and the emergency caused by the explosion in Beirut’s port in 2020.

**Resources**
For additional resources to support the implementation of this core action, please see Annex 14.
MHPSS advocacy refers to actions and messages intended to influence decision-makers, donors and other stakeholders to consider and prioritize the MHPSS needs of affected persons.

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

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

A number of tools and packages have been developed that are useful for MHPSS advocacy, including for specific MHPSS topics and areas of work.
**MHPSS is recognized as a cross-cutting priority for action.**

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

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

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

**CASE STUDY 9: RAISING AWARENESS IN CARIBBEAN ISLAND COUNTRIES**

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

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

A major goal of communication and awareness-raising was to address the influence of mental health stigma and traditional roles among Caribbean communities. To address these issues, actors implemented a campaign to raise awareness on MHPS issues within communities regularly affected by hurricanes, including many rural island communities, where emergency response relies heavily on community support and local actors.

Based on the “one love, one family” principle of many Caribbean cultures, an awareness campaign and a slogan, “Stronger Together”, were developed to disseminate information on better coping and to reduce stigma around help-seeking. This campaign consisted of public service announcements, radio and social media messages and testimonials and illustrated comic strips depicting the need for support to enhance the support advocacy among TWG members.

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

**Resources**

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

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National coordination mechanisms
In many settings, countries with pre-existing and prepared structures, lead on the coordination of emergency response, and external actors and other systems, such as the UN, play a secondary role, less active. Many of these same countries have also begun to emphasize preparedness and coordination, building the humanitarian coordination and development nexus. In these contexts, UN agencies and NGOs often take a supporting role to national disaster management agency (NDMA), or risk management (NDMRA) or similar body managing preparedness and response, and coordinates actors, including various government Ministries. As mandated response agencies in auxiliary roles to governments, Red Cross and Red Crescent (RCRC) National Societies play a role in humanitarian coordination mechanisms where they operate. However, these models of coordination can vary greatly. Collaboration between international humanitarian actors and governments, even if coordinated through coordination mechanisms in humanitarian response coordination system and emphasizes sectoral-based approaches, organized around the humanitarian programme cycle. A ‘sector’ refers to a discrete technical area of work (e.g. education, health, logistics). The implementation of the cluster approach aims to improve coordination through grouping humanitarian organizations, both UN and non-UN, according to these over-arching sectors of humanitarian action, while formalizing the responsibilities of agencies tasked with leading each cluster. Clusters are activated when 1) response and coordination gaps exist or issues change or deterioration of the situation and 2) existing national response or activities are unable to meet needs in a manner that aligns with humanitarian principles.

Cluster coordination
Cluster coordination is the approach that the United Nations and many humanitarian organizations use to facilitate coordinated humanitarian emergency responses in countries. This approach is based on the idea that humanitarian organizations should work together within defined sectors or themes to improve the effectiveness of their response efforts. The cluster approach is designed to improve coordination by bringing together organizations working in the same sector, allowing them to share information, resources, and best practices. This helps to avoid duplication and ensures that gaps in response are identified and filled. The cluster approach is not only used in emergencies but also in post-emergency settings like recovery. It is an important tool for humanitarian organizations to strengthen their response capabilities and improve the efficiency of their operations.

Humanitarian coordinator
The HC is responsible for the organisation and delivery of the international humanitarian response at the country level, coordinated and overseen by the Humanitarian Country Team (HCT) and under the overall authority of the Emergency Relief Coordinator (ERC). The HC is responsible for the global humanitarian response and the coordination of humanitarian assistance across clusters while aligning goals and reducing duplication. The HCT is the highest-level coordination forum in the humanitarian system, representing the humanitarian community, both national and international, and ensuring effective and efficient response efforts. The HCT is responsible for coordinating and managing humanitarian assistance in coordination with the international community and the affected countries, ensuring that aid is delivered effectively and efficiently to the people in need.

