



MANUAL ON
COMMUNITY-BASED
MENTAL HEALTH AND
PSYCHOSOCIAL SUPPORT
IN EMERGENCIES
AND DISPLACEMENT

The opinions expressed in the report are those of the authors and do not necessarily reflect the views of the International Organization for Migration (IOM). The designations employed and the presentation of material throughout the report do not imply expression of any opinion whatsoever on the part of IOM concerning legal status of any country, territory, city or area, or of its authorities, or concerning its frontiers or boundaries.

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental organization, IOM acts with its partners in the international community to: assist in the meeting of operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

This publication was made possible through the support provided by USAID - Office of U.S. Foreign Disaster Assistance (OFDA).

Publisher: International Organization for Migration
17 route des Morillons
P.O. Box 17
121 Geneva 19
Switzerland
Tel.: +41 22 717 9111
Fax: +41 22 798 6150
Email: hq@iom.int
Website: www.iom.int

Cover photo: Self-portrait elaborated by a Nigerian IDP and psychosocial worker, during a five-day workshop on autobiographical models through art, organized by IOM in Maiduguri, Nigeria @IOM 2018/Rola Soulheil.

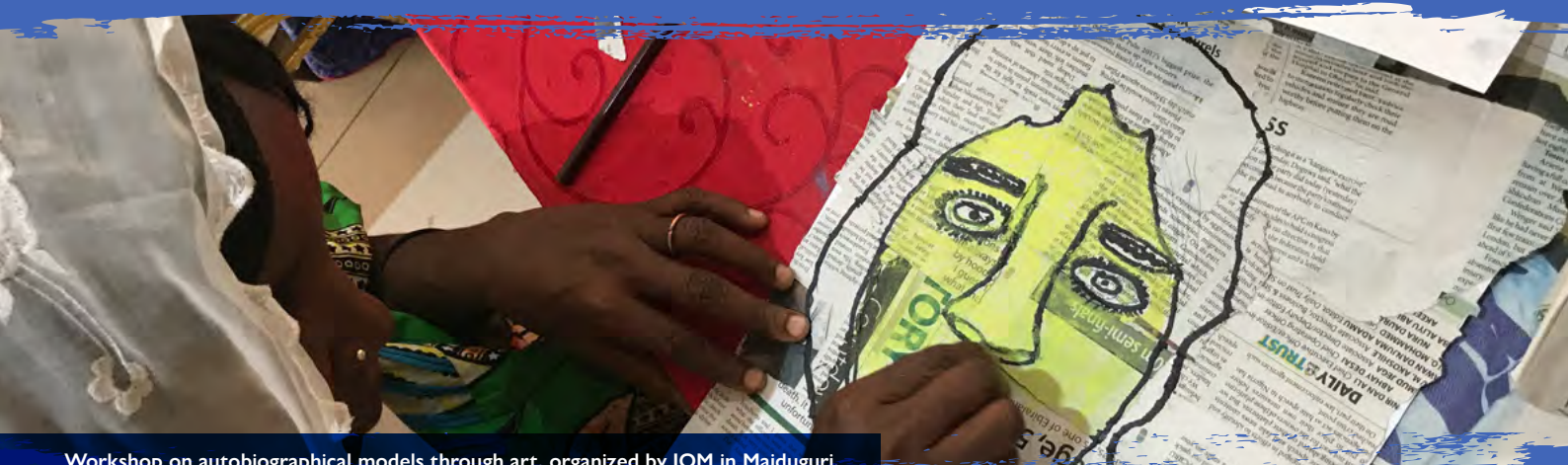
ISBN 978-92-9068-784-9

© 2019 International Organization for Migration (IOM)

Suggested citation:

IOM (2019), *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement*. IOM, Geneva.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise without the prior written permission of the publisher.



Workshop on autobiographical models through art, organized by IOM in Maiduguri, Nigeria. © IOM 2018/Rola SOULHEIL

- ➔ **ABBREVIATIONS**
- ➔ **ACKNOWLEDGEMENTS**
- ➔ **INTRODUCTION**
- ➔ **CHAPTER 1.** CONCEPTS AND MODELS OF WORK
- ➔ **CHAPTER 2.** ENGAGING WITH COMMUNITIES
- ➔ **CHAPTER 3.** ASSESSMENT AND MAPPING
- ➔ **CHAPTER 4.** PSYCHOSOCIAL MOBILE TEAMS
- ➔ **CHAPTER 5.** SOCIORELATIONAL AND CULTURAL ACTIVITIES
- ➔ **CHAPTER 6.** CREATIVE AND ART-BASED ACTIVITIES
- ➔ **CHAPTER 7.** RITUALS AND CELEBRATIONS
- ➔ **CHAPTER 8.** SPORT AND PLAY
- ➔ **CHAPTER 9.** NON-FORMAL EDUCATION AND INFORMAL LEARNING
- ➔ **CHAPTER 10.** INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN CONFLICT TRANSFORMATION AND MEDIATION
- ➔ **CHAPTER 11.** INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT
- ➔ **CHAPTER 12.** STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION
- ➔ **CHAPTER 13.** COUNSELLING
- ➔ **CHAPTER 14.** COMMUNITY-BASED SUPPORT FOR PEOPLE WITH SEVERE MENTAL DISORDERS
- ➔ **CHAPTER 15.** TECHNICAL SUPERVISION AND TRAINING
- ➔ **CHAPTER 16.** MONITORING AND EVALUATION
- ➔ **ANNEX 1.** INTER-AGENCY COORDINATION
- ➔ **ANNEX 2.** ETHICAL CONSIDERATIONS
- ➔ **BIBLIOGRAPHY**

ABBREVIATIONS

4Ws	Who is Where, When and doing What
AAD	Adversity-Activated Development
AAP	accountability to affected populations
CB MHPSS	community-based mental health and psychosocial support
CCCM	camp coordination and camp management
ECHO	European Commission Humanitarian Aid Office
GBV	gender-based violence
HIG	Humanitarian Intervention Guide
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IDP	internally displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
INEE	International Network for Education in Emergency
IOM	International Organization for Migration
IPT	interpersonal therapy
MEAL	monitoring, evaluation, accountability and learning
mhGAP	World Health Organization Mental Health Gap Action Programme
MHPSS	mental health and psychosocial support
MNS	mental, neurological and substance use
NGO	non-governmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PFA	psychological first aid
PMT	psychosocial mobile team
PTSD	post-traumatic stress disorder
RSL	religious and spiritual leader
SFBT	Solution-Focused Brief Therapy
SMART	specific, measurable, attainable, relevant and time-bound
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

ACKNOWLEDGEMENTS



The *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement* was developed by the International Organization for Migration's (IOM's) Mental Health, Psychosocial Response and Intercultural Communication Section; field-based managers and coordinators of IOM's and other agencies' mental health and psychosocial support (MHPSS) programmes in emergencies; members of the Steering Committee, including representatives from academia, United Nations agencies, international organizations, non-governmental organizations (NGOs), donor agencies and individual experts; and the co-chairs and various members of the Inter-Agency Standing Committee (IASC) Reference Group for MHPSS in Emergency Settings, particularly the subgroup on Community-Based Mental Health and Psychosocial Support (CB MHPSS) Programming. Additionally, the first draft was reviewed in field workshops conducted with field-based MHPSS managers and focal points of several agencies currently engaged in MHPSS programmes in north-eastern Nigeria (Maiduguri) and Iraq (Erbil).

Editor: Guglielmo Schininà (IOM).

Editorial support: Roza Copper, Michael Gibson, Valerie Hagger (IOM), Natalia Hortigüela Gallo (IOM), Renato Libanora (IOM), Leslie Snider and Emmanuel Streel.

Steering Committee members: Bashir Aboubakar (IOM Nigeria), Mazen Aboul Hosn (IOM Turkey), Nadia Akmoun (IOM Headquarters), Kathy Angi (Action by Churches Together), Tatsushi Arai (School for International Training), Amal Ataya (IOM Nigeria), Nancy Baron (Psycho-Social Services and Training Institute in Cairo (PSTIC), Pauline Birot (IOM Ethiopia), Antonio Bottone (IOM Lebanon), Martha Bragin (Silberman School of Social Work at Hunter College, City University of New York), Maria Bray (Terre des Hommes, IASC CB MHPSS Working Group), Elaine Duaman Joyce (IOM South Sudan), Fahmy Hanna (World

Health Organization (WHO), Co-Chair of the IASC MHPSS Reference Group), Sarah Harrison (International Federation of Red Cross and Red Crescent Societies (IFRC) Reference Centre on Psychosocial Support, Co-Chair of the IASC MHPSS Reference Group), Zeinab Hijazi (United Nations Children's Fund (UNICEF), Co-Chair IASC CB MHPSS Working Group), Renato Libanora (IOM Iraq), Christopher Maclay (Mercy Corps), Chissey Mueller (IOM Headquarters), Renos Papadopoulos (University of Essex), Olga Rebolledo (IOM Cox's Bazar), Alessandra Rossi Ghiglione (University of Turin), Monica Noriega (IOM Headquarters), Jack Saul (International Trauma Studies Program, New York), Marian Tankink (Consultant), Peter Ventevogel (Office of the United Nations High Commissioner for Refugees (UNHCR)) and Alys Willman (World Bank). Adjunct participants to Steering Committee: Chiara Giusto (ECHO), Katharina Montens (GIZ Berlin), Elizabeth Stickman (United States Agency for International Development (USAID) Office for United States Foreign Disaster Assistance (OFDA)), Sharon Weinblum (European Commission Humanitarian Aid Office (ECHO)) and Ann Willhoite (USAID).

FIELD REVIEWERS

Field reviewers in Erbil: Thekra Ahmed (Mental Health Centre), Hatem Alaa Marzouk (Médecins du Monde, Luther Atinya (IMC), Natalie Barillier (Yazda), Blandine Bruyere (IMC), Gulistan Chalabi (IOM), Abeer Daham (INTERSOS), Noemi Damasceno (Premiere Urgence Internationale (PUI)), Saido Daowwd Ali (Jesuit Refugee Service), Nemam Ghafouri (Swedish Charity Organization), Bryar Jabbar Bagg (Green Desert), Kateryna Katrashchuk (Step IN), Marwan Mohammed (Un Ponte Per (UPP)), Walaa Musheer Ahmed (Better World Organization for Community Development), Lia Pastorelli (UPP), Mustafa Qasim (Norwegian Church Aid), Sozan Safar (Dak Organization for Ezidi Women Development), Fadia Soheal (International Medical Corps (IMC)) and Hizrat

Tayib (Bishkoreen for the Development of Woman and Child).

Field reviewers in Maiduguri: Hazim Abdulkarim (PUI), Hannatu Alh. Adamu (BOWDI), Asaph Andrew Rufi (CHAD), Japhet Ayele (Save the Children International (SCI)), Christopher Chinedumuije Oguegbu (Goal Prime Organization Nigeria (GPON)), Amara Edeh (INTEROSOS), Emmanuel Gadzama (International Rescue Committee (IRC)), Reuben Ibaishwa (Street Child), James Izang (Médecins du Monde), Jonas Kambale (Transcultural Psychosocial Organization (TPO)), Ikwe Kennedy (IOM), Moses Nyam (PUI), Samuel Tarfa (WHO), Bem Tivkaa (Neem Foundation) and Abuhuraira Umar (IOM).

Thanks also to Catherine Panter-Brick (Yale University) and her collaborators for reviewing the chapters Assessment and mapping, and Monitoring and evaluation, and Alena Huss for supporting in compiling the bibliography.

Main authors per chapter:

Introduction: Introduction: Guglielmo Schininà;

Chapter 1. Concepts and models of work: Guglielmo Schininà, Renos Papadopoulos and Jack Saul;

Chapter 2. Engaging with communities: Marian Tankink, Guglielmo Schininà and Renato Libanora;

Chapter 3. Assessment and mapping: Marian Tankink, Guglielmo Schininà, Emmanuel Streel and Renato Libanora;

Chapter 4. Psychosocial mobile teams: Guglielmo Schininà and Emmanuel Streel;

Chapter 5. Sociorelational and cultural activities: Guglielmo Schininà, Pauline Birot, Elaine Duaman Joyce and Natalia Hortigüela Gallo;

Chapter 6. Creative and art-based activities: Guglielmo Schininà and Alessandra Rossi Ghiglione;

Chapter 7. Rituals and celebrations: Renato Libanora, Kathy Angi and Guglielmo Schininà;

Chapter 8. Sport and play: Maria Bray, Serena Borsani and Raphaële Catillon;

Chapter 9. Non-formal education and informal learning: Sylvain Fournier;

Chapter 10: Integration of mental health and psychosocial support in conflict transformation and mediation: Tatsushi Arai, Marine Ragueneau and Guglielmo Schininà;

Chapter 11. Integrated mental health and psychosocial support, and livelihood support: Alys Willman and Christopher Maclay;

Chapter 12. Strengthening mental health and psychosocial support in the framework of protection: Chissey Mueller, Nada Akmoun, Guglielmo Schininà and Renato Libanora;

Chapter 13. Counselling: Jack Saul, Guglielmo Schininà;

Chapter 14. Community-based support for people with severe mental disorders: Theresa Jones, Guglielmo Schininà, Peter Ventevogel, Fahmy Hanna;

Chapter 15. Technical supervision and training:

- Technical supervision: Ann Willhoite, Martha Bragin and Roberto Biella Battista;
- Training: Guglielmo Schininà and Nancy Baron;

Chapter 16. Monitoring and evaluation: Martha Bragin and Emmanuel Streel;

Annex 1. Inter-agency coordination: Renato Libanora, Sarah Harrison and Guglielmo Schininà.

Annex 2. Ethical considerations: compiled by Natalia Hortigüela Gallo.

INTRODUCTION



Home visits and recreational activities; Psychosocial Mobile Teams, Bassariya, South Lebanon. © IOM 2016

The present Manual aims to facilitate mental health and psychosocial support (MHPSS) experts and managers in designing, implementing and evaluating community-based MHPSS (CB MHPSS) programmes, projects and activities for emergency-affected and displaced populations in humanitarian settings. It is specifically designed to support managers and experts hired by the International Organization for Migration (IOM). However, it can also be used, in its entirety or in some of its components, by MHPSS experts and managers working for IOM's partners, including international and national governmental organizations, non-governmental organizations (NGOs), countries, donors and civil society groups. For this reason, the document is open source, refers to tools and researches of different agencies, and was conceived and reviewed by a variety of experts and practitioners from several **organizations**. Although it is written for an international intergovernmental organization, smaller non-governmental agencies can make use of parts of the manual, based on identified priorities of their own programmes.



WHY A MANUAL ON COMMUNITY-BASED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCY AND DISPLACEMENT

There has been a call in recent years to shift the focus of MHPSS programmes in emergencies from psychological symptoms, and their treatment and prevention, to collective and contextual elements of consequences of adversities. This includes the understanding of the importance of the collective reactions to adversity and of social cohesion, social supports, identities and social textures in determining individual and social well-being after disasters. It also includes the activation of context-specific, multidisciplinary support systems that build on existing strengths of affected communities, rather than limiting the intervention to the provision of services to respond to the deficits created by the emergency. In 2019, the Inter-Agency Standing Committee (IASC) Reference Group on MHPSS issued *Community-Based Approaches to MHPSS Programmes: A Guidance Note* (IASC, 2019a) to respond to this widely perceived need. The guidance aims at better defining principles of MHPSS in emergencies based on the understanding:

...that communities can be drivers for their own care and change and should be meaningfully involved in all stages of MHPSS responses. Emergency-affected people are first and foremost to be viewed as active participants in improving individual and collective well-being, rather than as passive recipients of services that are designed for them by others. Thus, using community-based MHPSS approaches facilitates families, groups and communities to support and care for others in ways that encourage recovery and resilience. These approaches also contribute to restoring and/or strengthening those collective structures and systems essential to daily life and well-being. An understanding of systems should inform community-based approaches to MHPSS programmes for both individuals and communities (IASC, 2019a).

Box 1

Institutional background

IOM's engagement in MHPSS stems from the *IOM Migration Crisis Operational Framework (2012a)*, which includes psychosocial support as one of the 15 priority areas of IOM's intervention in humanitarian and migration crises. The pursuit of the most attainable standards of health and psychological well-being of migrants and displaced populations is enshrined in both the United Nations *Global Compact for Safe, Orderly and Regular Migration (2018)* and the United Nations *Global Compact on Refugees (2018)*. The Sustainable Development Goals, from the United Nations **2030 Agenda for Sustainable Development**, call for universal mental health care and psychosocial support that leave none behind, including migrants and refugees.



This Manual aims to give operational and programmatic indications on how to make this happen within IOM MHPSS programmes, and those of partners working with relatable populations in similar contexts.

Box 2

Complementary resources

The Manual is complementary – not alternative – to a series of related tools, including:

- (a) **The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007);**
- (b) **The IASC Community-Based Approaches to MHPSS Programmes: A Guidance Note (IASC, 2019a);**
- (c) **The United Nations Children’s Fund (UNICEF) Operational Guidelines: Community-Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-Tiered Support for Children and Families (UNICEF, 2018).**

It differs from those in that it is a programmatic manual and not a guideline, and is not age- or gender-specific. Reference will be made to the above-mentioned tools throughout the Manual.

IOM has provided MHPSS to emergency-affected, migrant, displaced, returnee populations and host communities since 1999, in more than 70 countries worldwide. Based on its experiences and engagements, the Organization has developed holistic and systemic practices of MHPSS that are community based. Community is indeed a central concept in the Organization’s MHPSS approach, due to its mandate and target populations. The psychosocial well-being of migrants is indeed strongly linked to factors that are strictly interrelated with the concept of

community. These include a sense of belonging, social roles, culture and cultural adaptation, the dynamic between tradition and change, differences in paradigms of social support, a sense of identity, and in-group and out-group relations and stigma.

For many years, the harmonization of IOM MHPSS programmes in emergencies has been based on face-to-face trainings for the IOM experts and managers, but this approach has proved difficult to sustain, unless accompanied by a factual manual. From the one side, requests for MHPSS programmes have increased dramatically in the last few years, making it difficult to deploy managerial and expert teams that are already trained, or to train the deployed teams in a timely manner. On the other side, the need for a manual that could instruct newly hired managers and experts in the various steps of setting up a CB MHPSS programme with displaced populations has emerged in the evaluation of several IOM MHPSS programmes in emergencies, such as those in **Libya** in 2013 and the Syrian Arab Republic in 2016.

The Manual can be used by:

- IOM managers, to be instructed on IOM’s approach to CB MHPSS programming;
- Managers and experts in the wider MHPSS community, to respond to the need to identify and harmonize practices of CB MHPSS.


Box 3


Background knowledge

IOM, as with most agencies, hires MHPSS experts and MHPSS programme managers based on relevant academic background and prior experience in relatable programmes. This Manual is therefore designed with an expert reader in mind, although anyone engaging with MHPSS in an emergency could find it of use.

HOW THE MANUAL IS ORGANIZED

The Manual has three versions:

- A printed version that contains only essential knowledge;
- A PDF version that complements the printed version, and contains more in-depth readings, annexes and hyperlinks; and
-  A web-based version, that can be found [here](#). This version will be a living document and will be regularly updated based on new research, identified best practices and feedback from the field.

 The Manual is organized into **16 chapters and two annexes**. The first chapter introduces concepts, models and principles of CB MHPSS work; the other chapters are operational and programmatic. These chapters are of two types:

- Those that have to do with the process of a CB MHPSS programme:
 - Engaging with communities;
 - Assessing and mapping;
 - Psychosocial mobile teams;
 - Technical supervision and training;
 - Monitoring and evaluation;
 - Plus two annexes on coordination and ethical considerations.
- Those that introduce specific CB MHPSS activities:
 - Sociorelational and cultural activities;
 - Creative and art-based activities;
 - Rituals and celebrations;
 - Sport and play;
 - Non-formal education and informal learning;
 - Integration of mental health and psychosocial support in conflict transformation and mediation;
 - Integrated mental health and psychosocial support, and livelihood support;
 - Strengthening mental health and psychosocial support in the framework of protection;

- Counselling;
- Community-based support for people with severe mental disorders.


Each chapter:



- Provides a short theoretical background.
- Lists essential information on the topic useful for managers. This can include the mapping out of the activity against the various tiers of the IASC pyramid of MHPSS.
- Describes step-by-step the process that needs to be undertaken by an MHPSS manager to allow the implementation of the relevant activity process in a community-based fashion.
- Refers to the relevant points of the IASC Guidelines on MHPSS in emergencies.
- Presents examples and best practices.
- Refers to relevant internal and external tools, models of work and case studies. These are hyperlinked and can be directly accessed with a simple click.
- Identifies challenges.
- Provides a short list of additional readings, on the top of the articles and tools already hyperlinked in the text.

No chapter provides financial, logistical or other administrative indications that are embedded in each agency's rules and regulations.

The Manual can be read in its entirety, or by a single chapter of interest. Indeed, each chapter contains internal hyperlinks, bringing the reader with a click to parts of other chapters that are to be read to comprehend the issues at stake. Each chapter can be read autonomously, making use of the hyperlinks.

The Manual contains three kinds of hyperlinks:

- Some hyperlinks are indicated by this icon  and will bring the reader with a click to other parts of the Manual. They are particularly important if one reads the Manual starting from any given chapter.

- Other hyperlinks are indicated by this icon  and will bring the reader to further information on the same topic, in-depth readings and supporting materials that are embedded in the PDF, including original material developed by experts specifically for this Manual. They can only be read using the PDF and online versions.
- Other hyperlinks  will bring the reader with a click to videos, tools, trainings or guidelines that are available in the public domain and provide a practical complement to the processes described in the chapters. The corresponding materials have been researched and vetted by the authors, the Steering Committee and the editorial team.