Cluster members
Cluster members are agencies working in the sector and active in the cluster. They are responsible for coordinating and delivering humanitarian assistance in their assigned sector. They work closely with other clusters to ensure a coordinated response and avoid duplication of efforts. The clusters are activated when there are response gaps or issues that require a coordinated response. The clusters bring together agencies working in the same sector to share information, resources, and best practices. This helps to improve the effectiveness of the response and ensure that gaps in response are identified and filled.

Cluster coordination in public health emergencies
Public health emergency (PHE) response is organized around strategic partnerships and existing structures and systems. The humanitarian response is often driven by sub-national entities or actors, such as local actors, mayors, municipalities or governors/provinces, and places. It is critical to engage international actors in the role of working with and through existing systems. Area-based coordination (ABC) aligns well with the localisation agenda of the Grand Bargain, which seeks to increase local ownership and aid organizations that aims to put more means into the hands of people in need and improve the effectiveness and efficiency of humanitarian action. While area-based approaches take different forms, three defining principles have been identified. These are: 1) the programmes are organized and targeted geographically, recognizing that aid is needed in multiple individual crises; 2) they are multi-sectoral and multi-disciplinary, rather than being sector-specific (e.g. emergency logistics or relief for orphans and children); and 3) they are designed through local participation and ownership.

Annex 1
Brief overview of common coordination structures

1. In WHO’s Mental Health Atlas 2020, Mapping the Path for the First time on programmes integrating MHSS and PHE, 2020, indicating growing attention and effort in the field of mental health. Member States reported that such programmes were in place in their country.

2. For further discussion of the opportunities and challenges of government coordination and leadership, please see Section 3.4.2 in Knox-Clarke P and King D Humanitarian Response 2015. ALNAP Study on Government Leadership in Humanitarian Clusters. 2015. ALNAP is a UN-funded global humanitarian. https://www.alnap.org/support gusta/what-is-the-cluster-approach

3. Cluster coordination, please visit: https://www.who.int/emergencies/diseases-early-warning-systems

4. For more information about the various actors involved in the humanitarian system, please see: https://www.who.int/publications/i/item/who-does-what-clusters

5. For more information on cluster activation, please visit: https://www.who.int/humanitarian-situations/provision-of-aid/countries/cluster-coordination/

6. For more on area-based coordination and leadership, please visit: https://www.who.int/humanitarian-situations/area-based-coordination

7. For more on refugee and mixed setting coordination, please visit: https://www.who.int/hrp/countries/refugee-coordination-model

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

9. For more information, please visit: https://www.who.int/hrp/countries/refugee-coordination-model

10. For more information on area-based coordination, please visit: https://www.who.int/hrp/countries/area-based-coordination

11. For more information on area-based assistance, please visit: https://www.who.int/hrp/countries/area-based-coordination

12. For more information on the cluster approach, please visit: https://www.who.int/hrp/countries/cluster-coordination
Annex 2 MHPSS across PHE response pillars

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


Annex 3 Resources for integrating MHPSS across sectors

<table>
<thead>
<tr>
<th>Sector</th>
<th>Resources</th>
</tr>
</thead>
</table>
### Annex 4 List of indicators for Core Actions