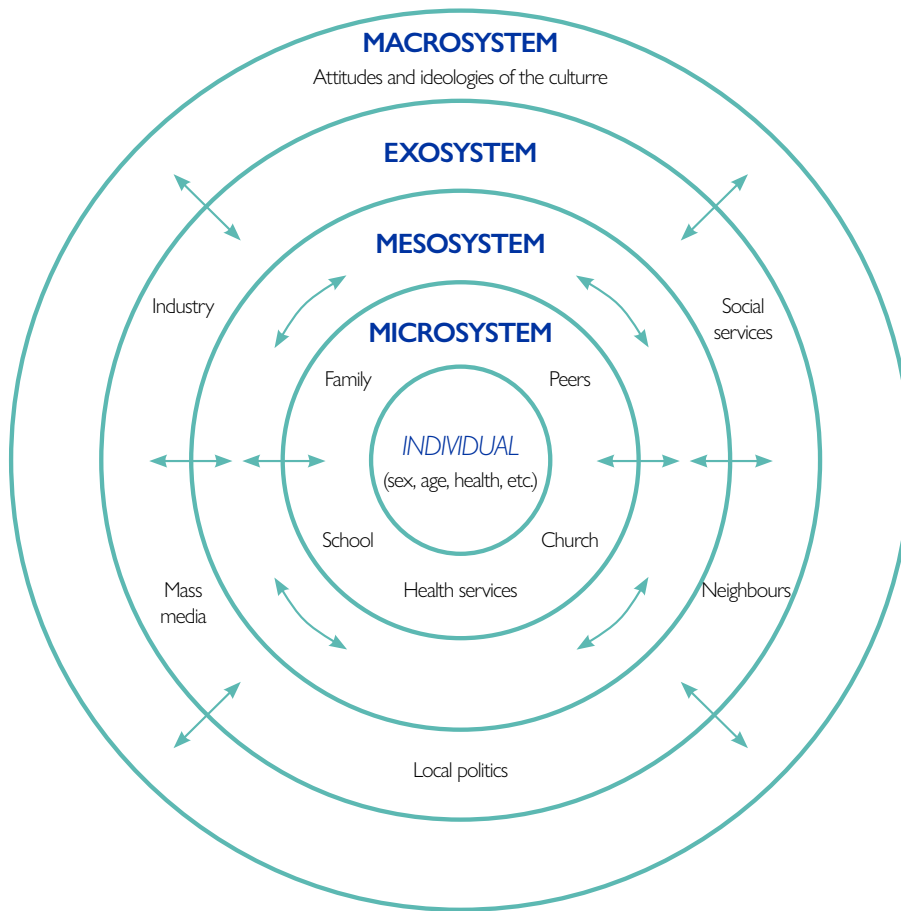


1. CONCEPTS AND MODELS OF WORK



This chapter introduces the main concepts at the basis of this Manual and presents a few models that link theory and programming, and can be helpful in designing and managing CB MHPSS interventions. The chapter introduces theories and paradigms, not practical actions. These theories and paradigms are fundamental to understanding an approach to CB MHPSS and to contextualizing the chapters that will follow. The informing principle of this Manual is that individuals are part of a socioecological system that includes families, larger human systems and communities (see fig. 1), and therefore communities are a cornerstone of MHPSS programmes that instead usually tend to focus on the individual needs.

Figure 1: Socioecological system



Source: Bronfenbrenner (1979).

→ 1.1. CONCEPTS

1.1.1 The meaning of community

In its widest sense, “community” refers to a group whose members share certain commonalities – such as geographical location or location of perceived origin, language, interests, beliefs, values, tasks, political affiliation, ethnic or cultural identity, sense of belonging and others – and whose size varies from very small, such as a nuclear family, to extremely large, such as inhabitants of an entire continent. More precisely, communities are human systems characterized by interrelationships and interactions among their members in a given context. As such, a community is a composite of clusters of:

- Individuals;
- Nuclear and/or extended families;
- Tribes and/or clans;
- Confessional groups;
- Political parties;
- Congregations;
- Men’s, women’s and youth associations;
- Professional associations;
- Amateur artistic groups;
- Sports teams;
- Interest groups, such as people who like a certain kind of music, or a football club, or a star;
- Many others.

The interrelationships and interactions between these groups are also informed by less actual and more constructivist elements, and include:

- Cultures;
- Belief systems;
- Epistemologies;
- Ideologies;
- History and historical perceptions;

- Sociopolitical interests;
- Visions of the future;
- Historical artefacts and monuments;
- Societal discourses and narratives.

Finally, community includes institutions such as political representative bodies, schools, health centres, and religious and civil society organizations.

Box 4

Power dynamics in communities

Hierarchical and non-hierarchical interrelationships among individuals, groups and systems of meaning characterize each community. Power is an important element to consider when engaging communities, especially after disasters and in **migration**.



Communities are dynamic and changing, not only in terms of their actual membership, but also in terms of their characteristics and preoccupations. Communities, like all systems, need both a degree of *stability* and a degree of *change* in order to survive and thrive. If there is too much stability, the system stagnates; and if there is too much change, the system is put into chaos. Communities always need to keep a viable contact with their roots and traditions, while they also need to adapt to the new circumstances and challenges they face along the time continuum, especially when encountering adversity.

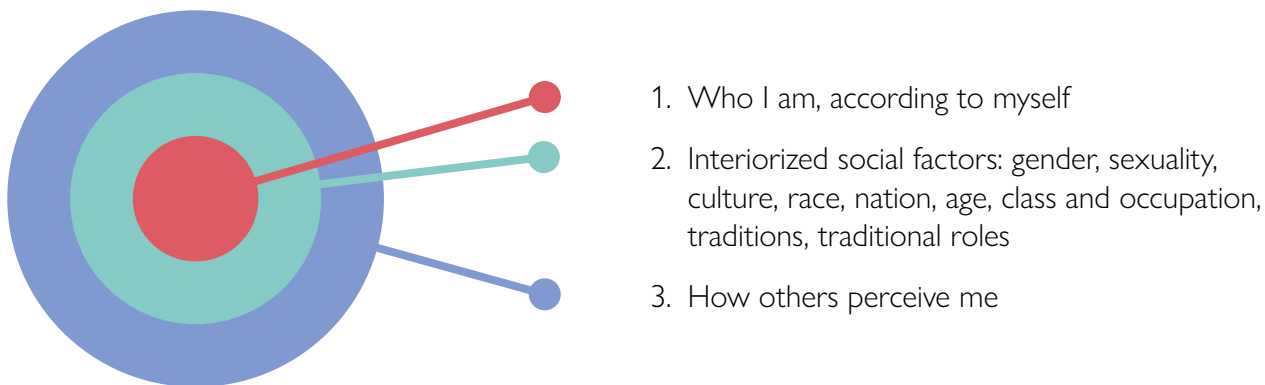
The interactions between individuals, between the resulting human systems, and between these systems and more transcendent elements – such as culture, beliefs and epistemologies – create a sense of belonging and safety and are central in defining identity. Identity is a cornerstone of a sense of community and of psychosocial well-being, and is central to understanding the psychosocial well-being of crisis-affected and migrant populations.

1.1.2 The meaning of identity

Identity is a central concept in the psychosocial well-being of individuals and groups, and remains so after adversity, disruptions and displacement. The simple definition of identity refers to the characteristics determining who a person is (OED, 2019), and the same would apply to collective identities, including community and groups identities. Generalizing for the use of a manual the common elements to most underlying psychological and sociological theories, identity can be considered a system constructed by the interrelation of three components:

- The first component (illustrated in red in Figure 2), is the self-concept, which corresponds to who one is to himself or herself (for instance, individual differences, self-attributions). The first component is not entirely neutral, since one self-attributes qualities, characteristics, cultural beliefs and roles based on interiorized societal factors, such as the culture, beliefs, education, gender and learned social roles.
- Dynamic theories add the influences of archetypes, and the subconsciously inherited cultural elements that are informed by the hegemonic and secondary cultures one belongs to, either for assimilation or for contraposition. (This part is illustrated in green in Figure 2.)
- Finally, there is a relational component to identity, which is determined by how one is perceived by others: family, friends, colleagues, clients, neighbours, persons of authority (in blue in Figure 2). These three components are continuously feeding back on each other.

Figure 2: Identity



Source: Schininà (2012).

Identity is multifaceted. The self is composed of different selves, for instance the parent self, the family self, the professional self, the partner self, and so on. The three components can have different “weights” in different communities in shaping an individual’s identity, and identity is the result of a continuous negotiation that the individual conducts with himself/herself, his/her culture and his/her community. Therefore, identity is in continuous evolution, and changes based on one’s own experiences, encounters, education and cultural transformations at the level of the system, among others. These changes are organic.

Adversity and forced displacement affect identity, on all levels. Self-concepts are questioned by victimization, inhumanity, torture and violence. The adherence to interiorized societal factors,

such as belief systems, is put into question by the causes of an emergency (especially in the case of conflict). In the case of migration and displacement, the hegemonic culture in the host community may not share the same societal factors as that of the migrants, since language, understanding of social roles, systems of meaning and simpler elements, such as sense of humour, may differ. More importantly, the feedback migrants receive from significant others suffers due to the loss of some of them, the fact that others are left behind, and finally by the fact of being immersed in a new community where one is not known and often stigmatized. Identities need to be readapted. This process may be painful and challenging, but its outcomes are not necessarily negative. In the process, however, confusion, disorientation and polarization can happen. In situations of war, in particular, the individual core of the identity tends to be assimilated to the hegemonic narrative of identities in war. The adherence to a core of values that are determined by opposition to the values of the other conflicting party becomes a fundamental prerequisite to be considered part of a community, and identity risks becoming exclusive.

In the emergency environment, humanitarian workers are part of the significant others for affected individuals. In this respect, humanitarian actors are co-constructing the identity of the affected populations they serve from a peculiar position of power.

It is therefore important that humanitarian workers do not contribute to creating a negative identity of the affected populations, basing the relationship only on their deficits and vulnerabilities, which risks creating a victim **identity**, or relying on predetermined categorizations. A community-based approach stems from the protection of the richness of the identities of the affected populations of concern to the CB MHPSS programme, and from the awareness that a humanitarian organization is part of a system that

determines to a certain extent the evolution of these identities. As a consequence:

- Identity should be understood in its community-relational and more individual components.
- Identity should be respected, as for the fact that identities may be in a crisis or a transition.
- Identity should be empowered, restoring a sense of agency and efficacy.

1.1.3 The meaning of culture

Although the definitions of “culture” greatly vary in literature, for the purposes of this Manual, culture is considered to be a system of shared beliefs, symbols, myths, behaviours, canons, images, narratives, metaphors, artistic productions, rituals, values and customs that the members of a society use to signify their world and relate with one another. They are transmitted from generation to generation through learning, and are interiorized to varying degrees by individuals. Culture encompasses collective materials and immaterial elements that allow a specific community to represent itself as distinct and cohesive.

In this perspective, culture and its elements might offer protective, restorative and transformative support after disruptions, promoting participation, a sense of continuity, acceptance, resilience and a venue for positive social interactions in emergency settings.

Culture can't be understood as a closed system, and the perfect juxtaposition of one culture, including language and religion in one social group in one territory, is a rare occurrence. It is most likely that culture derives from the coexistence of subcultures with their own characteristics. Usually, the main culture and subcultures are not exclusive or necessarily alternative to each other, and cultural and subcultural elements will both coexist in the same individuals and groups, and they will feed back on each other.



These dynamics are also at work in emergency settings and with migration, where even main cultures may differ between migrants and their hosts, with the problems to a sense of identity that this can bring to both communities. On the positive side, subcultures can cross-cut the main cultural frameworks with alliances, fostering integration. In fact, subcultures allow for mutual recognition and converging interests between people of the same subculture within different main cultures, such as migrants and members of the host communities who share a cultural or subcultural identity (for example, same religion, same musical culture, LGBTQI individuals).

Culture is immaterial in essence, but it brings objective manifestations, relations among specific sets of individuals, artistic productions, cultural canons, narratives of exclusion and practices of inclusion and care, and, more inherently to MHPSS work:

- Rituals, liturgies, commemorations and **celebrations**;
- Spiritual and healing practices, aetiologies and explanatory models of **diseases**;
- Legends and myths, novels and poems, proverbs and **jokes**;
- Memories and oral **histories**;
- Emotional expressions, social customs and courtesy etiquettes;
- Visual and plastic arts, songs and dances, theatre, drama, storytelling and **performance**;
- Handcrafts, dressing and ornaments, cooking and **hospitality**;
- **Sport and play**;
- **Learning**.

These elements will be tackled in more programmatic terms in the following chapters.

Box 5

Cultures

Cultures should never be read in hierarchical (better or worse, superior or inferior), ethical (good or bad, advanced or backward) or functional (competitive or cooperative) ways. Rather, an MHPSS programme manager should look at cultures as systems that need to be understood in their essence and respected in their values to inform effective programming.

➔ 1.2. THE NECESSARY LINKS BETWEEN COMMUNITY, MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING

Community is a fundamental aspect of mental health, as enshrined in the relevant World Health Organization (WHO) definition, which identifies good mental health as:

A state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community (WHO, 2012).

Likewise, community is central to the definition of the adjective “psychosocial”, which refers to the interrelations between mind and society (OED), since communities are a pillar of the larger society, and its more concrete manifestations.

In humanitarian action, the composite term “mental health and psychosocial support” has been used since 2007 to define “any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental **disorder**”.

Community is central to this construct as well.



Indeed, war and disasters, forced migration and displacement are not only disruptive to the individual, but they lead to shared injuries to a community's social and physical ecologies, which affect psychosocial well-being. As Erikson (1976:154) wrote, they represent:

[A] blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality... a gradual realization that the community no longer exists as an effective source of support and that an important part of the self has disappeared..."I" continue to exist, though damaged and maybe even permanently changed. "You" continue to exist, though distant and hard to relate to. But "we" no longer exist as a connected pair or as linked cells in a larger communal body.

These injuries require not only individual but also collective responses to promote psychosocial recovery and well-being, which often involve the restoration of moral, social and political agency through the creation of shared meaning and narratives.

In 2019, the IASC Reference Group on MHPSS issued *Community-Based Approaches to MHPSS Programmes: A Guidance Note* (IASC, 2019a) to respond to a widely perceived need to better define principles of MHPSS work based, as already mentioned, on the understanding:



Box 6

Migration and the definition of Mental Health

The simple definition of good mental health is challenged by the specific situations created by migration and displacement. Find additional information [here](#).



...that communities can be drivers for their own care and change and should be meaningfully involved in all stages of MHPSS responses. Emergency-affected people are first and foremost to be viewed as active participants in improving individual and collective well-being, rather than as passive recipients of services that are designed for them by others. Thus, using community-based MHPSS approaches facilitates families, groups and communities to support and care for others in ways that encourage recovery and resilience. These approaches also contribute to restoring and/or strengthening those collective structures and systems essential to daily life and well-being. An understanding of systems should inform community-based approaches to MHPSS programmes for both individuals and communities.

On the other side, a superficial understanding of a community-based approach could be summarized in the slogan "Communities know it all". Yet, disruptions and displacement can create situations where the sense of a community is under question, and the networks and interrelations that usually bring communities together are severed, while values and cultures are under redefinition. Disasters often pull communities apart (including creating fault lines and divisions between frontline national humanitarian workers). Strengthening the resilience of the community is a crucial factor in recovering from adversity, and in preventing long-term mental health and social difficulties. (Norris et al., 2008; Padgett, 2002).

In other cases, different communities are brought by the emergency to cohabit in one geographical location, without sharing the other, more constructivist elements that build a community. In all these cases, MHPSS needs to be provided at different levels, always considering deficits, resources and new developments.

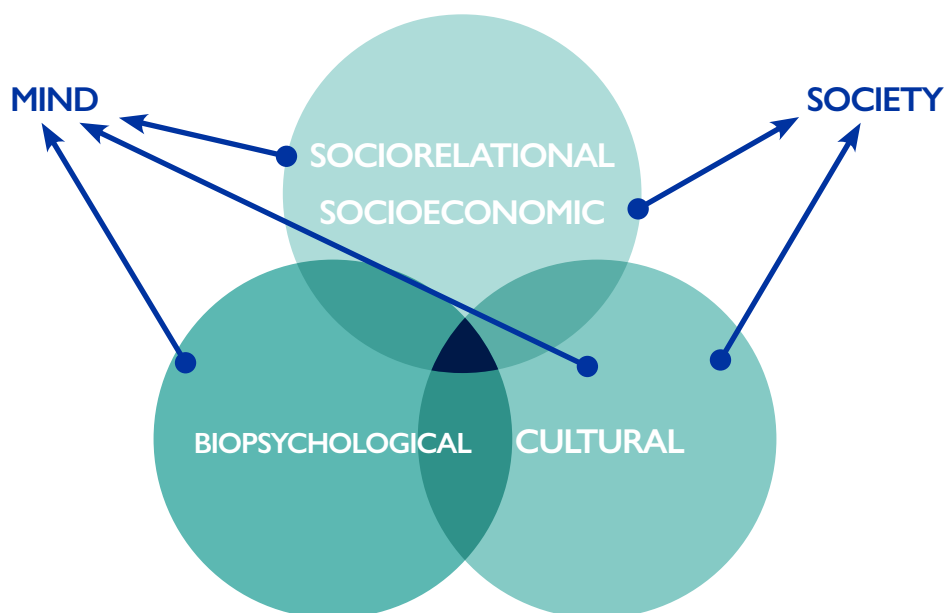
This Manual tries to operationalize this understanding within a model of work, derived and designed mainly for the MHPSS activities of IOM in humanitarian settings, but that could be applied to other programmes by other agencies. This work is based on the following models.

→ 1.3. MODELS

1.3.1 The model of a psychosocial approach to programming in emergency and displacement

This model lies in the fundamental interrelation of biopsychological, socioeconomic/sociorelational and cultural factors in defining the needs of migrants, displaced and crisis-affected populations, as well as the responses to these needs, as illustrated in Figure 3.

Figure 3:
The model of a psychosocial approach to programming in emergencies and displacement



Source: Schininà (2012).

The three spheres are equally important, interdependent and mutually influencing in defining psychosocial needs, resources and responses.

The **biopsychological** factor encompasses emotions, feelings, thoughts, behaviours, memories, stress and stress reactions. Psychological coping skills are related to this sphere. Body and mind are considered a unique system in this model.

The **sociorelational/socioeconomic** sphere focuses on the interactions and the interdependence between the individual and communities he/she belongs to. It consists of two complementary aspects: The **socioeconomic** aspect has to do with the availability of and access to resources, such as, for example, livelihood, health care or information technology. The **sociorelational** aspect brings up the quality of relations between an individual and his/her family, wider social systems and communities.

The **cultural** sphere regards, as already mentioned, a system of shared material and immaterial elements that members of a society use to signify their world and relate with one another, which are extremely important in how they make sense of adversities.

This scheme should inform the understanding of all humanitarian needs in a community in its interrelatedness. Therefore, biopsychological needs should be understood as being related to sociorelational and socioeconomic determinants, and their manifestations read based on culture. Likewise, socioeconomic and sociorelational needs should be understood as being interrelated to the biopsychological and cultural disruptions they derive from and generate.

Similarly, humanitarian responses should always be mindful of these interrelations. Needs must be prioritized, and agencies may respond to one set of needs rather than another. Yet, this interconnectedness should always be considered, for instance, by the following:

- Providing psychiatric support, one should be mindful of cultural explanatory systems and adapt culturally the diagnostic tools. One should also be mindful of how the provision of services can be understood by the community and how this can affect the well-being of the client and can't be detached from the consideration of the socioeconomic possibilities the family has to provide for the care.
- Distributing food, one should be mindful of the cultural elements of the distribution, such as which food is appropriate for that community and, for instance, how receiving in-kind charity can be perceived in the environment, to mitigate possible stigma. On the other side, one should also consider the emotions, such as the biopsychological element, the modality that the distribution can imply: such as shame and a sense of disempowerment, among others.

Keeping this interrelation in mind will make any humanitarian programme more psychosocially informed, and more community-based. A part of this Manual is about what the managers of an MHPSS programme should do to make sure that other humanitarian programmes organized by the same organization, or existing support mechanisms within the community that are not labelled as MHPSS programmes, use a psychosocial approach.

1.3.2 The model of CB MHPSS programming in emergency and displacement

To schematize the approach to dedicated CB MHPSS programming of the organization, IOM has for almost two decades used an adaptation of Renos Papadopoulos' grid of outcomes of disruptive events, applying it to programming. This model is in line with a socioecological model and with a community-based approach to MHPSS, as advocated by the relevant **IASC Guidance Note**.

To know more of the informing principles of the model, **here** is an original contribution Papadopoulos wrote specifically for this Manual. In the chapter, the model is instead presented as it is used for IOM programming, and therefore adapted from its original elaboration.



Figure 4: Grid of outcomes of disruptive events

	Negative psychosocial responses	Neutral psychosocial responses and resilience factors	Positive psychosocial responses or adversity activated developments
INDIVIDUAL			
FAMILY			
SIGNIFICANT GROUPS			
COMMUNITIES			

Source: Adapted from Renos Papadopoulos (2007).

A CB MHPSS programme will assess and respond to needs with a systemic and comprehensive approach that attends to:

- The suffering and the negative psychosocial consequences that the emergency and the displacement have provoked at the individual, family, group and community levels, and how they interrelate: It will therefore devise activities that respond to these different levels of suffering, which can include:
 - Ordinary human suffering due to mental disorders at the individual level;
 - Family violence, separation and roles readaptations at the family level;
 - Disruptions or polarizations of significant groups;
 - Community fractures such as stigmatization, conflict, divides, lack of sense of trust in institutions, and a lack of sense of trust in others, among others.

The tendency of MHPSS in emergencies to focus, almost exclusively, on the negative individual responses to adversity: In a CB MHPSS paradigm, these will instead be attended and responded to at all levels, always connecting the negative to the other two categories of responses.

- The neutral responses and resilience factors – that is, what makes people, groups and communities able to go on after a crisis counting on their pre-existing resources, qualities, skills, networks and coping mechanisms: A CB MHPSS programme will try to identify existing neutral responses and resilience factors, and strengthen them to mitigate the negative reactions. Resilience, as defined by Panter-Brick and Leckman (2013), “is the process of harnessing biological, psychosocial, structural and cultural resources to sustain well-being”.
 - An emphasis on strengths, resources and capacities, rather than deficits;
 - Anticipation of actions that reduce the impact of adversity;
 - Attention to multiple levels of influence, ranging from the structural and cultural through to the community and the individual;
 - Mapping influences within ecologically-nested systems (Ager et al., 2010). Resilience applies not only to individuals, but also to families, groups and communities. Thus, family resilience factors, for instance, can be used to respond to individual suffering, alone or in combination with tailored individual responses. Or, pre-existing support groups can be reactivated and trained to respond to the new challenges.
- The positive responses to adversity: In addition to the negative and unchanged responses to adversity, every person, family, group and community exposed to adversity also gains something to some degree from these experiences. There are endless examples of positive responses to adversity in real life: for example, altering previous individualistic style of life by appreciating the importance of

social networks, volunteerism, widening and deepening the scope of previous life goals, new community preparedness or learning new skills. A CB MHPSS will identify and give space for the presentation of these positive responses.

The original grid can be used in rapid assessments or any other form of assessment where the intention is to map out the entire range of effects following an **emergency**. Here it is presented as a model of the various components that should inform a community-based psychosocial programme, which includes:

- Mental health care for people with severe mental disorders, pre-existing or magnified by the circumstances of the crisis.
- Counselling to help individuals and groups to cope with their predicaments, focusing on their exiting resilience.
- Family counselling, parental skills trainings and family mediation, to help families to overcome their predicaments.
- Support to marginalized and affected groups, including minorities, and specific categories of survivors, in the form of counselling and integrated protection services.
- Community messaging addressing the identified root causes of community suffering, as well as conflict mediation and transformation to respond to the chain of violence that can characterize these situations.
- Promotion of activities that are known to alleviate individual, family, group and community suffering in a given community, strengthening the social fabric, and promoting and mobilizing the agency of individuals and groups who have skills and prosocial attitudes in a community. This includes fostering the creation of self-support, creative and cultural groups, and sport and learning activities; and re-establishing livelihoods, as well as those rituals and celebrations that are part of the natural ways people respond to adversity.

- Identifying and empowering positive responses to adversity through skills-building, capacity-building, mentoring, in-kind support, mobilization and engagement, volunteerism, and fostering civic participation.

To do these, CB MHPSS programmes should have:

- A specific focus; and
- Core teams that reflect a variety of needed background and expertise.

1.3.2.1 The focus of a CB MHPSS programme

MHPSS in emergencies is defined as:

“any type of local or outside support that aims to protect and promote psychosocial well-being and/or prevent or treat mental disorders”.

Within this definition, in a CB MHPSS programme, the focus is on strengthening local supports, and on looking at psychosocial wellbeing from a relational perspective. The “client” of a community-based MHPSS programme is therefore the social system, and the focus is on strengths, resources, continuity and adaptation to changes. The activities supported by such an approach are often those that community members are already engaged in, but not solely. The focus is less on direct services, and more on offering a structure that promotes positive connection and social processes. Most often, this involves helping to reactivate old and build new connections between constituencies, and helping people recognize and enhance existing resources for recovery. On the other side, CB MHPSS programmes recognize the changes and difficulties that war, disasters and displacement bring to the social and symbolic fabric of a community, which create gaps in interactions and services that will need to be addressed.

1.3.2.2 The background and expertise of the core team

The disciplines and competencies that a CB MHPSS programme should have include:

- Clinical psychology;
- Counselling psychology;
- Social psychology;
- Community psychology;
- Social work;
- Linguistics;
- Anthropology;
- Humanities;
- Sociology;
- Applied arts;
- Education.

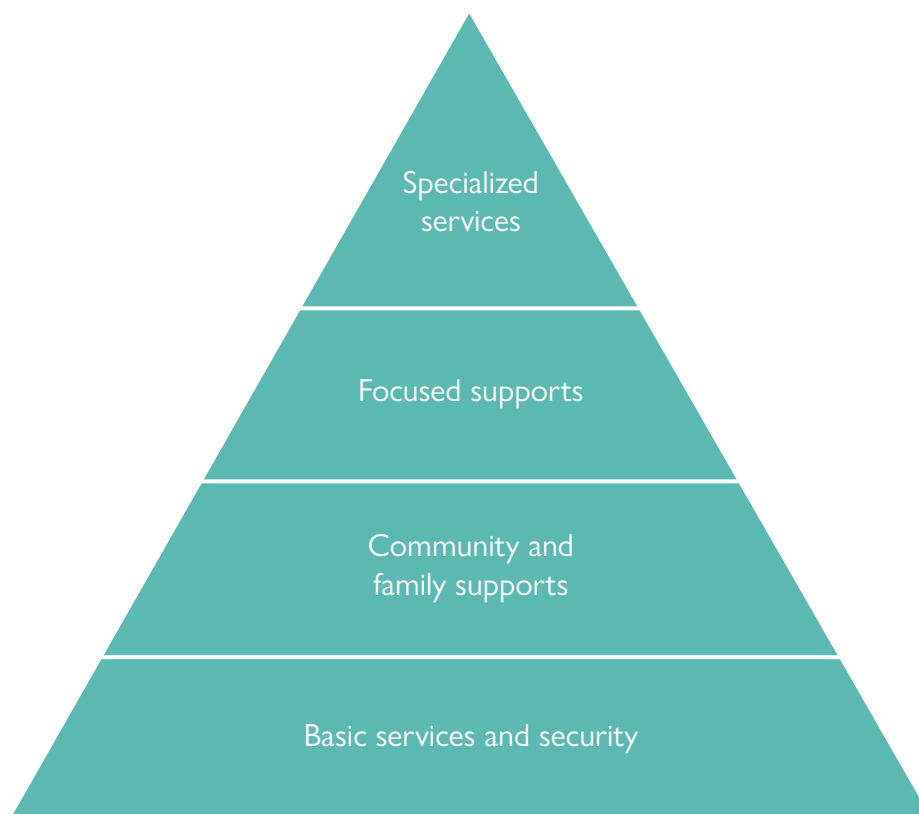
Professional staff in the programme, experts and supervisors will possess a combination of those backgrounds, or competencies will be prioritized according to the specific MHPSS components the programme focuses on.

Box 7

The IASC pyramid of MHPSS intervention

The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007) structure MHPSS activities in a pyramid, which has become extremely popular in MHPSS interventions in emergencies around the globe. The pyramid calls for a layered system of complementary supports that meet the needs of different groups (see Figure 5). These include basic services and security, community and family supports, focused services and specialized services. These layers are not hierarchical and should ideally be implemented concurrently. The second layer refers to “Community and family supports”, and draws attention to the importance of the role community plays in enabling the maintenance and improvement of the affected persons’ mental health, specifying activities such as “family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women’s groups and youth” (IASC, 2007). More specifically, the Guidelines recommend the facilitation of “conditions for community mobilization, ownership and control of emergency response in all sectors... community self-help and social support... conditions for appropriate communal cultural, spiritual and religious healing practices”. Most of the activities identified by the Guidelines at the community and family support level will be presented in this Manual following a different framework. Yet, wherever possible, the Manual will signal at what level of the pyramid of psychosocial intervention a certain proposed activity should be categorized. This is done to allow programme managers to present results within the IASC groups and frameworks in a way that can be understood by partners. On the other side, as it will become evident in the Manual, often the various layers of the intervention pyramid are more interconnected than a rigid categorization would allow, which will be also highlighted.

Figure 5. IASC pyramid of MHPSS in emergency (IASC, 2007)
(each layer is described in Box 7)



Source: IASC (2007).



➔ 1.4. CHALLENGES AND CONSIDERATIONS

Although community is a system that comprises different subgroups, levels of individual interiorizations and counternarratives, and is constantly transforming, it risks in certain instances to be perceived and performed as atemporal, normative and prescriptive by its actors as well as by external observers. This brings several consequences:

- CB MHPSS activities might consolidate negative stereotypes and bring about harmful practices as a reaction to the emergency (for example, early marriages, segregation of girls and persons with mental disorders, and aggressive behaviours).
- Psychosocial workers may tend to generalize community characteristics to all assisted individuals and consider them immutable. By contrast, they should always understand the dynamic and evolving nature of community.
- Competing discourses inform most functions of communities: a *dominant* discourse, which is responsible for forming the main position of the system; and *subjugated* discourses, which are

different if not contrary to the dominant one. The key dimension that distinguishes these two types of discourses is power. All discourses should be listened to and validated in a CB MHPSS programme.

- When community is identified with its dominant and hegemonic discourse, this risks exacerbating the marginalization/discrimination/stigmatization of subcultural and subjugated groups, reinforcing power imbalances or subverting existing power balances in a way that creates tensions and further oppression.
- Furthermore, communities are transformed due to emergencies. People might react and adapt to adversities in peculiar and different ways. Some of the community members might become more conservative, while others might become more explorative (or even negative) towards their cultural belonging than they were before the crisis. The same person might swing between these polarities at different stages of her/his journey-in-the-making. Therefore, community, in its cultural and identity aspects, needs to be contextualized in the present while an intervention is planned.
- Humanitarian workers can have an impact on the affected communities in terms of:
 - The human relationships that are developed between them and their clients;
 - The range of expectations and hopes that are raised;
 - The idealizations that emerge;
 - The identities that are formed as a result of the CB MHPSS programme;
 - The impact of the “beneficiary” identity;
 - The dependency that is created;
 - Focusing on a specific group of the population.

An MHPSS manager needs to be mindful of how all these impacts interact.

FURTHER READING

Bateson, G.

1979 *Mind and Nature. A Necessary Unity.* E.P. Dutton, New York.

Erikson, K.

1991 Notes on Trauma and Community. *American Imago*, 48(4):455–472.

Papadopoulos, R.K.

2007 Refugees, trauma and adversity-activated development. *European Journal of Psychotherapy and Counselling*, 9(3):301–312.

For other references, find the full bibliography [here](#).




2. ENGAGING WITH COMMUNITIES



→ 2.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Community engagement is considered a cornerstone of all humanitarian responses, and can be summarized as an operational approach that involves the affected communities in the different phases of the programme and the provision of services, not only as users, clients or beneficiaries, but to varying extents as agents of their own individual and collective well-being.

Community engagement can therefore be considered as both a process and a result of an MHPSS programme in emergencies.

- 
 • In terms of process, *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007)* guide humanitarians on how to facilitate the conditions for community engagement. In addition, the IASC Reference Group on MHPSS' *Community-Based Approaches to MHPSS Programmes: A Guidance Note (IASC, 2019a)* further emphasizes meaningful participation of communities in the provision of MHPSS in emergencies. As previously **mentioned**, communities are composite, and encompass different groups and social systems. All different components of a community, and all different communities coexisting in a territory, should be engaged, not only the mainstream one. For instance, in the case of IOM, the host community, various migrant communities and socially and culturally diverse subgroups should all be engaged. As a process, engaging communities:
 - Reduces conflicts and enhances trust: Engaging and informing communities help manage expectations, and avoid misunderstandings between the management of the programme and the affected communities.
 - Brings to more effective programming:

This is built on existing knowledge, resources, networks and concepts.

- Assures better access to the most vulnerable populations.
- In terms of results, engaging communities effectively brings a series of direct outcomes to populations' well-being:
 - Facilitates recovery: Through engagement, organizations can support communities' long-term recovery rather than only providing for immediate needs.
 - Grants agency and protect resilience: The use of existing resources within the community is an element of stability and limits the negative effect of the non-participatory approach of many emergency humanitarian interventions and the creation of **victim identities**.
 - Increases local ownership and empowers people: Being a part of the decision-making process, affected communities are more likely to own the intervention, and to learn and be empowered by this process.
 - Strengthens social cohesion: Different components of a community, and all different communities coexisting in a territory, should be engaged. Sharing activities and decisions enhances social cohesion between these communities and groups. And social cohesion enhances well-being.
 - Helps mend the social fabric where disruptions have torn it.



This chapter covers the objectives and stages of community engagement in an MHPSS programme, and describes a process of engagement suitable for IOM MHPSS programmes.

2.1.1 The three main areas of engagement

Community engagement can have a lot of positive effects, and is an essential feature of the process of implementing a CB MHPSS

programme. Its objectives can be organized in three main clusters:

- a) Informing decisions: Providing opportunities to the community to contribute to decision-making processes. This is important but at times difficult to achieve in emergency MHPSS programming, where at times the main activities of a programme are decided even before meeting the communities. And yet, a certain level of contribution to decision-making can always be achieved.
- b) Building capacity: Enhancing MHPSS capacities and competencies in a community.
- c) Strengthening relationships: Improving relationships between the agency and the community, and between some components of the community.

The three objectives are interrelated and should be pursued at the same time, but the timing of the programme and the nature of the emergency may bring a prioritization of one objective over another. For example, building relationships becomes the primary objective when the MHPSS intervention was designed without community engagement, to fit with the requests and timing of donors. Informing decisions is instead the primary objective of an agency that has money to spend but no preconceived ideas of existing needs and resources. Building capacity will be the primary objective of an agency that has a very technical profile (Capire Consulting Group, 2015). In an IOM CB MHPSS programme, for instance, engaging communities is a way to build relationships with all migrant and non-migrant communities of concern, and to facilitate the creation of relationship between them. It is a way to inform decisions about the programme (objectives, indicators and priorities, among others), and it is mainly a way to create capacity in communities, as will be explained in this Manual.

From a programmatic point of view, engaging communities in MHPSS happens in a continuum that invests all phases of the MHPSS programme cycle, from assessment to monitoring and

evaluation, taking into account the three objectives of community engagement in the process.

2.1.2 Gradations of community engagement

Community engagement can have different gradation and scales, as summarized below:

- **Passive:** Information is shared with communities, but they have no authority on decisions and actions taken.
- **Information transfer:** Information is gathered from communities, but they are not taking part in discussions leading to decision-making.
- **Consultation:** Communities are asked for their opinions, but they don't decide on what to do and the way to accomplish it.
- **Functional:** Communities are involved in the planning of one or more activities, but they have limited decision-making power.
- **Interactive:** Communities are completely involved in decision-making with the agency implementing the programme.
- **Ownership:** Communities control decision-making and agencies act only as facilitators (funders, supervisors and trainers).
- **Empowerment:** Communities are empowered in the provision of MHPSS, so that they can ultimately be able to respond to their needs with limited external support.

The aim should always be to strive for as much community engagement as possible, putting the bar at the functional level, aspiring to reach ownership and empowerment levels. In IOM MHPSS programmes, different levels of engagement will be used with different actors within a community. For instance:

- **Empowerment:** Professional categories and practitioners active in various domains of MHPSS will be empowered through academic level trainings, designed with local academia and experts as partners (see chapter on **Training**).



- Functional and ownership: Psychosocial teams are fully a part of the decision-making process of MHPSS programmes. They come from both the host and the displaced communities, and they have thought about how to engage and interact with others in the community (see chapters on **Psychosocial mobile teams** and on **Technical Supervision**).
- Functional and interactive: The activities that are proposed by the teams are both service-oriented and mobilization-oriented, therefore granting a balance between responding to needs and allowing a meaningful participation of volunteers, professionals, survivors, stakeholders and other actors (see chapter on **Sociorelational and cultural activities** and on **Creative and art-based activities**).



All this will be explored in the following chapters.

➔ 2.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

2.2.1 Whom to engage

Engaging communities means engaging people, social functions and institutions through a process, and specific actions that allow them to actively participate in decision-making, to the different degrees mentioned above. Whom to engage in an MHPSS programme is set in the objective of the programme itself.

2.2.1.1 Individuals

The first point of contact for IOM MHPSS managers should be MHPSS professionals and resources. Even in complex emergencies, national and local MHPSS professionals can effectively contribute to informing and shaping psychosocial support programmes.

Secondarily, many social, administrative, political and religious structures that are relevant to

mental health care and psychosocial support might be still in place. Even before starting with a proper mapping, one can engage with the leaders of those structures already known by the organization, or the most relevant and visible.

Finally, it is important to identify community gatekeepers who are able to help the manager engage with the affected communities or their subgroups. Gatekeepers are people with social functions in their community, in particular leaders, due to their influence and access to the community. For instance, civic and local government leaders, religious and spiritual leaders, leaders of other community-based organizations, teachers, artists and intellectuals, members of relevant departments at local universities, youth activists, elderly and female leaders and many others can be engaged as gatekeepers.

Both the MHPSS professional community and the other gatekeepers can help the manager in **assessing needs; mapping resources** with a snowfall approach; and learning about local concepts and idioms of distress and grief, frustration and fear, happiness and hope, as well as the local customs and beliefs important for the implementation of an MHPSS programme. The time taken to meet and listen will often pay off with appreciation and collaboration. However, in engaging with gatekeepers and members of different professional and administrative–political groups, managers should maintain a critical approach. Organizations, local governments and social groups have their own agendas and, without recognition of these strategies, wrong operational decisions are easily taken (**IASC, 2007**).

2.2.1.2 Families

Families are important social systems, and need to be engaged as such. In an emergency context, particularly in cases of displacement and forced migration, families are the cultural and social spaces where individuals express their stress,



fears and grievances, and receive basic care, emotional support and protection. Although families are usually part of larger social and territorial groups formally represented by cultural, administrative or political leaders (see above), it is important to establish direct operational engagement with extended families or clusters of families (camp's sections, neighbourhoods in urban settings, and villages in rural areas).

Families of primary concern for community engagement in MHPSS should be those whose members are:

- Affected by pre-existing cognitive and/or physical impairments;
- Affected by pre-existing or crisis-generated mental, neurological and substance abuse disorders;
- Survivors of violence and/or witnesses of disappearances and deaths that occurred during the crisis;
- Single-headed families with a large number of dependants (children, elders, relatives);
- Associated with or from different ethno-religious groups.

During the assessment phases, samples of families should be interviewed as a whole (allowing for active participation of all members, not only the heads or the most vocal), to understand MHPSS needs, and coverage and quality of delivered services. According to local cultural norms and emergency settings, representatives of extended or clustered families can be supported to establish projects' or parents' committees in support of the programme.

Box 8

Engaging with families

Engaging with families can include the establishment of an early warning system for cases of suicidal attempts, segregation of girls and persons with disabilities, early marriages, child abuse and domestic violence. For the purposes of such an informative system, usually youth and women are the best community members to engage with in monitoring family dynamics and hidden cases of abuse. Trust and confidentiality between community members and MHPSS staff are the core of this system, which can't be established at the very inception of the emergency response, but at a later stage.

2.2.1.3 Groups

Community engagement involves the inclusion of diverse groups in the community. These include men, youth and women's associations, professional associations and clubs, activists and self-help groups, community-based organizations, groups of interest, and groups that gather around a specific activity or interest (sports, fan clubs, choirs). In an emergency situation, these groups might be weakened by conflict, displacement, or logistical or political restrictions. Therefore, financial and technical **resources should be earmarked to revitalize, strengthen or even re-establish these groups**. Particularly relevant is the creation of networks and digital platforms where local NGOs and community-based organizations can share best practices, information and coordination, and promote campaigns of mutual interest.



2.2.1.3.1 Religious groups

Working with religious groups retains strategic consideration during the engagement process, because religion plays a relevant role in the value set and emotional and social life of many in the communities. Endorsement from religious groups and their involvement in the programme are thus important factors of community legitimation and ownership of the project. In fact, during an emergency, it is likely that religious organizations would already be conducting CB MHPSS activities, in which case the possible engagement can be extended to partnership.

It is also important to look at inclusion through the lens of religion. Local faith communities are usually able to stand close to people in emergencies and offer an interpretation of the experience that might prove to be meaningful to many. Therefore, religious and spiritual leaders can have a positive influence in channelling negative psychosocial reactions and promoting peaceful coexistence and participation. However, the involvement of religious and spiritual groups must be carefully considered and balanced in contexts with more than one group, or when a specific religious, ethnic, religious or social subgroup might be subject to open or covert discrimination by religious groups. For additional guidance on integration of faith, faith groups and leaders in CB MHPSS programmes, see



here. For a more structural approach, please see the guidelines on *A Faith-Sensitive Approach in Humanitarian Response: Guidance on Mental Health and Psychosocial Programming* (IASC, 2018a).



2.2.2 How to engage

There are several ways to keep communities engaged during the various phases of an MHPSS programme. The engagement process requires transparency and accountability, accessible and timely information, and clarity about the structures, processes, policies, capacities and limitations in human and material resources.

A project committee can be created with people who are a true representation of the different facets of the community. Regular meetings can be organized with them, building trust in the programme and in the process. The committees will include MHPSS experts, community leaders, religious leaders, and representatives from the various communities and groups. Consistent with the objective of the engagement and the gradation of engagement required by the programme, the meetings can be:

- Information sharing on the update of the programme (passive);
- Sessions where new information is shared with and gathered from the committee based on emergency technical and managerial needs (information transfer);
- Meetings where the opinion of the committee members on issues pre-identified by the managers is collected (consultation);
- Planning meetings where output indicators are evaluated together and important programme decisions are taken (functional–interactive) (Capire Consulting Group, 2016).

In addition:

- Psychosocial mobile team (PMT) members are a part of the community (see chapter on Psychosocial mobile teams).
- Each IOM PMT includes a community mobilizer (as above).
- Relevant local professionals are hired as consultants or in specific training and technical positions.
- Local experts and academics are part of the supervision team (see section 4.4 of this chapter).
- Artists, activists, promoters, can be given in-kind support to organize activities for the community (see Box 9).
- Existing networks, services and traditional practices can be supported in kind, or by training or network-building, to act as referrals or service providers.

- Structured forms are envisaged to receive feedback by the project's affected populations, decision-makers and the rest of the communities. These should take into account the **Accountability to Affected Populations framework and Communication with Communities mechanisms**.
- The engagement of migrants' communities can additionally require cultural mediation, adequate interpretation, and cultural competence trainings for the members of the committees and the MHPSS teams.
- Religious and cultural activities, such as fasting season and seasonal work, should always be considered – negatively, as they may affect participation; and positively, to be used in support of the communities' engagement with the programme.
- Capacity-building can be offered to community members.