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

<table>
<thead>
<tr>
<th>Core Action</th>
<th>Outcome</th>
<th>Indicators</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (Re)establishing and maintaining a functioning TWG</td>
<td>A functional MHPSS TWG is established and facilitates better coordination</td>
<td>- Existence of a functional workplan developed in collaboration with local actors and affected persons</td>
<td>- Workplan review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- % of workplan objectives achieved in specific period (e.g. one year)</td>
<td>- Meeting minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- % of MHPSS TWG members who are local or national actors</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Action</th>
<th>Outcome</th>
<th>Indicators</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Information management</td>
<td>The size and nature of the MHPSS response is known and needs and gaps are identified</td>
<td>- # of gaps addressed following mapping/gaps analysis</td>
<td>- Mapping and gaps analysis report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- # of needs assessments or workplans integrating MHPSS</td>
<td>- Assessment or workplan reviews</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Action</th>
<th>Outcome</th>
<th>Indicators</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Establishing links between stakeholders</td>
<td>MHPSS is integrated within the work of relevant clusters, sectors and partners</td>
<td>- # of joint initiatives or activities</td>
<td>- Activity reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Establishment of a functioning referral system</td>
<td>- Referral reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- # of sectors and AoRs represented in MHPSS TWG meetings</td>
<td>- Meeting minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Action</th>
<th>Outcome</th>
<th>Indicators</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Building capacity, knowledge exchange and peer support</td>
<td>Humanitarian actors demonstrate increased MHPSS knowledge, skills and capacities</td>
<td>- Existence of MHPSS TWG capacity-building plan with clear indicators</td>
<td>- Capacity-building plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- # of humanitarian actors oriented on MHPSS guidance and on how to avoid harm (e.g. on the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, the MHPSS MSP, disaggregated by type of workshop, and by sector/field of work)</td>
<td>- Inter-agency training needs assessment reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- # of identified capacity gaps addressed via capacity-building initiatives</td>
<td>- Training or workshop evaluation reports</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Action</th>
<th>Outcome</th>
<th>Indicators</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Ensuring monitoring and evaluation (M&amp;E)</td>
<td>Improved monitoring and evaluation of impacts of MHPSS programming</td>
<td>- % of affected people reporting active involvement in monitoring and evaluation of MHPSS programming</td>
<td>- Participatory evaluations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- # of MHPSS TWG members reporting M&amp;E of MHPSS programmes</td>
<td>- Survey or interviews of MHPSS TWG members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Annual review and revision of TWG workplan and strategy, based on M&amp;E data and feedback from affected populations</td>
<td>- Workplan review workshop report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Action</th>
<th>Outcome</th>
<th>Indicators</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Promoting long-term sustainability</td>
<td>The MHPSS response leads to sustainable systems and services</td>
<td>- % target communities where local people report being actively supported to design, organize and implement MHPSS activities themselves</td>
<td>- Participatory evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Existence of transition/handover plans (if external actors involved)</td>
<td>- Localization assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Regular review of localization, transition and handover (where international actors are involved)</td>
<td>- Sustainability checklist (Annex 13)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Action</th>
<th>Outcome</th>
<th>Indicators</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. MHPSS advocacy</td>
<td>MHPSS is recognized as a cross-cutting priority for action</td>
<td>- # MHPPS awareness-raising activities completed</td>
<td>- Event reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Adapted set of key MHPSS messages developed</td>
<td>- Pre and post surveys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- # and types of key response plans, strategies (e.g. national plans, humanitarian response plans, multisectoral strategies) or calls for funding that include references to MHPSS</td>
<td>- Stakeholder plans/budgets</td>
</tr>
</tbody>
</table>

### Annex 5 Checklist of Core Actions deliverables

<table>
<thead>
<tr>
<th>Core Action</th>
<th>Key deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Re)establishing and maintaining a functioning TWG</td>
<td>- Consensus-based ways of working, such as ToRs</td>
</tr>
<tr>
<td></td>
<td>- Workplan</td>
</tr>
<tr>
<td></td>
<td>- Coordination procedures and mechanisms</td>
</tr>
<tr>
<td>2 Information management</td>
<td>- Desk review of existing information</td>
</tr>
<tr>
<td></td>
<td>- 4Ws mapping (and plan for regular updating)</td>
</tr>
<tr>
<td></td>
<td>- Gaps analysis</td>
</tr>
<tr>
<td></td>
<td>- List of MHPSS assessment questions</td>
</tr>
<tr>
<td></td>
<td>- Resource centre</td>
</tr>
<tr>
<td>3 Establishing links between stakeholders</td>
<td>- List of MHPSS TWG focal points for each sector</td>
</tr>
<tr>
<td></td>
<td>- Partners brief on referral pathways and procedures</td>
</tr>
<tr>
<td></td>
<td>- Agendas for MHPSS orientation sessions</td>
</tr>
<tr>
<td>4 Building capacity, knowledge exchange and skills transfer</td>
<td>- Inter-agency training needs assessment</td>
</tr>
<tr>
<td></td>
<td>- Training/workshop plan</td>
</tr>
<tr>
<td></td>
<td>- Repository of training materials/trainers</td>
</tr>
<tr>
<td>5 Monitoring and evaluation</td>
<td>- Inter-agency monitoring and evaluation workshop</td>
</tr>
<tr>
<td></td>
<td>- Common set of indicators and means of verification</td>
</tr>
<tr>
<td>6 Promoting long-term sustainability</td>
<td>- Transition/handover plan (if applicable)</td>
</tr>
<tr>
<td></td>
<td>- MHPPS minimum standards</td>
</tr>
<tr>
<td></td>
<td>- MHPPS sustainability checklist (see Annex 13)</td>
</tr>
<tr>
<td>7 MHPSS advocacy</td>
<td>- Key MHPPS messages and IEC materials</td>
</tr>
<tr>
<td></td>
<td>- Distribution channels for messages (e.g. newsletters)</td>
</tr>
<tr>
<td></td>
<td>- MHPPS briefing sessions</td>
</tr>
</tbody>
</table>
## Annex 6: MHPS MSP section 1.1: Additional activities for consideration

<table>
<thead>
<tr>
<th>Core Action</th>
<th>MHPS MSP section 1.1: Additional activities for consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Establish (further) sub-national MHPS Working Groups if needed.</strong></td>
<td><strong>Establish joint workplans for MHPS within MHPS Working Groups, linking and supporting collaboration in activities within and across sectors and organizations.</strong></td>
</tr>
<tr>
<td><strong>Establish multidisciplinary tasks/forces to work on urgent context-specific issues that are not being addressed elsewhere (e.g. addressing an upsurge in suicide, MHPS for children associated with armed forces and groups, perinatal mental health, etc.).</strong></td>
<td><strong>Orient cluster coordination groups, multi-sector refugee coordination groups and AoR coordinators on MHPS to identify how their respective sectors contribute to MHPS outcomes and how MHPS activities can contribute to outcomes in other sectors, and to identify opportunities for effective integrated programming.</strong></td>
</tr>
<tr>
<td><strong>Establish multi-disciplinary tasks/forces to work on urgent context-specific issues that are not being addressed elsewhere (e.g. addressing a high burden of mental health disorders, identifying gaps in care for children affected by emergencies, etc.).</strong></td>
<td><strong>Develop and maintain a register of national expert trainers for MHPS curricula (e.g. basic psychosocial skills, WHO’s Mental Health Gap Action Programme Humanitarian Intervention Guide (mHGAP-HIC), psychological interventions, social and emotional learning (SEL), positive parenting packages).</strong></td>
</tr>
<tr>
<td><strong>Establish (further) sub-national MHPS Working Groups if needed.</strong></td>
<td><strong>Advocate for local and national policies and interventions to reflect international good practice guidelines for MHPS, and support government actors in designing, implementing or strengthening services.</strong></td>
</tr>
<tr>
<td><strong>Establish national-level capacity for the continuation of coordination by supporting or developing sustainable coordination structures, including government and civil society stakeholders.</strong></td>
<td><strong>Support the building of national-level capacity for the continuation of coordination by supporting or developing sustainable coordination structures, including government and civil society stakeholders.</strong></td>
</tr>
</tbody>
</table>