Box 9
Engagement and partnership with local organizations

IOM has successfully implemented in Colombia, Lebanon, Libya, Turkey, Serbia and Iraq, just to mention a few, structured forms of engagement and partnership with local organizations providing MHPSS. These intensive training programmes (usually a weekly session over three to four months covering theoretical and operational topics) helped not only in capacitating the organizations but also in establishing coordination and consolidating civil society networks. This was usually followed up by the delivery of practical in-kind support, and supervision and mentoring, to develop small-scale MHPSS activities.

These organizations represent several ideologies, motivations, operational capacities and concerns, including faith-based, humanitarian, educational, women and children support, elderly, persons with disabilities, minorities, migrants, and gender-based violence (GBV) and torture survivors. IOM's initiative helped these organization to increase their capacity to:

- Intervene and coordinate themselves during the acute phases of the crisis on the basis of territorial and operational proximity to the affected populations and host communities;
- Pool professional resources and share best practices to ensure compliance with community-based methodologies and quality standards of MHPSS;
- Lobby as a unified group for funding, capacity-building and administrative procedures towards local authorities, the private sector and public service providers;
- Advocate for recognition, protection and care of affected populations by international organizations, national governments and humanitarian systems (United Nations agencies, donors and embassies);
- Interact with IOM as an international partner in assessing and jointly implementing emergency MHPSS interventions.

The resulting community-based organization coordination groups and NGO networks proved to be crucial in the provision of CB MHPSS in Libya in the immediate aftermath of the resurgent civil war in the summer of 2014, and in Iraq after the military campaign to liberate the north-west governorates from ISIS, including Mosul, in 2017.

Box 10
Local committees

National staff members working for the organization could be in part biased by the fact of receiving salary or compensation, and could be preoccupied with adapting what they know about their cultures to the new organizational culture in which they are embedded. Local programme committees can be formed to steer MHPSS programmes and engage on regular basis (Sliep, 2011). **The local committees** should be involved throughout the project cycle. It can help in prioritizing assessment questions and advising on the appropriateness of the means of verification used. In the planning phase, the committee decides how to prioritize the findings of the assessments and help in developing mutually agreed action plans that facilitate ownership and control by the communities involved (IASC, 2007). These plans should clarify how decisions will be made, define common values, and negotiate rights and responsibilities for each stage in the process (why, who, when, where and how). During implementation, the committee will provide regular feedback on the results of the programme and vet training plans. The committee will also validate the tools of and participate in the evaluation of the programme. The committee members can also act as focal points for their subgroups (academic, professional, ethno-religious, geographical, gender, age, subcommunities). They are the ones to inform their community or specific group and try to get them involved in activities. MHPSS managers should support the committee members and gatekeepers to their own strengths through specific training sessions and active involvement in the activities. **Local committees should include gatekeepers and experts for both the displaced and the host communities, as well as subcommunities.**



2.3. CASE STUDY
LINC Community Resilience based on Transitional Family Therapy (Landau, 2018)

A LINC Community Resilience Intervention involves an entire community or its representatives in assessing a situation and designing its own intervention (Landau, 2007). This type of intervention can be used within a community or by governments and organizations as a way to prepare for and/or resolve the consequences of mass disasters (Landau, 2004, 2007, 2012, 2018; Landau et al., 2008; Landau and Saul 2004; Landau and Weaver, 2006). The intervention uses a series of maps to assess demographics, attitudes, customs, family structures and important events in the community. Following this assessment, community forums are organized, each representing a comprehensive cross-section of the population. In larger communities (more than 6,000 people), LINC Community Resilience Interventions begin with consultants who train local professionals to assist in facilitating the interventions so that the entire community may be reached.

Following LINC guidelines, members of the community are divided into small discussion groups, each representing a cross-section of the community. The groups identify the strengths, themes, scripts and resources that are available within the community, and discuss what the concept of resilience means to them individually, as well as to their families and community. Each group then develops overarching goals for the future. Groups usually embrace the goals set by the collective, but they also usually add several of their own. They discuss ways in which their available resources can be applied to each small and easily achievable task that is derived from one of the goals.

The groups then work as collaborative teams to select their community “Links”, or people from within their own group whom they trust and with whom they can communicate easily. Links are identified as people who would make good leaders and who are able to bridge the gap between the community and outside professionals. Members of the collaborative teams then identify practical tasks from their goals and arrange work groups to achieve them. The number of Links depends in part on the size of the community. Medium-sized communities (populations of 6,000–50,000 people) select, on average, 3 to 5 Links; larger cities (50,000–1 million people) select 8 to 10 Links, each of whom coordinates multiple projects. This model has been applied in Argentina, Australia, Brazil, Finland, Japan, South Africa, the United States, Kosovo¹ and elsewhere.

2.4. CHALLENGES AND CONSIDERATIONS

Community engagement is not an easy process, especially not with refugees, or displaced and migrant communities. Displaced communities are often fragmented, scattered and pervaded by a generalized lack of trust due to their experiences. In addition, at times they cannot fulfil their cultural and social roles and traditions. The host community can feel threatened and not receptive.

There might be struggles between different community organizations and NGOs (including international NGOs), lack of funding, corruption, lack of well-functioning (governmental) institutes, exploitation and a challenging existing power structure, fed by a non-participatory humanitarian system (Saul, 2017).

Sometimes humanitarian organizations or workers are not engaging communities throughout their programmes’ cycle for various reasons (**Health Communication Capacity Collective (HC3), 2017**; OCHA, 2017):

- Fear of the negative: Humanitarian workers might be afraid of negative feedback or that people see them as accountable for issues they have little or no control over.
- Lack of resources: Providing coherent and useful information and listening meaningfully to communities may be seen as tasks that require additional budget and dedicated human resources. As resources are strained in most emergencies around the world, community engagement often is not considered a priority investment.
- Competing priorities: In any emergency, time is always of the essence. Life-saving assistance needs to be provided quickly, and taking the time to consult with people may seem counterproductive. Food, water, shelter and health often are considered as the only or most pressing priorities in a crisis.
- Coordination: Organizations might also have conflicting or competing approaches or messages. Not all international organizations easily work with different local groups, such as the local media. Harmonizing this can be an ongoing challenge.
- Inclusion of different groups: It is often not easy to include all the different groups due to power relations and dominant sociocultural behaviour and narratives. In conflict situations, there is a risk that there is a mingling of perpetrators and victims. Because of cultural sensitivity, certain issues are not easily discussed by the various groups.
- Language barriers (see chapter on **Counselling**).



¹ References to Kosovo shall be understood to be in the context of United Nations Security Council resolution 1244 (1999).

→ FURTHER READING

Ager, J., E. Fiddian-Qasmiyeh and A. Ager

2015 Local Faith Communities and the Promotion of Resilience in Contexts of Humanitarian Crisis. *Journal of Refugee Studies*, 28(2):202–221.



Regional Psychosocial Support Initiative (REPPSI)

2010 *Mainstreaming Psychosocial Care and Support - Facilitating Community Support Structures*. REPPSI, Johannesburg, South Africa.



United Nations Office for the Coordination of Humanitarian Affairs (OCHA)

2015 *Community Engagement*. OCHA, New York.



For other references, find the full bibliography [here](#).



3. ASSESSMENT AND MAPPING



→ 3.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Assessing the MHPSS needs and resources of people affected by an emergency, and mapping existing MHPSS services, or resources that could be easily reactivated, are essential parts of community-based MHPSS programmes. MHPSS assessments and mappings in emergencies should not only aim at listing problems, they should also help managers in analysing how individual, familial, cultural, social and political factors are intertwined in emergency responses, and how these connections affect the mental health and psychosocial well-being of crisis-affected populations and migrants. It therefore becomes essential that the MHPSS needs of affected populations are assessed in ways that involve **community members**. This is clearly defined in *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007:38–45 – Action Sheet 2.1, Conduct assessments of mental health and psychosocial issues)*.



If assessment is aimed, among other goals, to get insights into the collective tensions that lie behind individual and family psychosocial problems and the way to respond to these problems, communities need to be engaged to the extent possible in all the steps of the assessment, as illustrated in Figure 6.

Since literature on how to design and conduct an assessment is copious, this chapter does not present an assessment method or a specific tool, but rather focuses on how to engage communities in MHPSS assessment and mapping, and make them more community-based, referring to existing tools. This will include:

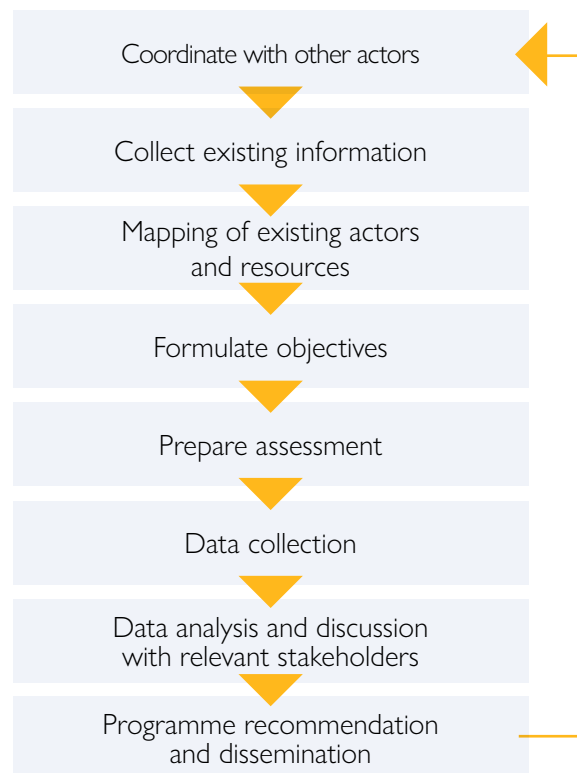
- How to include community members in the assessment team;
- How to validate and discuss the assessment's objectives, methods and priorities with key

community members;

- How to custom-design participatory assessments;
- How to select existing tools based on their participatory nature.

This chapter regards general initial MHPSS assessments. Once activities are set and the teams established, other assessments may be needed that are specific to the activity performed. For instance, (a) a livelihood programme that includes MHPSS components requires a market analysis; (b) the organization of creative activities requires a creative mapping of the community; and (c) in certain situations, a conflict analysis will be necessary to inform MHPSS activities in certain areas. These assessments are related to specific activities and are presented in the relevant chapters of this Manual.

Figure 6: Assessment steps



Source: adapted from WHO and UNHCR (2012).

The initial assessment should address three main questions:

- What are the existing resources and capacities in the communities (both affected and host communities) to cope with adversities and provide MHPSS services?
- What are the most urgent needs objectively identified by the project's staff and stakeholders, and subjectively perceived by the affected populations themselves?
- Who are the most vulnerable individuals, groups and subgroups in need of MHPSS in the affected community?

The answers to these questions will help the PMTs reach the aims of the assessment, listed in Box 11.

Box 11
Main aims of MHPSS assessments

- To learn about the MHPSS concerns created by the emergency and how they are being addressed, with special attention to those most vulnerable;
- To identify social, cultural and professional resources that exist in the affected community to address psychosocial issues and reactivate self-confidence, resilience and agency;
- To identify existing structures that could serve as referral, particularly for those affected by severe mental, neurological and substance use disorders;
- To identify and provide special protection to groups excluded from or stigmatized by the community;
- To obtain the baseline data against which the programme's strategies, activities, outputs and outcomes can be measured later.



3.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

3.2.1 Coordinate assessment with other actors

Assessment and mapping should be coordinated with other concerned agencies and actors in the field. This includes (a) other agencies involved in MHPSS activities; (b) other humanitarian actors, including the cluster system; (c) local authorities; and (d) communities:

- Other agencies involved in MHPSS activities in a given context can be contacted through the IASC field-based technical MHPSS group, if one exists (see Annex 1). To the extent possible, assessment and mapping efforts should be coordinated among different agencies to avoid overlapping and enhance complementarity.
- Other humanitarian actors shall be contacted, especially within the cluster system, to explore whether part of the information has been or is being collected through other assessments, and whether some items of the MHPSS assessment could be included in ongoing humanitarian assessments. In addition, they can be contacted for facilitation, coordination and clearances. For IOM, MHPSS items could be included in Camp Coordination and Camp Management cluster mappings and in Displacement Tracking Matrix assessments (see Box 12), through coordination with the responsible officers.
- Local authorities should be informed about the plans and made aware of what exactly is meant by a participatory MHPSS community-based assessment and its implications.
- Communities should be engaged, not only as participants, but as decision-makers in the assessment. A way for engaging communities in the assessment is by establishing a

community committee when the assessment is being planned. The membership can be enlarged during the assessment based on the results of the mapping, with the task of providing inputs and feedback into the assessment's topic and methodology (and later, analysis and results). For the formation and dynamics of a community committee, see the chapter on **Engaging with communities**.



Box 12

MHPSS questions in the Displacement Tracking Matrix

Two questions pertaining only to the realm of MHPSS could be included in **Displacement Tracking Matrix** protocols:

- (a) Are there psychiatrists, psychologists or doctors able to treat people with mental disorders in your community?
- (b) Are there services or individuals that people in your community can refer to, when they do not feel psychologically well? In case psychology is not understood, local idioms or the formula “do not feel well at heart” can be used.

3.2.2 Collect existing information

A desk review can be done remotely and *in loco*, searching for, reading and analysing academic studies and grey literature, including scientific articles, field reports, books and materials produced by humanitarian agencies.

If resources allow, or if a strong partnership with relevant faculties exists, academic centres could support the desk review, mobilizing their students and experts. IOM, or the IASC MHPSS group, would identify and partner with a relevant academic institution and commission a review. A best practice of this approach was seen in Haiti, soon after the earthquake of 2010, when WHO commissioned a review by McGill University of existing information on mental health concepts and services in Haiti, which was ready within weeks after the catastrophe.

For the methodology used in such reviews, see this **article**.

To read the report produced by McGill University on Haiti, see the document **here**.

To read the report produced by IASC after the earthquake in Nepal **see here**.

The desk review analyses existing information about cultural, social, political and religious background of the affected communities that



Focus group discussion in Bentiu, South Sudan. © IOM 2018



are relevant to an MHPSS intervention in the context. It helps in having precious information at the inception of programmes, and in focusing subsequent assessments and mappings.

3.2.3 Mapping of existing actors and resources

Mapping of existing services, capacities and resources, and needs assessment, are complementary exercises. Focusing on the presence or absence of services the humanitarian system deems necessary might give an idea on what is available or missing, but it might not clarify if what is available responds to what affected populations and community members perceive as the most needed, risking to underplay communities' perceptions of their own needs. On the contrary, an assessment without a mapping of services and resources might give an idea of what people perceive as needed, but it might not describe if these needs can be addressed with local resources, potentially overlooking the community's capacity to cope and respond to the situation.

3.2.3.1 Inter-agency mapping

The IASC Reference Group on MHPSS in emergencies has elaborated a “4Ws” mapping tool, which is a helpful matrix aimed at providing an overview of the existing MHPSS responses within the humanitarian system. The 4Ws mapping focuses on “Who is Where, When and doing What”, to get insight into the provision of related resources, capacities and services along the four tiers of the IASC MHPSS intervention pyramid (IASC, 2012).

The IASC 4Ws was designed to serve the humanitarian intervention. As such, it is a powerful tool to identify geographical and thematic gaps, avoid duplications and foster coordination among humanitarian actors involved in MHPSS. However, in some instances, it risks focusing primarily on what humanitarian agencies

are doing or plan to do, thus missing pre-existing community-based resources that are currently inactive (but could be easily reactivated), or active but unknown to the humanitarian system. Also, agencies that receive funding from the humanitarian system are the most motivated to participate in such mapping exercises, which may be unknown to community-based actors that receive their funding from other sources, or operate according to different paradigms (pre-existing governmental services, churches and traditional resources, spontaneous volunteer groups, professional groups, and so on). It is therefore important that IOM fully engages with the inter-agency 4Ws exercise, while also enlarging the scope of the mapping to community-based resources that may be unknown to the humanitarian system, and foster ways in which these resources can be included and represented in the mapping.

Box 13

Resources

Some hints on where to look for free access existing information remotely:

- <https://publications.iom.int/> – bookstore;
- www.mhps.net;
- www.reliefweb.org;
- www.who.int/hinari/en;
- www.academia.edu;
- www.apa.org/pubs/databases/psycinfo/index.aspx;
- www.ncbi.nlm.nih.gov/pubmed/;
- <https://scholar.google.com/>;
- www.humanitarianresponse.info/;
- www.interventionjournal.org.

In loco: In the field one could consult academic archives, repositories of theses of relevant faculties, local libraries, among others.



At the beginning of an emergency, mapping often happens through a snowball approach (an actor will refer the mapper to another, who will refer the mapper to a third, and so on). It is therefore important to consider the mapping as an ongoing exercise to expand throughout the life cycle of a programme. In addition, while in this flowchart mapping is presented as step 2, in practice it can also be conducted at the same time as the needs assessment or after the needs assessment.

Box 14

Assessment and mapping of specialized services for those with severe mental disorders

When designing and delivering interventions targeting those with mental disorders, mapping should focus on:

- Existing “informal” sources of care available for people with severe mental disorders at the community level;
- Knowledge around the different sources of available care;
- Attitudes towards the different sources of care;
- Health-seeking behaviour of people with severe mental disorders;
- Existing coping mechanisms, including social, cultural and spiritual outlets, which could be usefully strengthened;
- Any current or previous community plans to address the needs of people with severe mental disorders, including capacities, gaps and requests for additional support;
- Resource persons from different community subgroups (for example, women’s groups, youth organizations, cultural and religious associations) who could potentially be recruited and trained to support individuals with severe mental disorders.

This information should facilitate IOM MHPSS managers to identify:

- Services for immediate referral of those in need;
- Services IOM should partner with, with the objective to gradually build their capacity to receive referrals;
- Possible obstacles created by perceptions and health-seeking behaviour of affected individuals, families and communities.

However, this mapping should always be accompanied by quality control and human rights compliances of the mapped services (See Chapter on **Community-based support for people with severe mental disorders**).



3.2.4 Formulate objectives

The objectives of the assessment are highly dependent on the results of the desk review, the organizations' mandate and actual possibilities to respond to the current crisis, and the discussion and inputs received from the members of the project's committee, if already established, or the first community gatekeepers met during the process. In general, as identified in the *IASC Community-Based Approaches to MHPSS Programmes: A Guidance Note (IASC, 2019a)*:



A CB MHPSS assessment should identify mental health and psychosocial problems as well as safe and quality resources and strengths; including individual, family, community, traditional, religious and cultural coping mechanisms, social support mechanisms, community action and government and NGOs capacities.

An important distinction is whether the primary aim of the assessment is of advocacy or to plan a direct intervention. Another important factor is the nature of the programme. If the programme can respond to different emerging needs with a flexible approach, the goal can be broader. If the scope of the programme is limited – for instance, it can only provide urgent clinical services to people with severe mental disorders – then the goal should be restricted in identifying issues around this subject. Doing otherwise would not only be ineffective, but also tiring for the community, risking assessment fatigue and raising false expectations.

For IOM, typically, the first MHPSS assessment is broader, aiming at understanding people's psychological reactions – their own perception of what causes these reactions, and people's existing coping strategies, at the individual, family and community levels – and their understanding of needed services.

The objective of the assessment should be as specific as possible, realistically considering a minimum amount of information needed, timing and resources available (staff, logistics, access) to achieve the required output (**ICRC and IFRC, 2008:25–39**).



3.2.5 Prepare

In this phase, several decisions and actions related to the assessment must be taken. They are addressed briefly below.

3.2.5.1 Select methodology and tools

The methodology should be based on:

- Objectives;
- Scope of the programme;
- Availability of time;
- Availability of financial resources;
- Availability of human resources;
- Informing logic of the intervention.

In general, assessment methodology determines the degree to which participants and therefore communities can freely express ideas, which are an essential aspect of community-based and participatory approaches. The existing tools vary in the way they allow the expression of and/or emergence of participants' opinions. In this regard, a distinction needs to be made between at least four methodological approaches:

- A nomothetic approach based on types or categories: A nomothetic approach brings an assessment constructed around categories that are predefined. For instance, how many people fit in a certain category or need that the assessment aims to identify?
- An ideographic approach that aims at understanding meaning and perceptions of cultural or subjective phenomena: This approach lets participants express more what matters the most for them and then analyses the results, giving them a coherent form. Results can be categorized, but categories are not predetermined. They emerge from the assessment.
- Quantitative methodology that will result in prevalence data, number of people in need of a certain service, among others.
- Qualitative methodology that will result in insights on the issues at stake, a grasp of participants' perceptions of various issues, among others.

Checklists and closed-ended questions with binary answers (yes or no) are quantitative measures, part of a nomothetic approach. Semi-structured interviews with open-ended questions, case studies, group discussions and art-based assessments are all qualitative measures, part of an ideographic approach. While a qualitative and ideographic approach could be considered more community-based, in that it lets participants express more freely their concerns, and grasp what is more accessible in their narratives, it may bring data that are more difficult to analyse or whose analyses are more dependent on the researcher's point of view. It may also bring results that are not strictly related to the sort of programme the organization has the capacity to run. Table 1 presents a series of complementary information addressed by different methodological perspectives.

A quantitative, nomothetic approach is more likely to bring valid and precise results, but also to be based on categories of needs that may not be what matter the most for communities, grasping what is available in participants' cognition but not necessarily what is most accessible and therefore relevant for them, and to limit the scope of the assessment to narrow, predetermined elements.

In any approach chosen, questions should be limited to collect exclusively the information needed to plan a successful project. The focus should be on the quality of the information, not the quantity, to avoid exposing communities to lengthy assessment and maximize resources.

WHO and UNHCR have developed a toolkit that includes several MHPSS assessment methods and tools that can be used in an emergency, which are for the most part quantitative and nomothetic, but with notable exceptions, such as the last three, tools 10, 11 and 12 (**WHO and UNHCR, 2012:63–77**).



Another relevant source of useful procedures and tools for MHPSS assessments is the *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide* (IASC, 2013).

Relevant for the aims of this Manual on CB MHPSS are the two annexes on participatory assessments (ibid.:15–26).



A useful compendium of assessment tools to be used in a community engagement perspective (see also Chapter on Engaging with Communities) is proposed by the Capire Consulting Group in the *Inclusive Community Engagement Toolkit* (**Capire Consulting Group, 2016**).



Figure 7, retrieved from the Capire Consulting Group's *The Engagement Triangle* (**Capire Consulting Group, 2015**), presents different assessment tools that can be used in humanitarian emergencies: interviews, intercept surveys, vox pop, briefings, meetings, focus groups, consultative groups, citizen juries, kitchen table discussions, workshops, field trips and deliberative forums. It details which tools are recommended (✓) or highly recommended (★) for each assessment purpose.



Figure 7: Capire Consulting Group’s scheme of selection of tools per assessment objective

A range of tools and techniques have been mapped on the Engagement Triangle, based on the intent of the community engagement.

These tools and techniques are just mediums to facilitate the community engagement. The content and delivery needs to be tailored on a project by project basis.

Note: This sample of tools and techniques are drawn from Capire’s recent projects and experiences.

	Small group											
	One-to-one							Large group				
	Interviews	Intercept Survey	Vox pop	Briefing	Meeting	Focus group	Consultative group	Citizen jury	Kitchen table discussion	Workshop	Field trip	Deliberative Forum
1 To inform decisions	★	✓	✓		✓	★	✓	★		✓		★
2 To primarily inform decisions and secondly build capacity	✓		✓	✓	✓	✓	✓	✓	✓	★		✓
3 To primarily inform decisions and secondly strengthen relationships	✓		★	★	✓	✓	✓	✓	★	✓	✓	✓
4 To build capacity				✓							✓	
5 To primarily build capacity and secondly inform decisions	✓		✓		✓	✓	✓	✓	✓	✓		✓
6 To primarily build capacity and secondly develop relationships				★								
7 To strengthen relationships									✓		✓	
8 To primarily strengthen relationships and secondly build capacity				✓	✓				★		★	
9 To primarily strengthen relationships and secondly inform decisions	✓		✓		★		★	✓		★		✓
10 To inform decisions, build capacity and strengthen relationships	✓				✓	✓	✓	✓	✓	✓		✓

Source: adapted from Capire Consulting Group (2015).



Table 1: Nomothetic/ideographic – Practical differences

NOMOTHETIC – QUANTITATIVE	IDEOGRAPHIC - QUALITATIVE
<p>Topic: Incidence of people who define themselves as psychologically stressed or very stressed and rank “anger” as the most recurrent feeling in the last 2 weeks.</p> <p>Key Question: How much would you define yourself psychologically stressed on a scale from 1 to 5, and how many times have you felt anger as the most relevant emotion in the last two weeks?</p>	<p>Topic: Identification by affected populations of the main emotions and states of mind felt during the crisis, risky journey, forced movement, displacement and confinement (if any).</p> <p>Key Question: Can you describe your prevalent feelings and emotions over the different periods: when the crisis started, during the journey to the camp/centre, now that you are settled in a safer space?</p>
<p>Topic: List of mental health and psychosocial support resources (practitioners, clinics, hospitals) available in the camps, centres and host communities.</p> <p>Key Question: Who are the available psychologists and psychiatrists and which health posts can you refer to if you need medical care?</p>	<p>Topic: identification by affected populations of the main providers of affective support, emotional and spiritual care, medical and religious services in the communities.</p> <p>Key Question: To whom in your family and neighbourhood do you refer when you need emotional support, you want to share your bad feelings and you are searching for medical treatments?</p>
<p>Topic: Number of individuals who show mild to moderate symptoms of depression related to displacement situation and irregular migration.</p> <p>Key Question: How many persons have developed symptoms of depression (ideas, attitudes and behaviours) due to crisis, journey or displacement in this service?</p>	<p>Topic: Description of the occurrences that make people living in camps and transit centres feel sad, melancholic, apathetic or hopeless.</p> <p>Key Question: Could you recall situations, places, people or discourses that make you feel bad, sad or concerned about your emotional balance in the camp/centre?</p>
<p>Topic: Number of survivors of torture, GBV and domestic violence living in the camps and host communities.</p> <p>Key Question: How many persons are survivors of violence or (actual and potential) survivors of abuse in their families in the camp/centre</p>	<p>Topic: Identification by affected populations of vulnerability factors, aggressive communication and negative social codes that affect survivors, women and children in displacement.</p> <p>Key Question: Which do you think are the most offensive behaviours, words and attitudes for persons who have been survivors of abuse and violence, and might threaten their sense of safety and protection?</p>
<p>Topic: Number of families who have one or more members with disabilities experiencing difficulties in accessing services.</p> <p>Key Question: How many families have one or more member with disabilities and where are the closest facilities to support them?</p>	<p>Topic: Description of the efforts made and obstacles found by families and friends to ensure appropriate care and access to services by persons with disabilities.</p> <p>Key Question: Where did you get support to provide members of your family or friends with disabilities with appropriate care? Who usually helps you (if anyone) and which challenges did you usually face?</p>
<p>Topic: List of the most important religious rituals, civic celebrations and family activities usually performed by affected communities and/or their subgroups.</p> <p>Key Question: What are the most relevant religious festivals and public ceremonies for the affected community or for specific subgroups/families?</p>	<p>Topic: Identification by affected populations of collective and family practices that offer a sense of belonging and homeness to people who share cultural practices such as spiritual beliefs, aesthetics, arts and crafts, and cooking.</p> <p>Key Question: Which kind of religious festival and rituals, public ceremonies or social meetings, creative activities or domestic chores do you most like to attend and perform, and why?</p>

In emergencies, IOM normally uses an MHPSS Rapid Appraisal Procedure assessment toolkit that contains quantitative elements (surveys), qualitative elements (interviews) and observations. The protocol and methodology can be:

- Very simple, in case of assessments taking place in the immediate aftermath of a disruptive event or a displacement in under-resourced realities (**see, for example, IOM, 2014**).



- More elaborate, for instance in situations of protracted displacement, or situations where expert interviewers can be identified (**see, for example, IOM, 2010c**). All in all, the best way to proceed is for an MHPSS manager and his/her team to tailor a context-specific assessment method and tools that take into consideration all the above-mentioned resources, or others, and pick those that are suitable for the context, more community-based, doable in the time and with the resources available, and pertinent to the scope and the kind of programme the agency can actually run. In addition, the tools, especially the ones that are ideographic, can be transformed, adding or deleting certain items. For instance, each of the tools of the IOM MHPSS assessment toolkit is not to be considered as final, but as a list of questions and items that can be reduced, expanded or prioritized upon need. In addition, whatever method and tools are used, they should be contextualized and adapted to the specific languages of participants, cultural context and stage of the emergency. This should be a collaborative process between the IOM international team, the IOM national team involved in the assessment, and the project committee or community anchors identified at that stage. A context analysis can be planned to better understand social, political, cultural and economic aspects of the changing environment in which the affected population lives.



Box 15

Assessing prevalence of mental disorders. Cautions

Differentiating between what is abnormal “pathology” and what is a normal emotional response to an abnormal event is a global challenge. Large-scale epidemiological surveys, especially those that have not been culturally validated, may not be able to differentiate between the two – for example, sleeping poorly can be a “symptom” or an expected response to an adversity or stressor. This can mean rates of disorders could be overestimated when local expressions of adaptive distress reactions are confused with psychopathology. Any study into the prevalence of mental disorders needs to begin with ethnographic understanding of people’s lived experiences and different social and cultural expressions of distress in order to find holistic and accurate descriptions. These include:

- Cultural frameworks for mental disorder and associated belief systems;
- Community attitudes towards mental disorders and their impact;
- Relevant information on social, cultural, religious, economic and political structures and dynamics (for example, conflict issues, ethnic/class divisions, individualistic/collectivistic);
- Ethnographic information on relevant sociocultural norms and practices;
- Understanding the impact of the emergency context on the above.

In addition, diagnostic (mental health) questionnaires need to be validated, and clinical interviews are better predictors than checklists and self-reports. In fact, if surveys are just translated but not validated and administrated by interviewers who are not (mental health) professionals, results could be misleading. It should be noted that assessment is not the same as epidemiological research, and the collection of prevalence data is rarely feasible or useful as part of an initial assessment.

3.2.5.2 Select target groups and interviewees

Participatory assessments are conducted with different members of the population to understand specific needs, resources, capacities and proposals, and to test the validity of the existing set of information.

The IOM toolkit includes specific batteries of questions for national stakeholders, international stakeholders, local/community stakeholders and affected families. Other tools in the WHO–UNHCR toolkit (WHO and UNHCR, 2012) can be addressed to affected individuals only, or to groups. In any situation, participants can be randomly selected and, depending on the objective, there should be relevant participation of men and women, and people of different age, ethno-religious, socioeconomic and culturally diverse groups, including different migrant groups, if relevant. In order to have relevant communities and subgroups represented, purposive sampling can also be adopted (see Box 16). A mixed approach that remains random in the selection of participants but fixes minimum and maximum quotas of people to interview for each representative group is always preferred.

Box 16

Purposive sampling

“Purposive sampling (also known as judgment, selective or subjective sampling) is a sampling technique in which a researcher relies on his or her own judgment when choosing members of a population to participate in the study... The purposive sampling method may prove to be effective when only limited numbers of people can serve as primary data sources due to the nature of research design and aims and objectives. For example, for research analysing effects of personal tragedy such as family bereavement on performance of senior level managers, the researcher may use his/her own judgment in order to choose senior level managers who could participate in in-depth interviews.”

Definition taken from the website Research Methodology, available [here](#).



Language and culture should be considered. There may be a need to develop a lexicon of words, phrases and expression according to affected populations' understanding, cultural practices and belief systems. For instance, when talking about feelings without knowing that “feeling” in a language means only physical sensations, there is a risk to misjudge the collected information, generating far-reaching effects on the intervention.



3.2.5.3 Selection of interviewers

A team that will carry out the assessments needs to be selected. The size of the team should be decided in relation to the number and distance of the sites, sample to be interviewed, their location, the time frame and budget. The following points should be considered when identifying staff for assessments:

- **Technical expertise:** Ensure that the team or individuals engaged in the assessment have the appropriate or the most relatable expertise and capacities.
- **Personal qualities:** Good communication, compassionate ability of good listening, basic reporting skills.
- **Context:** Ideally, the assessment team is comprised of members of both the host and the displaced communities, or at least by professionals familiar with the local context and the language used in the area where the assessment will take place. If this is not possible, at least a cultural mediator or translator should accompany the interviews.
- **Communities' involvement:** Make sure to involve and engage communities and include members in the assessment team. Further information about team selection can be found in the **Psychosocial mobile teams chapter**.

In general, one could expect each member of the team to conduct four individual interviews or three focus groups per day, plus writing and reporting.

3.2.5.4 Training of interviewers

Before the assessment starts, all interviewers need to be trained in:

- Interviewing and communication skills;
- Documentation skills;
- Analytic and problem-solving skills;
- Understanding of basic mental health and psychosocial issues;

- Ethical principles, confidentiality and informed consent;
- Psychological first aid (PFA) to support the interviewees if needed;
- Administrating the specific tools that will be used for the assessment.

In emergency situations, where the protocols are prepared in a hurry, the training can contain a workshop to discuss and transform the assessment protocols based on feedback received by the trainees in terms of suitability, lexicon, cultural elements and possibly stigmatizing elements of the protocol. At times, some items will need to be deleted because they may not be comprehended by the team.

An important element of the training is ongoing supervision and support during data collection (see chapter on **Technical supervision**). The training should ideally take no less than three and no more than five days.

One consideration is that vulnerable groups are to be included, such as persons with disabilities and **children**. However, criteria for vulnerability in an emergency need to be contextualized. For instance, men in displacement might become psychosocially vulnerable, since they cannot fulfil their role as head of the **family**.

3.2.6 Data collection

The methodology for carrying on a good data collection exercise should include the following points when possible:

- Reading situational analyses from at least three viewpoints, including external and community ones (triangulation of information), while interviewing key informants and direct observations on the ground;
- Meetings with community and religious leaders, stakeholders, teachers, health workers, focusing group discussions with members of the community affected by mental, neurological and substance use disorders, persons with disabilities, their family members and relatives;

- Using different visual (photos, drawings, emoticons) and interactive (participatory ranking, voting, walks) exercises to also allow children and individuals with low levels of formal education to actively contribute;
- Community consultations, which should be carried out by means of semi-structured interviews that allow for a full range of qualitative data;
- Participatory mapping exercises aimed at identifying existing MHPSS services for referral and human resources (displaced health workers, teachers, trainers), which should be carried on at this stage, as well as social networks diagrams, which should be drawn in camps, transit centres and neighbourhoods hosting internally displaced persons, refugees and migrants;

It is important to inform discussants and leaders that data collection is part of a learning exercise, and might be repeated at later

stages. Data collection will vary according to the methodology adopted. It is important to consider that data collection will first and foremost follow ethical principles and participatory standards based on *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007:8)*. In this regard, it is mandatory to ensure that data collection would be confidential, grant anonymity and be based on voluntary participation and informed consent. It will be condensed in a short period of time, given the high volatility of the environment of an emergency and in order to timely inform programming.



Interviewers will usually be divided by camp sector, or neighbourhood, and each team will comprise a man and a woman, allowing participants to choose the gender of the assessor.

Interpretation and cultural mediation should be provided, if needed.

Clinical assessment, IDP centre, Sana'a, Yemen. @ IOM 2014



Given the fact that participants may have conflicting needs, lengthy interviews should be avoided. In some context, it is preferable to have multiple interview sessions, rather than a very long one-off one.

Especially when an assessment includes clinical components, a referral system should be put in place before the assessment takes place.

In addition, data collection should be conflict-sensitive and limited to the minimum disruption to the community fabric that may derive from the ways in which data are collected. Those modalities are best assessed and reviewed with the project committee and the project team, as well as camp managers and other local authorities.

Key points to be considered in terms of community-based approaches include:

- Cultural sensitivity, gender diversity and inclusiveness: For example, discussing sexual violence with a woman in a mixed group can cause punishment or exclusion for the women afterwards. On a different level, if the tool is addressed to families as a group, the male head of household may have a prominent role and focus groups with women and younger people may become necessary to balance information.
- Power relations: People with power can exercise control on what is being publicly said, or participants might exercise self-censorship in their presence.
- All the actors involved in the assessment retain a degree of preconceived knowledge, which might marginalize alternative views of a specific group. Therefore, constant attention for stigma and biases about and within certain groups, including the humanitarian community, should be exercised.
- A focus group is not always representative of the most compelling needs of the whole affected population, as some individuals might monopolize focus group discussions,

particularly related to sensitive topics. It might be helpful to take that person out of the group dynamic and proceed with an individual interview because s/he has such clear information and opinions.

Box 17

Power structure

Working in a community-based approach, the acknowledgement of the role that power structures play in a community is vital, so parallel interviews or focus groups with individuals or small groups should be promoted, because it is inappropriate to talk about certain issues in a larger group or, if the issues are too sensitive, to address them in mixed groups. It is essential to create a space in which people can openly talk. Dividing groups according to gender and age can be useful for the assessment, but the social, religious and cultural dynamics of the specific emergency context ensure that all voices are heard and that everyone can speak about the needs and problems, which can lead to different results, such as in this example:

Ask the young men what they see as the most important issue to the women in their community. The women are, at the same time in a small group discussing what is important to them. When everyone comes together again, the men are given the opportunity to share their thoughts on what women consider important at this moment and time in their lives, with the group. They usually get it wrong and this creates a lot of laughter. The roles are then reversed, so that everyone has a chance to get it wrong, and to laugh, so we feel that we laugh with the people and not at the people (Sliep, 2009:16).

Such a reflective exercise should only be done early in a meeting and by workers who have experience. It may be totally inappropriate or ineffective in communities where women are not allowed or used to judge **men**.



3.2.7 Data analysis and discussion with relevant stakeholders

The procedures of data analysis will also largely depend on the methodology adopted to engage communities and collect information. Ideographic and qualitative tools are typically more difficult to read than nomothetic quantitative tools. The procedures through which data are going to be analysed and the needed capacity should be considered from the very beginning of designing the assessment. See below examples of:

Figure 8: Data analysis

Data analysis of a quantitative nomothetic tool:	Social network analysis, cluster analysis, trend analysis, descriptive statistical analysis, incidence and prevalence analysis, regressions and correlations analysis.
Data analysis of a qualitative ideographic tool:	Discourse analysis, narrative analysis, content analysis, grounded analysis (themes, categories and codes), framework analysis.
Data analysis of a mixed method tool:	Complementary analysis, comparative analysis, contest analysis, inferential analysis.

Preliminary analysis and clustered findings should be shared and discussed with community representatives, to the extent possible and using visual representations such as graphics, diagrams, drawings and pictures. These meetings can include:

- The assessment team, which includes experts or activists from the affected communities;
- The project committee or relevant stakeholders (including at least those who were interviewed);
- Local leaders and representatives of affected populations, including representatives of the most vulnerable categories.

This ensures that interpretations are made more in line with community perceptions and avoid misunderstandings. This analytical process in a community engagement perspective is also aimed at identifying local resources to be mobilized during the implementation phase and monitoring and evaluation exercises.

In IOM rapid MHPSS assessments, results are presented based on Renos Papadopoulos' systemic grid of outcome of consequences. See [here](#).

For contextualization, see the full study [here](#). For a more recent study, using a similar but simplified model, see a MHPSS assessment conducted in South Sudan in 2014, [here](#).



3.2.8 Discussion and dissemination

Findings and data analysis should be discussed with all involved: NGOs, government, community and subcommunity representatives. After this discussion, findings and data analysis should clarify needs and available resources, and bring actual programmatic recommendations, including an evaluation of obstacles, misperceptions or any issues of credibility related to the assessment. Findings (for example, report, summary and/or presentation) should be shared in the local language and in culturally appropriate ways, when possible. For the purpose of this Manual, the assessment findings and recommendations need to be shared with the IASC system, especially if there are recommendations for other sectors to mainstream MHPSS, and the academic partners, and through the identified gatekeepers and members of the project committee. Gatekeepers and members of the project committee can describe findings and recommendations to their specific communities and subgroups in the perspective to (re)activate individual and collective resources, reducing the risk of “learned helplessness” generated by the range of problems detected by the assessment.

→ 3.3. CHALLENGES AND CONSIDERATIONS

There are multiple challenges associated with the assessment phase in emergencies:

- It can be problematic to reach remote areas that are heavily affected by the emergency, ensuring that all community subgroups (social

status, ethno-religious, political) are represented on the assessment team, as well as in the interviewed populations (including elderly, women, men, youths, children and persons with mental problems and/or disabilities). Community engagement and working with partners can help alleviate this concern.

- Assessments can raise false expectations in the communities. It is important to inform them on the objectives of the assessment in advance, and be honest about goals.
- It can be challenging to train people from the community to ensure high-quality, safe, culturally sensitive and ethical data collection, as there are also time limits.
- Analysis of data is often challenging because of the lack of statistical expertise in the MHPSS teams. It is important to choose assessment objectives as well as methodology based on the existing capacity of analysis; otherwise, a lot of efforts will be nullified by the impossibility to meaningfully analyse the gathered data.
- It can be challenging to gather sensitive data, such as human rights violations, and make sure the data collection is confidential (UNFPA, 2014).
- Tools have limitations, as described throughout the chapter.

Reasons for not doing an assessment include:

- When conducting a needs assessment will put data collectors or interviewees in danger or are harmful;
- When a population feels over-assessed and possibly hostile to additional needs assessments.



Table 2: Dos and don'ts

Dos	Don'ts
Respect ethical principles and heed protection concerns	Don't do harm
Only collect information that will be used to design interventions	Don't collect information that will not influence programme decisions
Coordinate assessments with all relevant stakeholders	Don't collect information without involving others
Include the affected communities in the design, analysis and decision-making	Don't neglect the perspectives of those affected by humanitarian crisis
Assess problems and resources	Don't focus on the problems only
Ensure that the assessment tools are culturally appropriate	Don't use assessment methods across cultures blindly
Tailor each assessment to the particular situation and phase of the crisis	Don't employ a standardized assessment package
Check beforehand what is already known in the area	Don't immediately start collecting new information
Include different sections, age groups, gender, ethnic and religious groups	Don't forget the "silent" groups
Be attentive for conflict and tensions	Don't put people at risk by asking questions
Ensure that assessment teams are trained and knowledgeable of the local context, balanced in terms of gender, and include members of the populations	
Make sure that the assessment is timely and tailored to the phase of the humanitarian crisis	

Source: Based on Ventevogel and Schininà (2009).


FURTHER READING

International Medical Corps (IMC)

2016 *Rapid Mental Health and Psychosocial Support Assessment: Needs, Services, and Recommendations for Support to Individuals Affected by the Mosul Emergency.* IMC, Erbil, Iraq. 

2017 *Ethnographic Assessment of Psychosocial Needs of Children at Vasilika Camp.* IMC, Athens. 

International Organization for Migration (IOM)

2011 *Who am I? Assessment of Psychosocial Needs and Suicide Risk Factors Among Bhutanese Refugees in Nepal and After the Third Country Resettlement.* IOM, Kathmandu, Nepal. 

For other references see the full bibliography [here](#). 

4. PSYCHOSOCIAL MOBILE TEAMS



→ 4.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

IOM CB MHPSS programmes in the aftermath of an emergency usually make use of a standardized approach: the psychosocial mobile teams (PMTs). PMTs are multidisciplinary psychosocial support teams that offer services not in a facility-based but in a community-based fashion, which is why they are called mobile. They have been engaged by IOM to respond to the MHPSS needs of displaced populations in many emergency situations over two decades, including in Chad, Haiti, Lebanon, Libya, Nepal, Nigeria, Serbia, South Sudan, Sri Lanka, Kosovo¹ and many others. While many elements of the work of the teams depend on the dimension, quality, characteristics, cultural context and existing MHPSS capacities of each emergency, a series of common standards and suggested processes have been identified.