### Core Action

- Establish coordination between different actors to avoid duplication, address obstacles and fill gaps in the response based on the MHPS MSP and relevant assessments.
- Facilitate coordination between different actors to address and mitigate gaps in the response.
- Support MHPS needs assessments and the inclusion of MHPS in other needs assessments and ongoing monitoring by relevant sectors to inform response planning (e.g. Humanitarian Needs Overviews, Humanitarian and Refugee Response Plans).
- Conduct and distribute a comprehensive mapping of MHPS actors, services and activities (e.g. A4A MHPS service mapping, MSP gap analysis). Review gaps in services at regular intervals to inform planning.
- Regularly share information among humanitarian MHPS and other actors (e.g. assessment reports, service directories and collated information in designated groups on MHPS.net).
- Develop, strengthen, update and implement joint referral pathways to facilitate access to the full range of MHPS services and activities and to additional support (e.g. Protection including Child Protection (CP) and GBV, Health, Education, Livelihoods and community-based support) as needed (e.g. a directory of services and referral information, common referral forms and pathways, standard operating procedures (SOPs)).
- Coordinate with all relevant sectors, clusters or coordination groups (e.g. Health, Education, CCM, Nutrition, Protection, including AoRs (e.g. CP, GBV, Mine Action, Housing, Land and Property (HLR) AoRs, and the disabilities TWG), with civil society (e.g. CBOs, CSOs) and with government actors (e.g. ministries of health, social welfare, education). This includes ensuring mutual representation, participation and contribution at coordination meetings.
- Disseminate and adapt MHPS guidance (e.g. IASC resources, the MHPS MSP) and conduct rapid orientations on this guidance for agencies funding, planning or implementing MHPS activities.
- Support information management and the reporting of MHPS activities and indicators. This includes defining MHPS M&E indicators for humanitarian information systems (e.g. inter-agency/cluster reporting systems) and orienting agencies on how to use these systems.
- Promote the development of sustainable mental health, social care and education systems as part of early recovery planning and during protracted crises. Link MHPS emergency activities with comprehensive and complementary development activities in coordination with donors and government actors (e.g. supporting long-term planning with government and national actors centrally involved, workforce development activities, demonstration projects showing system reform across a geographical area).
- Advocate for the inclusion of MHPS in funding and resource allocations (e.g. targeting donors, funding mechanisms).
- Advocate for MHPS considerations for adults and children in different sectors and for different actors (e.g. delivering humanitarian aid in a way that reduces distress and promotes dignity, including MHPS in referral pathways developed by other sectors).
- Make MHPS a recurring agenda item at inter-agency meetings (e.g. Inter-Cluster Coordination Group (ICCG) and UN country meetings, cluster coordination and multi-sector refugee coordination meetings) and forums to help ensure an inter-sectoral response and support for MHPS priorities.

---

### Key considerations in analysing existing coordination structures

- **Key consideration: What is the structure and function?**
- **Key consideration: Does the structure fit the needs of the emergency?**
- **Key consideration: Does the structure fit the needs of the emergency?**
- **Key consideration: What role do the national authorities play, or plan to play, in MHPS or coordinating MHPS?**

---

1. To avoid fragmentation and duplication, it is important that only one MHPS coordination group is operational. Where separate coordination groups exist (e.g. a mental health coordination group and a psychosocial support coordination group), they should be merged into one overarching group to coordinate the MHPS response as a whole. See the IASC 2009 Guidelines on MHPS in Emergency Settings, the IASC Principals Decision of 5 December 2019, the Sphere Handbook 2018 and the MHPS and Protection Outcomes (Global Protection Cluster, 2020).

### Annex 8 Potential stakeholder roles and responsibilities

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

### Potential stakeholder roles and responsibilities

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

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

Annex 9 Tips for MHPSS TWG terms of reference and workplans

Tips for building ToRs and workplans

Goal: Engage partners and build consensus.

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

Examples of workplan activities

- Assess needs, human resources and services by mapping (e.g. 4Ws).
- Coordinate programme planning and implementation.
- Integrate MHPSS in response plans.
- Review mental health laws and policies.
- Plan for broad capacity-building activities.
- Advocate for funding.

Example ToR outline

- Background.
- Definition of MHPSS.
- Guiding principles.
- Scope and objectives.
- Membership, roles and responsibilities.
- Key functions and general activities.
- Assessment, analysis and information-sharing.