The key strengths of PMTs have proved to be:





- Their multidisciplinary composition: The combined expertise of a range of team members is used to deliver community-based comprehensive care to individuals, families and groups (IOM, 2016).
- Their participatory approach includes members of the concerned communities with various types of educational backgrounds, cultural competencies and professional skills.
- They allow for flexibility of programming (sites, responses, timing), which is an essential component when dealing with emergencies.
- Their mobile nature allows outreach and proximity to the communities over time and displacement phases.

This chapter of the Manual illustrates the process of establishing and maintaining a PMT, more in terms of teamwork than taskwork. The actual activities and services offered by the teams are in fact

described in subsequent parts of the Manual. This chapter mainly illustrates the experiences of IOM's PMT, but its overarching principles and recruitment methods can be applied to any MHPSS team.

4.1.1 The composition of IOM PMTs and what the team members do

Each PMT is composed by up to six team members with the following qualifications/roles:

- A team leader, coordinating the activities of the teams, linking the necessities of the teams with those of the project management, identifying training gaps, supporting the teams in designing activities based on assessed needs, and attending to output-level monitoring (see chapter on **Monitoring and evaluation**) and reporting: If properly trained, team leaders can also act as supervisors for the teams (see chapter on **Technical supervision**). 
- A member tasked with directly attending or organizing provision of individual and group psychological counselling and support: Ideally, this team member would be a clinical or counselling psychologist or a counsellor. In situations in which this profile is not available, the functions can be carried out by a social worker, or a health counsellor, a pastoral counsellor, a midwife or a traditional resource, who will be supervised and trained for the **scope** of the team's activities. 
- A member tasked with social support, including referral to additional services, family mediation, social support organizations, and problem-solving: Ideally, this will be a social worker. If social workers are not available, the function can be performed by a counsellor, or a social activist, and **training and supervision will be adapted accordingly**. 
- A member tasked with the organization of sensitization sessions, psychoeducation sessions, awareness sessions and informal educational activities for the community: This professional 

¹ References to Kosovo shall be understood to be in the context of United Nations Security Council resolution 1244 (1999).

will be an educator or a trainer.

- A member tasked with the organization and promotion of cultural, socializing, sport and recreational events, both in terms of structured activities that s/he facilitates directly, and mobilizing, supporting, framing and putting in a network of already existing activities: This professional will usually be an artist, an anthropologist, a sport coach or a cultural and social mobilizer (activist, journalist, animator), who is usually named artist-animator.
- A community mobilizer, who understands the community very well and assists in the mobilization of its various sectors: This can be either part of the core team, or someone who acts as a community focal point for the teams. The community focal point differs from the mobilizer because his/her function is mainly of support and does not require full-time engagement. Moreover, the focal point is not mobile but is bound to that specific camp sector or neighbourhood.

Other team members may include:

- A member tasked with small-scale conflict mediation (see chapter on **Integration of MHPSS in conflict transformation and mediation**).
- A health worker (typically a nurse) in case no one else is providing medical services, and just for the time necessary to cover the gap.

Box 18

Selection of PMTs

In some contexts, one or more of these profiles may not exist or are not represented in the sites of displacement. In these cases, based on mapping of capacities, teams are selected among the most relatable professionals or activists. The frequency and scope of supervision, as well as training, are therefore strictly connected to the existing capacities within the teams, the nature of the needs that the team respond to, and the type/context of the emergency (see chapters on **Training and Technical supervision**).

The PMTs start their engagement with communities by assessing the needs of specific sites and/or groups, based on IOM and other assessment and mapping tools (see chapter on Assessment and Mapping).

They then provide psychosocial support based on the multitiered approach suggested by the pyramid of MHPSS **intervention** covering tier one (basic services and security, mainly in terms of information, field coordination, advocacy and referral to services); tier two (community and family support); and tier three (focused services), establishing referrals to the teams in charge of clinical referral and **follow-up**, or the services or agencies providing clinical care for people with mental disorders. See **box 20**.



See relevant terms of reference [here](#).



Their approach is twofold. Most often the mobile teams provide support both through:

- Direct provisions of services and activities; and
- Mobilization of and support to community-based resources.

In general, each one of the team members has his or her own function, but they all collaborate on needs assessment and the design of the interventions. They refer clients (individuals and groups) to each other, and when they think their internal support is not sufficient, they seek help and supervision from international or senior national experts within the programme (manager and supervisor).

Each of them is able to provide psychological first aid (**PFA**). The educators produce and disseminate messages related to psychosocial well-being and health promotion. They provide or organize the provision of informal education to children and adolescents, and organize safe spaces and child-friendly spaces. They additionally organize adult non-formal education classes and support the educational and awareness activities organized by other members of the teams.

The social workers attend to vulnerable social cases and make referrals to service providers that are previously mapped and mobilized. Moreover, they support the rejuvenation of community support and safety networks, and attend family mediations.

The artist or community animators engage the communities in some of their traditional, cultural and religious activities, which helps them maintain a sense of identity. This includes traditional arts and crafts workshops that are used as income-generating activities as well as a form of psychosocial support (Babcock et al., 2016). They can also organize and propose specific structured cultural and artistic activities in forms of workshops and or events that promote expression through artistic means, either directly or by mobilizing existing creative resources.

The counsellors in the team offer (lay) individual or group counselling to people they directly identify, who seek assistance or who are referred by other members of the teams and train other key people in the community in buddy-to-buddy **systems** and **PFA**.

Conflict mediators intervene to mediate small-scale family and community conflicts, while nurses or other health professionals attend to the referral to health services and help the educators to design health awareness inductions.

The community mobilizer or community focal point supports the team, sharing with them relevant information about the security and social situation in the sites on a daily basis, as well as linking with local authorities and keeping the community informed and reminded of the activities of the teams.

The specificities of all sectors of involvement of the teams are explained in more details in the forthcoming chapters.

Box 19

Local partners

In some contexts, IOM might be unable to directly recruit people to set up a mobile team, or similar multifunctional community structures already exist. In these situations, one should work through identified local partners. A mapping analysis (see chapter on **Assessment and mapping**) helps to identify local stakeholders and available resources, where IOM aims to provide complementary programmes such as trainings, supervision and other capacity-building initiatives (see chapter on **Training and Technical supervision**).

→ 4.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

4.2.1 How PMT members are selected

IOM, like any other agency, considers a well-established set of practices, from recruitment to deployment, that will need to be administratively followed in those cases. This chapter does not dwell on administrative procedures and types of contracts, but the general scope of the selection. PMTs, in IOM and other agencies, are built through active mobilization of communities, in order to reach people in camps, transit centres, and urban and rural areas. How teams are selected therefore becomes of paramount importance. Applying a community-based approach to team selection and composition requires a good understanding and engagement of:

- Communities and subgroups and their **dynamics**;
- Economic, social and political contexts and their actors (stakeholders, leaders, influential individuals);
- **Conflict and conflict sensitivity**;
- MHPSS concepts and needs.

Ideally, after the adoption of terms of reference, the various positions will be advertised through ministries, local authorities, relevant faculties of local universities, interest groups, professional and civil society organizations, websites and social media. The PMTs will then be composed taking into consideration their language skills, expertise, references, ethnicity, nationality, gender balance and educational backgrounds and, ideally, balance between members of both host and displaced and migrant communities, noting that this may not be always the case due to bureaucratic impediments, work permits and other obstacles.

Considering the necessary emergency development nexus, the fact that often professional resources are few in emergency situations, and the fact

that the PMTs receive extensive supervision and training, members of the teams can also be appointed from the staffs of university faculties, ministries, and existing professional and civil society groups. These engagements can take the form of secondments, extra-time volunteer work, or part-time engagements, through agreement with the respective employers. This will allow the concerned institutions, universities and civil society organizations to acquire knowledge and trained staff over the longer term, ensuring sustainability. In addition to the core team, other members can be attached to the teams and included in the trainings based on identified needs, or for determined periods of time, with a capacity-building objective in mind. Starting the programme with advocacy and sensitization actions can give the programme higher chances to be successful. The community should be informed on the roles and functions of the teams before MHPSS activities begin to be better accepted.

Box 20

Care for people with severe mental disorders

PMTs do not deal directly with clinical support to people with severe mental disorders. Usually, their work is complemented by dedicated smaller referral teams, comprised of health counsellors and, when possible, psychiatric nurses. They usually receive referrals by the PMT and other actors after informed consent is signed, and arrange, after consultation with the manager or the supervisor, the appointment and transportation of the person in need to the nearest mental health care or health care facility; attend to the psychoeducation and support of the family; and provide follow-up care, including making sure that the prescription is followed, and inclusion of the clients and their families in the activities promoted by the PMTs. For more information, see chapter on **Community-based supports to people with severe mental disorders**.

Box 21
Engaging academia

An example of engagement of university students come from post-earthquake Haiti, where the entire university's infrastructures were destroyed and fourth-year psychology students were able to achieve their last year, supporting the teams and being involved in their trainings and supervision sessions, which were recognized by the university as part of their curriculum for the year. This brought to an entire generation of psychology students the experience of being exposed to post-disaster practical provision of psychosocial support, and helped the university to adapt its curriculum based on training they received.

Induction and core training modules must be standardized and institutionalized as much as possible. For more information, see chapter on **Training**.


4.2.3 The role of hubs as anchors of the work of the teams

Hubs are temporary structures run by the PMT that can vary in form and size according to needs, but they are usually constructed with the same material used for the other units in the camps or displacement site (tents, caravans, prefabricates, shadings structures), or created in existing rooms or flats in neighbourhoods. They ideally comprise a small office for management and counselling purposes, a big room for larger events, and two rooms for workshops and classes, one of which can also be used for counselling. Hubs are better located close to schools and sports grounds if available, or they might include playgrounds for children (also to support caregivers to attend courses and psychosocial sessions) and volleyball/mini-soccer grounds to facilitate sports activities for youths, particularly girls, in safe and protected spaces. They should be safe and protected spaces (choose the location and eventual protective measures in coordination with the security unit), and close to latrines for males and females, water points or hand-washing stations.

Hub structures are usually decorated internally, and externally if appropriate, in order to communicate a sense of welcome and home to the affected populations. PMTs are mobile by definition, in the sense that they cover different camps and neighbourhoods, and adapt to the movements of the populations they serve, with an aim to grant continuity to the intervention. In some situations, however, it has proved useful to create these hubs in different sections of camps, transit or community centres, hosting neighbourhoods that can be used by the teams to organize and implement activities. The hubs can be used to host activities organized by the teams, and also activities organized by members of the

4.2.2 How the PMTs are trained and supervised

Supervision and training of PMTs are crucial, and they receive continuous training through different modalities:

- Induction training predeployment, covering basic MHPSS topics: This includes an introduction to the IASC Guidelines, community-based MHPSS, PFA, communication skills, ethical considerations, self-care and other relevant topics.
- Monthly training sessions, which address more specialized topics: The supervisor and manager decide on the topics to be presented, based on emerging needs identified in the field: for instance, peer-to-peer support, case management, counselling, sexual and GBV, work with children, work with people with disabilities, art-based interventions, conflict mediation, and the subjects of the chapters of this Manual.
- On-the-job training and supervision: Team members receive on-the-job training and supervision through regular meetings or field visits. The manager and supervisor may also organize on-the-job training delivered by external experts, based on specific identified training needs.



Community mobilization in IDPs sites. Psychosocial Mobile Teams, Ethiopia. © IOM 2018

communities mobilized by the teams, including meetings, workshops, classes and events. Activities should always follow a schedule (daily, weekly) and should be well communicated through boards and visual/verbal announcements (for those who cannot read). The schedule will be up to the team leader, and the daily operations of the centre could be included within the functions of the community mobilizer or community focal point, as appropriate.

The hubs are not long-term centres, but temporary facilities that help the logistical part of the work of the teams, and provide suitable spaces for activities that require higher confidentiality (counselling, group discussions on sensitive topics), and in ritualizing the work done attaching it to a physical space. The work of the team will, however, remain highly mobile, with regular outreach activities.

4.2.4 What is next

Usually, the PMTs, or at least their members that come from the displaced communities, follow the populations in their movements. For example, in Haiti, two years after the earthquake, MHPSS teams were fully engaged in the return process “from camps to communities”, accompanying communities to return areas or to transitional shelters, offering MHPSS, referral, and special assistance to disabled and other vulnerable individuals.

When the population stabilizes in one place due to relocation, return or because the displacement becomes protracted, the work of the teams consolidates in two ways:

- From the one side, if the affected population and authorities consider that there is still a need for regular MHPSS, recreational and counselling centres for families are established. These centres expand their functions over emergency interventions and thus are not included in this Manual.
- On the other side, the training provided to the teams is evaluated and consolidated in a national curriculum, which can take the form of a master programme, an academic diploma, creating preparedness in the country for the next emergency to come, as it is better explained in the chapter on **Training**.



➔ 4.3 CASE STUDY

For an example of the work of the PMTs, see this **video** on how PMTs were utilized in north-east Nigeria. Since then the project has expanded and some teams have accompanied the displaced populations in their return home.



→ 4.4. CHALLENGES AND CONSIDERATIONS

There are also challenges associated with a community-based approach to team selection:

- Different languages spoken by the host and displaced communities can create challenges in recruiting and training the most adequate staff. In these cases, consider adding cultural mediators to the teams (see chapter on Counselling).
- In some countries, it is challenging to recruit both females and males within the same team with the same level of education, skills and professional levels, because of cultural considerations on gender. In those situations, the number of team members could be expanded, to allow gender balance.
- Balance in ethnicity of the team members with the same level of education and skills might also be difficult to achieve in some contexts. Expanding the number of members to include different ethnicities can also be considered.
- The competition among relief agencies during a humanitarian operation can sometimes interfere with the recruitment of candidates or the retention of team members after training is provided to them. This can be mitigated by establishing inter-agency agreements and including actors from other agencies in the trainings provided to the teams.
- While different contracts are offered to different team members based on their level of expertise and prior engagements, teams may allow volunteers to join them to achieve flexibility and sustainability. The different contracts among team members can create dissatisfaction and tensions within the team, which need to be addressed in a participatory way, through supervision and clearly set and transparent differentiations.
- Likewise, when teams operate with a mobilization approach, the difference between the team member, who is paid, and the mobilized community resource who conducts an activity usually for free, can create a grey area. In these cases, it is important to find forms of gratification for the community resource (training, in-kind compensation, public recognition), and identify time and engagement limits between volunteer and paid functions.
- Finally, conflicts might occur within and between teams or between the teams and other providers or some community members, due to different reasons, including personalities, cultural and political attitudes, and stressful working conditions, which tend to exacerbate over time. These can be addressed in **supervision**, and time and resources should be dedicated for **staff care**.



Box 22

How many teams for how many services?

There is not a unique formula to calculate how many teams are necessary to serve a certain number of people. This ratio is highly dependent on the service the teams are providing, their expertise, the size of the problems, the other services and support networks available, and the general population to serve. In general, a team of five should be able to provide around 4,000 services per month. This figure includes people participating in one-off events and psychoeducation sessions, several sessions of a workshop with multiple affected populations, sporting events and others, and should not be considered as the total number of individuals receiving counselling or case management, which cannot be more than 30 per month per dedicated team member.

FURTHER READING

Bjerneld, M.

2009 Images, Motives and Challenges for Western Health Workers in Humanitarian Aid. *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine* (453).



Kutash, K. et al.

2014 Quality Indicators for Multidisciplinary Team Functioning in Community-Based Children's Mental Health Services. *Administration and Policy in Mental Health and Mental Health Services Research*, 41(1):55–68.



Schininà, G., M. Aboul Hosn, A. Ataya, G. Dieuveut and M. Salem

2010 Psychosocial Response to the Haiti Earthquake: The Experiences of International Organization for Migration. *Intervention*, 8(2):158–164.



Schininà, G., N. Nunes, P. Birot, L. Giardinelli and G. Kios

2016 Mainstreaming Mental Health and Psychosocial Support in Camp Coordination and Camp Management. The Experience of the International Organization for Migration in the North East of Nigeria and South Sudan. *Intervention*, 14(3), 232–244.



Yeboah-Antwi, K., G. Snetro-Plewman, K.Z. Waltensperger, D.H. Hamer, C. Kambikambi, W. MacLeod, S. Filumba, B. Sichamba and D. Marsh

2013 Measuring Teamwork and Taskwork of Community-Based Teams Delivering Life-Saving Health Intervention in Rural Zambia: The Qualitative Study. *BMC Medical Research Methodology*, 13:84.



For other references, see the full bibliography [here](#).



5. SOCIORELATIONAL AND CULTURAL ACTIVITIES



→ 5.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

In the first chapter, a series of MHPSS operational models were presented. The first model gives centrality to sociorelational, cultural and biopsychological factors and how they influence each other, both in determining psychosocial well-being and in the provision of effective **MHPSS**. The section of the Manual encompassing chapters on **Sociorelational and cultural activities, Creative and art-based activities, Rituals and celebrations, Sport and play** and **Non-formal education and informal learning** describes activities that work mainly at the cultural and sociorelational levels, and that can have a profound impact on the biopsychological well-being of crisis-affected individuals. These activities can help to bridge tradition with the necessity to change and transform what individuals and communities face after a crisis, helping to maintain a sense of **identity**. Considering the model of MHPSS **programming**, these activities respond to the suffering of individuals and groups, focusing on enhancing resilience factors and activities that traditionally mitigate distress, while giving evidence to the positive outcomes of the emergency in terms of skills, creativity and reflections. Culture has a significant contribution to an individual's well-being because, in all its forms, it strengthens the social fabric, including a sense of belonging and being **supported**.

Sociorelational and cultural dimensions regard the full spectrum of a community-based mental health and psychosocial support programme in emergencies, including specialized mental health care and focused counselling services. The sociorelational and cultural aspects of those services are discussed in the respective chapters (**Counseling** and **Community-base support for people with severe mental disorders**). The following chapters present dedicated sociorelational and cultural activities that can be mainly included in MHPSS programming at the second and third layer of the **pyramid of MHPSS in emergencies**. More specifically, these chapters will introduce the reader to collective community-based, sociorelational and cultural practices, such as sociorelational and cultural activities, art-based and creative activities, collective rituals and celebrations, sports and play, and informal education and learning.

The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007), point out the relevance of cultural, spiritual and religious practices, both as forms of community engagement and in the provision of mental health-care services, respectively, in **Action Sheets 5.3 and 6.4**. These paragraphs are concise and comprehensive, and they should be considered for complementary reading.

Specific to children and families, the UNICEF *Operational Guidelines: Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families* (UNICEF, 2018) provides guidance on activating or restoring community structures that strengthen social networks and protect and support children and families, and should be used as reference.

Box 23

Safeguards for children

As soon as children are involved, safeguards against abuse should be put into place, they include behavioural protocols for the coaches, training and complaint systems. This regards not only sociorelational and cultural activities, but also Creative and art-based interventions, Sport and play, Non formal education and informal learning. For advices on the practical implementation of the principle **see here**.



Games for youth with and without disabilities. Recreational and Social Centre for Families, Moultakana-Abu Sliem, Tripoli, Lybia. © IOM 2013/Stefano SPESSA

Box 24

Selection of activities

The selection of the activities described in this and the following chapters is embedded in the IOM operational framework and past experiences and is, in this sense, partial. In particular, the sociorelational and cultural relevance of social media and other web-based tools should not be underestimated in how it shapes bodies and their perceptions, minds, values, sense of community, value of memories, group building and socialization practices, as well as reactions to the emergency. Affected communities, particularly youth and those on the move, are usually connected among themselves and to external networks through smartphones and computers, searching for information, entertainment and guidance. How and when these connections have an impact on their mental health and psychosocial well-being should also be taken into consideration by programmes. While some examples of best practices are presented, this version of the Manual won't provide a complete overview and reflection on these possibilities.

Apart from the activities that will be presented in the following chapters, which are based on specific mediums, MHPSS programmes should support a series of spontaneous or induced groupings of affected populations, with an aim to

foster social cohesion and social supports.

These activities very often build on existing practices. In any community and in any group, people have their ways to relate to and support each other. In some cultures, men may meet to play chess or backgammon at the end of the working day in the main square; in others, women may meet to cook together. These sociorelational and cultural activities and groupings, after emergencies, should be restored, facilitated and supported. For instance, during the Balkan wars, it was noted that traditionally women, especially those who were married and in rural areas, would gather at certain hours of the afternoon to crochet and knit together. This was an occasion for them to share resources and skills, to relate and socialize, and to receive social support. During and after the various Balkan wars, many organizations started supporting women to re-establish these practices in camps, refugee centres and affected neighbourhoods. The support varied from context to context, and could include outreach, provision of a safe space, provision of materials and tools, provision of access to markets and fairs, and in some cases facilitators, animators and even psychologists, who could help the women use these venues to discuss in more structured and non-stigmatizing ways their psychosocial problems and negative feelings, or could provide **psychoeducation**. Another example is the coffee ceremony in Ethiopia. Coffee ceremonies – such as



gatherings in which women usually roast, grind and brew coffee beans for family, friends and neighbours – play a strong social support role and provide occasion for positive socialization. After displacement, the affected population could no longer participate in such ceremonies and reported that this was affecting their coping capacity. MHPSS activities included material support (cups, coffee, pots, among others) to enable the resuming of such ceremonies. Not only were the coffee ceremonies strengthening the social fabric and support network, they also became an easy avenue for MHPSS team members to engage with the community.

These kinds of activities are socializing, not entirely structured, and possibly non-validated. They sit between discussion groups, livelihood support, group psychological intervention and counselling, without following entirely the standards of any of these activities. Yet, in a community-based MHPSS approach, they are a fundamental tool to support communities, starting from their resilience and traditions. Another difficulty with these activities is that they are very context-specific, while humanitarian interventions tend to favour interventions that are duplicable and scalable.

IOM MHPSS programmes have found, intuitively, ways to support spontaneous and traditional social gatherings, with specific MHPSS objectives in mind. Such activities also provide necessary social conditions for equitable learning spaces, considering the complexity and the diversity within the targeted population.

These groups can largely be categorized by:

- **Interest group:** A group that gathers around a specific interest, a preoccupation, or an affiliation. IOM Iraq works with displaced people in urban settings, who want to be active members of their new communities. Neighbour groups gather regularly to discuss issues of concern for the neighbours around hygiene, decorations and others, and propose initiatives for improvement, such as launching cleaning campaigns.

- **Activity group:** A group that gathers around an activity, for instance watching television, playing chess, crocheting, preparing the church or the shrine for the weekly or daily celebrations. In South Sudan, for instance, women's groups were supported that gathered each week for tailoring and crocheting the decorations and textiles for the Sunday mass.
- **Problem-based group:** A group that gathers around a problem, for instance female heads of household, men who can't find a job. In both Iraq and South Sudan, IOM facilitated support groups for women who lost their husbands due to conflict. They gather regularly to do social activities, such as knitting, sewing or sweets baking, and connect with other women in the same situation. The PMTs supported these groups with complementary sessions on loss, grief, life skills or parenting skills.
- **Traditional group:** Elderly, congregation meetings, traditional spontaneous dance groups, religious/inter-faith groups, among others. Men's support groups were facilitated in South Sudan as often they are considered as vulnerable and overlooked in internally displaced person (IDP) camps. They gather not only to discuss issues or problems, such as unemployment, but they also reach out to other men, and elderly or sick people in the community, to offer their help: for instance, repairing damaged shelter after a rain, bringing sick people to the clinic, visiting the members of the groups who are sick or those who are bereaving. They try to find their purpose and these actions are well-thought by the groups.
- **Structured group:** Scout groups, organized youth groups, students' associations.

Often, groups can fall under more than one category. For instance, in Cox's Bazar, Bangladesh, IOM organized communal kitchens where refugee women from different parts of a camp could gather to cook together. This

has created a group that is at the same time an interest group, based on the preoccupation of being able to feed the family; an activity group, revolving around cooking; and a problem-based group, because these are mainly vulnerable women.

Regardless of their nature, all of them can function as peer-support groups, if empowered to do so. For instance, the communal kitchens groups helped to identify women particularly at need and refer them, and to provide basic forms of MHPSS, since IOM psychologists spend time with the groups of women while cooking.

5.2 WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

Managers should envisage and design programmes that allow for supporting spontaneous and traditional forms of gatherings that can have specific MHPSS objectives and outcomes. While they are not going to run these activities directly, they should be aware of the process that needs to be involved in supporting them:

- (a) Assess which traditional ways of gathering exist in a community, with a gender and age differential approach, as in the example of crocheting groups in the Balkans.
- (b) Identify what kind of support may be needed to reactivate or maintain these groups. This can include in-kind support, transportation, or the establishment of a space where people can meet as they are used to.
- (c) Identify the value that these groups and ways of gathering can have for the objectives of the programme, for instance:
 - (i) Entry points to the community;
 - (ii) Easy possibility to organize assessment and focus groups;
 - (iii) Fostering community mobilization and agency;
- (d) Foster the creation of additional groups that are not spontaneous but project-generated. These can be useful in supporting particularly vulnerable individuals or to respond to identified problems: for instance, the communal cooking groups in Cox's Bazar, or the men's groups in South Sudan.
- (e) If the group can have a specific MHPSS outcome, or is designed to have an MHPSS objective:
 - (i) Identify a leader or facilitator for the group, and train him or her in peer support and mentoring techniques; or
 - (ii) Provide a skilful facilitator to the group, from the MHPSS programme team.
- (f) Create a network between relatable groups, through exchanges and events, or mobilizing the groups for support in the organizations of rituals and celebrations, sporting activities, and so on. In South Sudan, an IOM-supported cultural dance group became well known and was often called in to participate in important community ceremonies: weddings, birth celebrations and memorials. While the group was important for the participants' own coping strategies, it also had an impact at the community level. In Iraq, participants in hairdressing, baking, sewing and makeup courses would often support community activities with their skills: for example, offering free haircuts before important celebrations, baking sweets for the community, making toys for children, offering hairdressing and makeup services for weddings, among others.
- (g) Monitor and evaluate how the activities of the group have helped to achieve the intended MHPSS outcome.
- (iv) Support to groups for particularly vulnerable individuals or groups;
- (v) A combination of the above.

5.2.1 How to identify and support the group mentors towards MHPSS objectives

The mentoring and peer support mechanism is based on a supportive relationship between peers with similar experiences. It is an empowering lay form of psychosocial support that is learned through organized training activities.

The mentor is a volunteer, the spontaneous leader of a social group, who is available to support his/her group, but is not a counsellor. The mentor's role is to help his/her peers in the group, identifying problems, helping people to refer them, and giving information about services, networks and resources. The mentor should be sensitive, empathic and available.

The mentor should receive a training, covering aspects such as:

- The types of activities that s/he can do with the group;
- How to listen effectively;
- How to manage and adapt expectations;
- How to encourage equal and respectful relationships;
- How to refer others to services;
- How to provide PFA;
- How to end the group;
- The specific needs of children and families (see here for more information and guidance on resources for **training**).



The programme can set up an effective mentoring system by:

- Identifying mentors;
- Organizing formal trainings, covering the above described topics, which usually should entail a five-day initial training and refreshers;
- Organizing regular supervisions with peers so they can share their views and tackle the

most common issues and ask for solutions;

- Supporting them in their emotional needs;
- Evaluating the system on a regular basis.

5.2.2 Informal groups as peer-support groups

In some cases, the gatherings of these groups can become forms of group peer support, in which individuals having similar life experiences interact and form helping connections. In this sense, peer support groups provide social, emotional, physical and tangible support, and can help the participants to overcome feelings of social isolation and build a bridge towards the community. A structured peer support group would consist of:

- (a) One initial meeting.
- (b) Ideally 8 to 20 participants: Newcomers should not be included in existing groups, but form new ones. This can be kept flexible due to geographical distances, and pre-existing bonds considerations.
- (c) A trained facilitator: For instance, the mentor.
- (d) During the first meeting, explanation of the purposes, agreement on the calendar, and choosing the topics to discuss: Participants learn how important it is to listen to each other's story, without forcing a disclosure and without being intrusive. They learn how beneficial from an emotional point of view it is to find out that not only predicaments but also resources are common among them.
- (e) Follow-up sessions organized based on the interest and availability of the group.

This **guide** shows more about how to organize these groups.



To finalize plans and organize trainings for the facilitators, one can refer to IOM Mental Health, Psychosocial Response and Intercultural Communication, Global Section (**contactpss@iom.int**).

→ 5.3. CASE STUDY

5.3.1 South Sudan

An example comes from South Sudan, where spontaneous groups have been supported by the programme through a process of facilitation of conditions for the groups to meet, and training for their leaders and facilitators.

In this video can be found the genesis and evolution of a gathering of female-headed households (problem-based group) that started as a support group and, while the women gained confidence, quickly became a peer-support group, an activity group and finally a livelihood **activity**.



In this publication can be found the voices of those group leaders, who were empowered by the programme to provide peer-support to the other members of the same interest and problem **groups**.



5.3.2 Ethiopia

A youth group was formed based on the principle of inclusiveness: participants were male and female, and included IDPs as well as youths from the host community. The group was supported by two MHPSS team members (also young, one male and one female). It wanted to engage in positive activities that would benefit both the group and the community as a whole. It decided to engage in honey farming, and identified resources to build traditional beehives and spaces where to place the beehives, while IOM provided minimal material support (some plastic sheets). This process meant that the youths engaged actively with the community, starting a process of changing perceptions about youths, who can be negatively stereotyped and stigmatized. The group also engaged in volunteering activities such as helping affected community members to build shelters or carrying water for those who were not able to do so on their own. This contributes to promoting positive social interaction between

IDPs and the host community, where the host community can realize the value that IDP youths can bring.

→ 5.4. CHALLENGES AND CONSIDERATIONS

One of the main challenges is establishing who is part of the group. Some groups may be spontaneously established, which can create challenges. For instance, the group composition could create difficult dynamics if all group members are from the same ethnicity (in a context with ethnic tensions). Groups including several members of the same family may affect participants' ability to share in a confidential manner. However, spontaneous groups can also prove very useful: they are rooted in the community's own support structures system and have a good understanding on how to navigate those. Group members may feel more comfortable, as they know each other and trust each other's motivations. Establishing groups may make it easier to influence group dynamics: members can be selected to ensure a helpful balance.

How to select group members can also be challenging. It must be decided if the group is heterogeneous or homogenous. Membership will be influenced by the objectives of the group. For instance, if the group aims to provide a safe forum of socialization to women-headed households, the group may wish to exclude men from this specific group. Factors to consider when establishing membership criteria could include: age, sex, clan/tribe, interest, commitments, areas of origin, social status, IDPs/host community members and religious affiliation, among others. This is not say that there should be segregation based on those factors, but rather that it is important to recognize that these factors will have an impact on the group dynamics internally and also on how the group will be perceived by the rest of the community, which in turn can also affect the groups' own self-perception.

Another consideration to take into account is whether the group will be open, welcoming newcomers, or closed. In order to address this, it is important to look at different criteria:

- The size of the group: If the group gets too big, it may be more challenging to ensure it reaches its objectives.
- The structure of the group: If it is a more informal group focusing on social activities, or a more structured group with defined roles for its members and a psychosocial objective. In the latter case, it may be more difficult to incorporate newcomers.
- The journey of the group: As the group evolves, and members have gone through the life cycle of the group, newcomers may find it complicated to fit in.

Handling of difficult support group members and their unintended impact of activities must be taken into account. MHPSS teams should be aware of any potential negative effects of difficult group members in social and cultural activities, and adopt mitigation measures. For instance:

- People with mental health issues may feel worse and become more withdrawn if they try something that is too challenging for them, affecting the group environment.
- Highly disruptive individuals can interfere in the participation of other group members.
- There can be negative health impacts for some people with health issues while taking part in certain activities.
- The possibility of violent behaviour and fights must be prevented.
- Members who attend and don't participate, or experience communication problems, might affect the group environment.
- More dominant group members might try to impose their values.
- It is important to create boundaries and manage expectations so that people will know what is appropriate and what they can expect. If people

have a bad experience, it can prevent them from engaging in activities in the future.

The use of cost-effective ideas versus having variety in activities is also important. The most popular activities will reach a wider sector of the affected population but might risk leaving individuals out of the programme or specific needs unmet.

Keeping the groups going can be challenging, especially in protracted displacement situations. The dynamics of a group may change over time: for example, it could become more social in function, or it could change focus in terms of topic and membership. No matter how the group changes, its primary purpose is to provide support and understanding to its individual members. Groups can also eventually end, as the members either move out of the communities, or can decrease, due to irregularity of attendance shrinking the group in terms of numbers. It can also give birth to new groups or subgroups, depending on the need to recognize new “groups” as they arise. For example, mothers’ support groups were organized in the Primary Health Care Clinics in Wau, South Sudan, as part of a nutrition programme. Teenage/ young mothers were usually quiet during the meetings. When asked by the facilitator, the young mothers shared that they were not comfortable in speaking or discussing certain issues related to their status in front of older women, including relatives. Eventually, this led to the formation of a new subgroup within the mothers’ group.

Groups may end for different reasons: members may choose to end the group as they have achieved their objectives, or are displaced again by the conflict. As the group evolves, and especially as emotional investments are made by its members, it becomes more crucial to prepare for such a possibility. The possible ending of the group could also influence how groups are formed: for instance, in Nigeria, some groups were created with members who came from the same locations so that in the event of return they could continue the group at their location of origin.

For references, see full bibliography [here](#).



6. CREATIVE AND ART-BASED ACTIVITIES



6.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

This chapter will introduce the use of expressive art-based and creative activities, such as music, theatre and drama, storytelling, poetry and creative writing, dance, painting, sculpting, photography and video-making within MHPSS programmes. The aim is to inform MHPSS managers on how to design and monitor MHPSS programmes that include these fundamental cultural components, facilitating expression, relaxation, symbolic re-elaboration and transformation of painful predicaments, agency, relationships, problem-solving and peaceful discussions through metaphors, social communication and documentation. These activities can activate processes that are at the same time healing, educational, social and cultural, and that are rooted in structured and recognizable (and therefore safe) forms, but allow for individual, subcultural and collective changes and transformations.

Box 25

Effects of art-based and creative activities

Art-based and creative activities can have a positive effect on social and cultural determinants of health, such as social capital, literacy, life skills and auto-efficacy. Furthermore, recent neuroscientific and psychological, neuroendocrine and immunological studies have claimed that participation in cultural and artistic activities can have a positive impact at the organic level, containing the negative outcomes of protracted distress and empowering the immune responses. According to the most recent studies of neuroaesthetics, the vision and creation of artistic forms solicit the mirror neurons and stimulate empathy and “atunement”.

Art-based and creative activities are strictly connected with the paradigms presented in the chapter on **Models of work**. Artistic interventions work on the connection between the three spheres of the psychosocial approach model, since they link body and mind in a creative action that is relational, rooted in culture, and creates cultural “objects”, such as songs, sculptures, paintings, plays, videos, etc. They are central to the model of CB MHPSS programming, since:

- The arts, with their capacity to transform suffering, negative experiences and collective wounds in artistic production of aesthetic, social and cultural significance, work at the interconnection of the individual, collective and societal dimensions, and the intersection between suffering, resilience capacities and practices, and the positive outcomes of the adversity.
- They also connect individuals with their families, subgroups and larger segments of society, possibly including new narratives in the public discourse.
- With their metaphorical yet recognizable language, they can at times voice the unspeakable, and link the unlinkable.

They represent an important dimension of identities in that they are a fundamental feature of collective identities and can also give a voice to subcultural identities, while promoting individual agency.

The relations of these activities with the IASC MHPSS pyramid of intervention will be explained in the following section.

First, the chapter will look at common programmatic indications to consider when including creative activities within an MHPSS programme. Then it will describe programmatic steps that should allow this integration. Finally, it will describe in more detail some processes and models of work that regard only one of the arts, such as theatre and drama. Theatre and drama





Portraits. Art therapy workshop. Maiduguri, Nigeria. © IOM 2018/Rola SOULHEIL

are specifically used as an example for reasons that will be better explained later in the chapter.

6.1.1 Programmatic indications

Art-based and creative activities are rooted in the agency of populations and exist in any community. An MHPSS programme should provide so that these practices can be protected or reactivated after the emergency and/or the displacement, allowing theatre ensembles, dance troupes, music groups, individual artists, among others, to continue producing their artistic creations. This can include in-kind support and distributions of materials, or equip a psychosocial hub or a community centre with musical instruments, for example. These are called community-generated activities.

Since these activities create social capital, occasions for collective discussions and making of meaning, the psychosocial programme should purposely create occasions to link these experiences between them and, in the case of displacement, to link similar artistic experiences between the host and displaced communities. This means creating or supporting spaces, such as festivals, events, contests and art exhibitions on a given theme. It also includes common productions and dedicated multidisciplinary spaces, where integration is easier than other domains, being based on agency and a common artistic language, rather than vulnerability

and services. These activities are defined as programme-facilitated.

In addition, and most inherently to its objectives, an MHPSS programme should try to mobilize and capacitate artists and people who like using various forms of arts in the facilitation of workshops and processes with more precise MHPSS (relaxation, self-esteem, social cohesion, community development, peaceful discussion, documentation) focus for more vulnerable populations. This is not only about supporting existing practices, but engaging with different artistic communities and individual artists, proposing that they put their wisdom and skills at the service of others in need in their communities, with a more direct healing and reparative objective. Most of these artistic forms have indeed been used with different social and psychological aims in developed countries, as well as in the psychosocial domain in humanitarian action for decades ([Schininà, 2009](#)), and best practices have been identified throughout the years. These workshops and activities are defined as programme-generated.

Finally, creative and art-based interventions can be used as an entry point to the community and also as an assessment tool to inform programme design.



Box 26
Three categories of activities

- Community-generated activities protect, support and reactivate existing creative and art-based resources;
- Programme-facilitated activities build on existing creative and art-based activities, creating occasions for networking, mobilization and display;
- Programme-generated activities mobilize art-based and creative resources in specific activities with a clear psychosocial support aim, targeting specific problems or vulnerable groups.

Art-based and creative activities act simultaneously on various levels:

- Individual expression (for example, painting, singing, dancing);
- Group building (for example, choirs, music ensembles and groups, dance and drama groups);
- Peaceful discussion and identification of problems within the group (for example, theatre forums, setting the programme for a concert, among others);
- Social communication from the group to the community (for example, theatre plays, concerts, exhibitions, videos).

Notable differences exist between different forms of art in the prominence they give to these levels. For instance, figurative art activates the level of individual artistic expression, and of social communication through the “objects” it produces. Theatre and dance give more importance to the relational aspects and group building because they are often ensemble works and need an audience, which is a relation with an out-group, to take place. Video documentary productions and art exhibits of photos usually focus on social communication. An MHPSS programme will mainly engage with existing resources and practices, but it should consider the pertinence of the used medium when assigning more psychosocial support-related objectives to the activity.

Art-based and creative activities encompass a series of practices that act at the four levels of the pyramid of psychosocial interventions, with most practices positioned at **levels 2 and 3**. The scheme below exemplifies a few of the possible uses, without aiming at being exhaustive.

However, in an emergency context:

- Art-based therapies as a form of treatment of mental disorders (fourth level) will be used only if certified experts exist in the given context; otherwise, the programme should not engage in creating such an expertise.

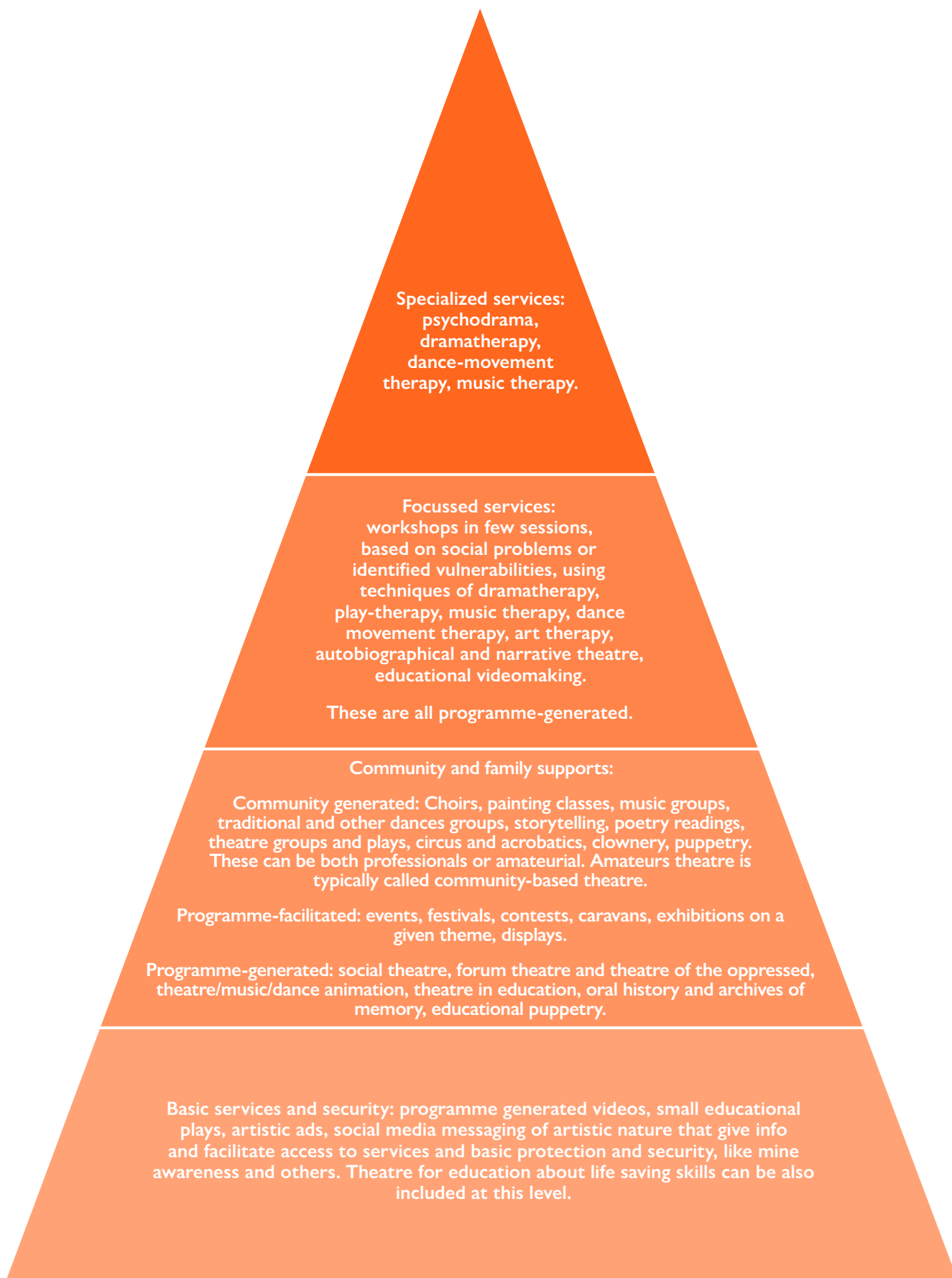


Group painting. Dohuk, Iraq. © IOM 2018



6. CREATIVE AND ART-BASED ACTIVITIES

Figure 9: Creative activities along the MHPSS pyramid



- Softer forms of application of these practices for problem-based focused support (third level) can be a part of the MHPSS programme, and training can be provided to artists and activists in this respect, but it should always be accompanied by supervision of the facilitators or be conducted and facilitated by mixed teams of artists and psychologists.
- Community-based uses of art and creativity can be performed and facilitated by anyone who has a skill in the specific art medium. These can be divided in two: those that are generated by the community and that the programme just mobilizes or supports, and those that are generated by the project to respond to specific socialization needs of a community. They include the recreational use of arts.
- At the basic services level, arts are engaged to inform people creatively about existing services and life-saving measures through performances, simulations, radio ads or songs with this specific purpose.