MHPSS TWG workplans

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

Annex 10 Tips for integrating MHPSS into rapid needs assessments

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

Key integrated needs assessment tools and approaches

- The Multi-Cluster/Sector Initial Rapid Assessment (MIRA) is a joint tool that can be used in sudden-onset emergencies, including IASC system-wide scale-up and response.
- The Joint Intersectoral Analysis Framework (JIAF) is a set of protocols, methods and tools designed to capture humanitarian needs and inform decision-making. The JIAF was piloted in 27 countries to produce HNOs in 2021.
- Many other resources for integrated needs assessments exist. For more information, please see Annex 14 Core Action 2.

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

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

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

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

1 For more information and guidance on humanitarian needs assessments, please visit: https://www.humanitarianresponse.info/en/programme-cycle/space/page/assessments-overview.
MHPSS assessments in the context of COVID-19 and PHEs

1. Background

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

2. Purpose of this annex

This annex provides practical guidance on conducting MHPSS assessments in the context of PHEs. This guidance supplements resources for conducting MHPSS assessments in emergency settings

3. Practical tips for conducting MHPSS assessments during PHEs

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

4. Selecting tools for MHPSS assessments

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

5. Tailoring MHPSS assessment tools to PHEs

MHPSS assessments in the context of PHEs will require many adaptations similar to those necessary for MHPSS operations and interventions generally. Likewise, assessment teams must be given adequate training in adapting assessment approaches or using adapted tools that are currently available.

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7 The approach to conducting MHPSS assessments will vary depending on the context and purpose of the assessment. In general, MHPSS assessments in emergency settings should be aimed at 1) providing an understanding of the situation from an MHPSS perspective; 2) analysing problems and the ability to cope; and 3) analysing resources to inform the response required. The following “dos and don’ts” can be used to effectively design an assessment in order to address these aims in the context of PHEs.
9 For further guidance, please visit: https://www.who.int/health-topics/coronavirus
d10 A resource group for sharing MHPSS assessment tools for COVID-19 is available on MHPSNet. For more information, please visit: https://www.mhpsnet.net/gupps/current-mhpss-emergency-ressources/novel-coronavirus-international-health-emergency-2020/covid19-assessment
Examples of specific adaptations of tools for PHEs

1. Who is Where. When, doing What (4Ws) in Mental Health and Psychosocial Support
   - Assess service availability and adaptations required during PHE based on local measures. 
   - Review codes and sub-codes to include activities adapted for the PHE and relevant to the local context. 
   - Assess training on remote service provision and remote access, such as in Sheet 2 - Columns S, T or U/V.

2. WHO-UNHCR Assessment Schedule for Severe Symptoms in Humanitarian Settings
   - Decide whether there is a need to implement this tool to assess new problems related to the PHE or rely on existing data. 
   - If implemented, conduct remotely and develop a plan for ensuring access to vulnerable groups or remote locations.

3. Humanitarian Emergency Setting Perceived Needs Scale (HESPER)
   - Conduct interviews adapted to the PHE context (e.g. remote) and ensure that staff are trained in conducting adapted assessments where possible. 
   - Consider creating surveys or adapting physical spaces to allow for safe distancing if remote tools are not available.

4. Checklist for site visits at institutions (e.g. hospitals, care homes, other residential facilities)
   - Determine if inpatient units for mental health are included in PHE prevention and mitigation plans. 
   - Determine if precautions are in place to protect persons in institutions if someone is infected during the PHE.

5. Checklist for integrating mental health into primary health care (PHC)
   - Assess facilities’ capacities to adapt MHPSS services and access to remote means, if necessary, including in assessing worker competency (Section 2), impact of the emergency (Section 6), and social indicators (Section 7). 
   - Review the files of all service users and prioritize care for people with severe conditions or distress to minimize health visits. Include estimated number of service users in relevant areas (e.g. Section 5).
   - Assess plans to integrate MHPSS into infection prevention and control (IPC) measures, such as quarantine units.

6. Neuropsychiatric components of the health information system (HIS)
   - Adapt the HIS to deliver remote consultations and other adapted service delivery, if relevant locally.

7. Template to assess mental health system resources
   - Assess # of facilities with capabilities for remote services. 
   - Assess # of personnel with experience of providing remote services or available for home visits, if safe and feasible.

8. Checklist on obtaining general information from sector leads
   - Assess adaptations across sectors due to the PHE and impacts on access to various services (e.g. school closures). 
   - Identify opportunities to integrate MHPSS within adapted services.

9. Template for desk review of pre-existing information relevant to MHPSS
   - Review internal and external documents, guidance notes or recommendations related to the PHE response and concerning health, protection, risk communication and community engagement in the local context. 
   - Assess access to and acceptability of technologies (e.g. internet, cell services, cultural acceptance of technology).

10. Participatory assessment: perceptions of general community members
    - Prioritize vulnerable groups, such as older persons, persons with health issues or pre-existing mental health conditions, women and children, persons with limited access to services or support, and persons who have themselves or whose family members have been infected during the PHE and may be in quarantine or isolation.

11. Participatory assessment: perceptions of community members with in-depth knowledge of the community
    - Include targeted questions that ask about the PHE, such as “How are people who are infected treated?” and “What do people think is causing the PHE?” to assess perceptions of the pandemic and at-risk groups.
    - Assess potential protection issues that may be amplified due to mobility and other restrictions.

12. Participatory assessment: Perceptions of severely affected people
    - Assess participants’ knowledge, fears, concerns, coping and needs regarding the PHE.
    - Assess continued access to social support or unique barriers to seeking support, such as in Question 2.2.

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

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

### Challenges and potential solutions

#### Challenges

- **HNOS and HRPs have limited space for each sector:** There is generally little space in HNOs and HRPs to describe the needs of each sector. As a result, there is often little space for lengthy paragraphs devoted to MHPSS or other cross-cutting areas.
- **There is massive pressure from many areas of work:** HCTs, cluster coordinators, AoR coordinators and others who develop HRPs experience massive pressures to include many areas of work, not just MHPSS, and can be overwhelmed with guidance on doing so.
- **Every cluster has its own methods:** Every cluster has its own methods to determine people in need and to prioritize geographic areas or response actions. Thus, what works in one setting or with one cluster may not work for another.
- **Opinions about MHPSS, and where it fits, vary:** Although the IASC (2007) Guidelines clearly establish the cross-cutting nature of MHPSS, actors do not always agree on where it fits within and across sectors.

#### Potential solutions

- **Try to be part of the solution:** Assist coordinators in preparing relevant text, offer to review or rewrite text if needed, and be generally available to offer solutions, not problems.
- **Work bilaterally:** Every cluster is different, and so too is every cluster coordinator. It is essential to work in collaboration with these colleagues to identify the best ways to support their integration of MHPSS.
- **Be present at key moments:** Advocating for a “seat at the table” in HNO and HRP planning and development meetings, in ICCG meetings and other needs assessment teams (that will feed into the HNO process) is key to ensuring that MHPSS has an active voice in the process.
- **Remember the cross-sectoral nature of MHPSS:** Because MHPSS is by nature cross-cutting, try to make links across sectors in suggested text. For example, link areas of work that relate to one another, such as child protection and education.

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Annex 13 MHPSS sustainability checklist

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

Annex 14 Resources and materials

Core Action 1: (Re)establishing and maintaining a technical working group
- Sample MHPSS TWG ToR description (including competencies or minimum requirements for coordinator position, surge capacity deployments of coordinators), Available in English.
- Sample MHPSS TWG ToRs, English, English 2, French, French 2.
- IASC (2019), Community-Based Approaches to MHPSS Programmes: A Guidance Note. Available in English.

Core Action 2: Information management
- MHPSS.net online 4Ws mapping tool. Available here.
- MHPSS.net collation of tool translations, reports and previous mappings. Available here.

Core Action 3: Establishing links between stakeholders

Core Action 4: Capacity-building, knowledge exchange and peer support
Annex 14  Resources and materials

Core Action 5: Ensuring monitoring and evaluation

Core Action 6: Promoting sustainability

Core Action 7: MHPSS advocacy
- The INDIGO Network. Available here.