The categorization of these practices for levels of intervention may be fluid, yet it is important, since very often in humanitarian MHPSS programmes, terms and concepts related to the psychosocial application of artistic disciplines are not used consistently. In many cases, games with an educational purpose offered at the community support level are labelled psychodrama, which creates both the wrong impression that these are a possible treatment for mental disorders, and a bias that they can harm. The same often happens with the definitions of dramatherapy, art therapy and others that define activities that are in fact not what they are called, but just the use of creative tools in an MHPSS programme. However, when actual art-based therapies are used, they need to be accompanied by the supervision, safeguards and strict methodologies that these disciplines imply.



6.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

MHPSS programme managers most likely won't conduct art-based and creative activities by themselves, but they should make sure their programmes allow for the use of such methodologies and practices as follows:

- (a) Mapping of existing and pre-existing arts-based and creative practices and resources, and assessing perceptions in the community, including:
 - (i) Individual artists or amateurs;
 - (ii) Teachers of related disciplines;
 - (iii) Ensembles, groups and companies, both formal and informal;
 - (iv) Spaces and venues where these activities take place, if any;
 - (v) Art-based and creative activities more recognized by the communities at large, including the traditions linked to the cultural and artistic heritage of that culture.
- (b) Reactivating and protecting the existing or pre-existing practices and resources: These can happen in many ways and need to be contextualized. Support can be material or immaterial, in network or in training, and include barter. For instance, the project could provide in-kind support to individual artists and groups using arts, as materials, instruments, equipment and safe venues. This support can be subject to a barter (see (d) mobilizing the arts, below) and is better provided to:
 - (i) Collective rather than individual initiatives (for example, a choir rather than a singer);
 - (ii) Initiatives addressed to vulnerable groups, if already existing (for example, a theatre class in a disadvantaged school or neighbourhood, or minority cultural centres);
 - (iii) Artistic processes with a wider social impact (for example, traditional dance

6. CREATIVE AND ART-BASED ACTIVITIES

groups involved in Sunday masses or other civic celebrations, radio shows);

- (iv) Dedicated spaces and places, such as psychosocial support hubs (see chapter on Psychosocial mobile teams), or collective centres.

Since these practices have strong subcultural values, understanding that practices and perceptions can differ for different groups in the same community is necessary. Conflict and context sensitivity should be adopted in selecting activities to support, as well as the “do no harm” principle.

- (c) Catalysing these initiatives and bringing them in a network: This is usually programme-facilitated and is done by:
 - (i) Reactivating past festivals, contests and celebrations;
 - (ii) Finding ways to foster the inclusion of displaced people’s artistic production in events, exhibitions and festivals happening in the host community;
 - (iii) Calling for contests, festivals, events and campaigns with a given theme, exhibitions, readings, regular or mobile cinema caravans and tours, in order to facilitate a network;
 - (iv) Either basing the events on specific media (for example, a film or video festival, a day of theatre shows, dance contests), or making them neighbourhood-based (see a possible model in Box 27);
 - (v) Informing local authorities and linking with them.
- (d) Mobilizing the arts: These capacities and energies should be mobilized to respond to specific problems the communities are facing or to facilitate the inclusion of specific groups or to create social cohesion, absolving proper psychosocial support functions. This can be prompted in different ways, which include:
 - (i) Campaigns calling people who have an artistic skill that they want to put to the services of their communities to come out (see, for example, Box 28).

- (ii) Organizing trainings in using arts as a form of social action, like in social theatre, art in education, safer forms of art therapies adapted to social mobilization, and problem-based groups (see, for example, Box 29).

- (iii) Offering incentives or grants for small-scale interventions involving vulnerable communities in artistic activities with a social aim: These may be linked to training.

- (iv) Barter, which are related with the support given: For instance, if the programme equips one of the psychosocial hubs with instruments for a musical band and gives access to the instruments to the bands in the neighbourhood in shifts, the bands can be requested to give back to the community. The giving back can take different forms.
 - o A concert, either stand-alone or during an event or a celebration.
 - o A course in playing a particular instrument for displaced youth.
 - o If people wish to be trained and feel such a drive and/or have the right attitude, a workshop in the use of music and rhythm as a form of expression and relaxation.

These are just examples, and similar options can be given to painters, drama professionals, poets and writers, among others. What is important is not to force anyone to perform psychosocial support functions that they are not ready or willing to perform because of the barter, but to find the best barter that can fit anyone’s attitudes and engagements with an MHPSS programme.

The mobilization can bring a series of activities involving specific groups of community members in theatre, dance, music, video and creative writing workshops, among others, which involve the group in a creative process where the dynamic and the well-being of participants are more important than the realization of a performance. In case the performance is achieved, it will be opened only to the proximal community



Art workshop. Psychosocial Mobile Teams. Gubio IDP camp, Maiduguri, Nigeria. © IOM 2018

(for example, friends, family, caregivers). It can also bring community events, as artistic nights/meetings realized with musical bands, traditional dance groups, recreational activities (for example, knitting and games) planned with small groups of competent community members and targeted at the proximal community.

Box 27

Mobilization of artistic and creative resources

The social and community-based theatre group attached to the University of Turin has adopted a model to mobilize artistic and creative resources in marginalized neighbourhoods and camps for humanitarian responses. They create moments of artistic barter, in the form of community events, where the most creative part of the population is invited to perform and the other to attend. These should happen in locations that are safe, ample enough and yet can have a symbolic value for that community, including IOM's psychosocial support hubs and centres. They include parades, concerts, readings, and displaying of arts and crafts, and have become a ritual/repeatable event.

(e) Including in the plan of support groups, community-based interventions and focused services specific art-based workshops and processes: These activities, due to their psychosocial objectives, which can be diverse (from relaxation and stress management to social cohesion), are usually structured with a series of safeguards and boundaries. The MHPSS programme manager is not supposed to be an expert in all these applied forms of the arts, and should rely on national, regional and international capacity in the design phase. However, most techniques and processes have a few elements in common:

(i) Graduality: There is no rush towards a product, but time is allowed for individual expression,

6. CREATIVE AND ART-BASED ACTIVITIES

relationship-building, creation of a safe space, trust-building, explorations, contracting and feedback.

- (ii) Resource-based: The work focuses on resources. People may be grouped, based on their needs, but within the group of work, their resources (relative to the media of the workshop) are the focus of the work, what they are able to do.
- (iii) Agency-based: Art-based psychosocial support activities are neither top-down nor didactic, but are facilitation and valuing processes built with the participants. Activities ownership is a condition and an objective of the activities themselves.
- (iv) Diversity-focused: Activities allow each participant to express his or her own personal and cultural identity, and to pacifically and respectfully find an encounter with others' identities, through the development of inclusive behaviours. Socialization of differences is allowed by the fact that, in creative processes, more diversity brings better creative outcomes.
- (v) Group-building: Participants are stimulated through training exercises, games and artistic processes to discover their diversities, similarities and communalities at the physical, emotive and cultural levels. Theatre expression and artistic creation help in developing group communication and group cooperation, often without the use of words, which especially in conflict situations can be the most divisive.
- (vi) Metaphor-based: Most of these activities, especially those engaging theatre and music, are metaphorical in nature. The problems and the expression of personal feelings and experiences are mediated by a so-called transitional object – a song, a character, a puppet or a sculpture – that allows one to express but take a distance from and control the expression of personal issues.
- (vii) Quality of processes and products: Activities stimulate participants not only to express themselves, but also to search together the most effective ways to communicate. The research of quality in the relationships,

and in the realization of the products, allow participants to activate self-efficacy strategies and resources, and to develop an aesthetic satisfaction, important for the development of well-being.

- (viii) Multidisciplinarity: Usually, the workshops will be jointly facilitated by an artist and a psychologist or counsellor.

Typically, these workshops engage in a process that starts with individual empowerment, then creates trust and a safe space for people to express freely and enter into a relation through their expressions. When the group is consolidated enough, it can start tackling problems through metaphoric and artistic means, and finally goes on to produce an artistic object for an audience that is usually preselected and consists of proximity groups (families, friends, neighbours, caregivers and stakeholders with decision-making powers on the issues at stake). Engaging artists in these forms of support should come with a solid training programme for them, which will be specific to the technique and the medium involved.

Box 28

“I can do”

In the Bekaa Valley, one of the Lebanese regions most affected by the war with Israel of 2006, after the war was over and people returned home, IOM and UNICEF launched a campaign called “I can do”, to mobilize individuals and groups with artistic and creative skills to create interventions of social utility for the most affected communities. (See the English version of the [campaign materials](#).) The campaign attracted a large number of people who proposed activities that were implemented at the inception of an IOM-run recreational and counselling centre for families. Twelve years on, the centre is still running, operated by a local NGO, and some of the people who responded to the call at the time are still among its facilitators.



→ 6.3. EXAMPLES OF THEATRE AND DRAMA ACTIVITIES THAT ARE PROGRAMME-GENERATED

These techniques and processes that can be used for programme-generated MHPSS activities are various and can't be exhausted in this chapter. As an example, a series of techniques linked to theatre and drama are presented below. Theatre and performance art are indeed the arts that have enjoyed more declinations in the community development, psychosocial and mental health fields. This may be due to the fact that theatre and drama trainings are usually based on physical and emotional expression and their interrelation, improvisation and relations with a team. Their products are relational in nature, because they need the co-presence of at least two persons, the performer and the spectator, to exist, and can work on catharsis (emotional release thanks to the experience lived by the character), or metaxis (the ability to understand a problem in its fundamental points thanks to the staged action). They include the following:

(a) **Dramatherapy:** This is a certified form of therapy based on the links between body and mind, memories and expression, emotional

regulation and physical expression of emotions, role-play and creative discussions. It works on re-elaborating personal experiences, in a safe fashion, thanks to the use of transitional objects (puppets, stories, characters) and metaphors. There are two main non-exclusive practices in dramatherapy: one that brings participants to work on existing plays, characters, stories, myths and legends that can resonate with experiences of their own lives; and one that stages the lived traumatic experiences from participants' pasts. Dramatherapy could be used in IOM MHPSS programmes in emergencies with people with severe mental disorders only if the practice is pre-existing in the context and dramatherapists are trained. Otherwise, some dramatherapy practices can be taught and used as focused, problem-based support activities, especially those using pre-existing creative materials. For softer applications of dramatherapy practices in focused activities, see Jennings (2005, 2009, 2017, 2018).

(b) **Psychodrama:** Similar to dramatherapy, psychodrama is a certified therapy that entails a process bringing the restaging of a traumatic event from the past with a group of peers, which will allow the protagonist to change elements of his/her own behaviour in the situation, or ask others to do the same, to reach catharsis. It can be used only when certified psychodramatists are already present in the





context. It is otherwise not recommended due to skills, time, setting required. See Moreno (1987) and [here](#), and [also here](#).



- (c) Playback theatre: Similar to psychodrama, but less emotionally charged, Playback theatre implies a group of actors or trained individuals who are able to stage impromptu the storytelling of someone from the group or the audience, giving it a visible form. It is widely used in situations of human rights violations. See Dennis (2004) and [here](#).



Box 29

IOM training in the Syrian Arab Republic

In Damascus, in 2014/2015, IOM organized a one-year ongoing training course for artists and activists who were facilitating artistic workshops in the context of psychosocial support programmes for displaced and crisis-affected women, youths and children in the country. Participants included painters, actors, musicians and animators working for 20 different organizations, volunteer groups and churches, and included 5 residential modules of 24 hours each plus distant supervision. The modules included dramatherapy and art-therapeutic techniques, social theatre, puppetry for social intervention, and theatre of the oppressed. These techniques were found particularly useful in the context, because they allowed practitioners to express their issues through metaphors, allowing a sense of privacy and safety that was missing in other more talk-based interventions, due to the specific nature of the crisis. An 18-month evaluation showed that participants benefited greatly from the trainings, both in terms of professional skills and through the personal empowerment that came from the interactive and experiential parts of the modules. Modules can be obtained from contactpss@iom.int.

- (d) Social theatre (applied theatre): At the beginning of the 1990s, a new form of theatre – taking inspiration and methodologies from theatre animation and community-based theatre, new theatre and art and theatre therapy – found its way into direct interaction with the problems of individuals and groups in specific areas. It was a theatre based upon the body and relationships, but distanced from purely therapeutic approaches, and without solely aesthetic and artistic goals. It was, in fact, less self-centred and was ready to become an instrument of social action through laboratories, workshops and performances, with a goal of healing and of heightening the quality of social interactions. It was a theatre that linked the experience with the group to the sociocultural, economic, and historical context the group emerged from and remained a part of. This was and is called social theatre. As Bernardi stresses, social theatre is part of the current involvement of anthropology in society and facilitates: the social construction of the individual; the dynamization of interpersonal relations and inter-subjective comprehension; and the structuring of the entire community and of the smaller social institutions of which the community is compromised, such as schools, hospital, villages. See Schininà (2004c) in further reading, and Pitruzzella (2006). For practices and examples on the differential use of dramatherapy and social theatre, see Jennings (2009), [here](#). For practices and examples of the use of social theatre, in refugee settings, see Balfour (2013) in [further reading](#).



- (e) Theatre of the oppressed: This encompasses a series of techniques and practices of the theatre to use for social, political and well-being purposes. The most famous techniques are its games, image theatre and theatre forum, which are both described in annexes to this chapter. [See Boal](#) (1995, 2002, 2008).



- (f) Theatre in education/theatre for development:

Theatre in education consists of the preparation of theatre play with educational goals, which are designed to be interactive and accompanied by a series of warm-up games. The play is presented in front of an audience (typically of students), twice. The second time, the play is interrupted at different significant points and a discussion is solicited with the students on emerged topics.



[See here.](#)



6.4. CASE STUDIES OF ART-BASED AND CREATIVE ACTIVITIES IN PROGRAMMES

Examples include:

- (a) Art-based workshops with a group: The objectives and subobjectives are based on the typology of participants, needs assessed and media used. It has a variable duration (minimum five meetings of two hours each) and can host from 5 to 30 participants. The document in hyperlink is the report of a **training module** Guglielmo Schininà conducted with the students of one generation of the Summer School Psychosocial Interventions in Migration, Emergency and Displacement on social theatre workshops of this kind whose structural elements can be applied to other media. These are typically community support or focused activities, depending on the composition of the group or the objective.
- (b) Narrative theatre: This is a narrative theatre approach to working with communities affected by trauma, conflict and war. The approach was initially tried in villages within rural Malawi in relation to issues of HIV/AIDS. It has been developed further over the last 10 years in different parts of the world, and is currently being engaged with in Uganda, Burundi and eastern Democratic



Republic of the Congo. This paper explores the effects of disruptive events or situations on community life and grassroots, theatrical means of responding. This approach has been influenced by the ideas and practices of Narrative Therapy and Forum Theatre (Sleip, 2005, 2009). This can be used at the community support and focused levels.

- (c) Theatre forum: Another example of staging stories can be inspired by the theatre forum, a technique created by Augusto Boal (Sullivan and Lloyd, 2006), whose characteristic is the active engagement of spectators with the performance. A problem that oppresses an individual is presented unsolved in a theatre scene. The scene is repeated twice and, during the replay, which is facilitated by a presenter or joker, who is also expert in moderating the interactions, each member of the audience can stop the scene at any given moment, step forward and take the place of the oppressed character, showing how they could change the situation to allow a different outcome. Breaking the barriers between the performers and the audience, the dynamic engagement on stage is powerful and has transformative effects on all the people in the theatre. In addition, practical and shared solutions to general problems can be sought. Usually, the scene is the result of a workshop of a few days with a group of people sharing similar situations, such as returning migrants. Forum theatres on problems faced by returnees would sensitize communities on these problems, and help returnees and communities to solidarize, create bonds and find solutions in a creative and participatory fashion. One can find an example of how IOM has used forum theatre in a different context in the past, for instance in post-earthquake Haiti, with a process illustrated in the attached article (**Schininà et al., 2011**). The forum is a community support activity, yet the process brought to it could be also a focused service.



6. CREATIVE AND ART-BASED ACTIVITIES

- (d) Circus arts: This can be used as a way of expression and as physical activity with different age groups. Clowns' organizations have been involved in emergency settings in different countries, working especially with children and families. For instance, Clown Science Dreams, in collaboration with Jesuit Refugee Services, worked on enhancing resilience, self-development skills and self-confidence through art-based interventions, theatre and clown activities in Iraq.
- (e) Community events with narration or other artistic activities (music, dance, among others): These events are properly structured and developed based on artists', professionals' or dilettantes' competencies. They can be developed with a small group of stakeholders and community members, can involve traditional arts, and can consist of a single performance or concerts, or storytelling, or require the active participation of those attending. These are full community support activities. **See** the example on the use of choirs.
- (f) Collective narrative practice, honouring and building on local skills, stories and knowledge: In many cultural contexts, talking in the first person about hardships is not culturally resonant. Collective narrative methodologies such as the Tree of Life and Team of Life approaches enable meaning to be conveyed through metaphor in culturally diverse and resonant ways. These folk cultural methodologies can be engaged with, not only by highly trained professionals, but also by key community and family leaders, who may not have had the privilege of extensive schooling or education (Denborough, 2008, 2012, 2014; and Ncube, 2006). These are both community support and focused services, based on scope and objectives.
- (g) Visual arts: In various settings, visual arts have been used in the provision of MHPSS at the community level, from communal mural painting to representing people's daily lives and experiences through images. It is a valuable tool to express realities and ideas without words, frequently used with children and youth. It can include painting, drawing, ceramics, textile art, photography, video and other expressions, depending on the cultural context. For instance, Alta Mane Foundation developed the toolkit "Art for change makers on the move" within the YOU CREATE project, targeting refugees in Egypt and displaced youth in Iraq. Visual arts can be combined with other interventions. For instance, IOM Nigeria uses **portrait painting and storytelling** as tools to facilitate self-empowerment among affected populations. IOM South Sudan used theatre and moviemaking, working with youths affected by conflict.
- (h) Storytelling events: Storytelling is an effective tool for mobilizing communities and promoting social cohesion towards integration and healing. Stories that relate experiences can create understanding, and



have the power to unite people while they are being told. They play on a deep emotional level, benefiting all participants: it is not only the listener who learns, but also the teller who becomes aware of the value of his/her own unique experiences and background, and the solidarity that can come from a recognition of mutual or similar feelings and experiences. Storytelling can be verbal, in the form of a video, or a reading. A facilitator can help the returnees to combine their stories in different narratives to share in public.

A new form of storytelling is possible with the help of technology. Digital media have been playing an increasingly influential role in shaping both the perceptions and outcomes of emergencies. The combination of words and images can magnify the impact of stories. An example of audience engagement with visual storytelling is given [here](#) by IOM. These are community support activities that can derive from focused interventions.



- (i) Archives of Memory: In many places, from Kosovo¹ to Colombia, IOM has used an approach that links creative activities, rituals, oral history and documentation, facilitating communities in creating Archives of Memory, which are physical and/or digital archives collecting personal, creative, photographic, diarist memories of the experience of displacement that can be then used as a cultural testimony, and a living memorial for generations to come. The booklet based on the experiences in Kosovo¹ is in further reading. The development of new media, which allow storage and dissemination of memories that are not bound to a physical space, has changed the way archives are conceived. In 2017, IOM Indonesia organized a digital storytelling room for refugees and stranded migrants hosted in a migrant centre. This consisted of a room equipped to create short autobiographical videos using pictures and voice-overs, and a short tutorial for the

interested migrants on how to create these videos. In 2010, IOM Jordan, in coordination with the River Jordan Foundation, created an online Archive of Memories of Iraqi refugee children enrolled in Jordanian schools. A profile was created for each child, in which were included photos, drawings and memories under the supervision of an expert facilitator. The archive was online for five years.

- (j) Youth workshops: An example of a youth workshop is a series carried out in South Sudan titled “Piece of Art to Arts for Peace”. This was an interactive intervention designed to facilitate increased connections among group members. It is intended to bring together multiethnic groups of displaced children and young people who met regularly in the psychosocial support resource centres, either during sports, craft activities or group discussions. In this workshop series, they learned about growing and fostering relationships, without relying on sophisticated verbal abilities. Specific techniques encourage the expression of “feelings and thoughts” and other interpersonal dynamics that cannot be easily translated into words. The interactive nature of the art projects creates a context where interpersonal disconnections can be explored and understood, and connections can be celebrated, both by talking and by making art.
- (k) Often programmes and workshops mix various practices and objectives. By instance, in Lebanon, in 2013 a group of Syrian displaced female teenagers that was already involved in various activities at one of IOM recreational and counselling centres, subscribed for a workshop aiming at developing a video animation. The workshop was run by a psychologist and an artist-videomaker and mixed artistic, technical and autobiographical elements. After an initial period, the participants decided to focus

¹ References to Kosovo shall be understood to be in the context of United Nations Security Council resolution 1244 (1999).

the workshop to the autobiographical element, maintaining only a small animation component. This brought to the video *Letter from a Refugee* that went on to win human rights awards at video competitions and to be translated in several languages, in order to be used as educational and antistigmatization tool, including in countries where Syrians were about to be resettled. See the video [here](#).

engage in ludic activities and performances in some cultures. However, other artistic media – such as singing, playing music, and oral and written poetry – can be considered a fit. Likewise, while in the West bodily training is the first step of theatre-based workshops and practices, women in certain cultures find it difficult to engage in bodily expression.

MHPSS programmes can have two roles in engaging with art-based practices. One is supporting the reactivation of existing cultural and artistic practices, for which conflict sensitivity and inclusion always need to be taken into account. The other is to initiate specific psychosocial support activities with well-being objectives based on artistic practices. This will require dedicated expertise in the MHPSS team or in the supervisory team, and trainings for the facilitators, who may be skilful artists but lack the necessary psychosocial skills or be psychosocial workers with no specific skills on the media and the arts engaged, which are equally important.

Continuity is key for these interventions to be successful. One-off recreational sessions can be entertaining, but can hardly reach the intended psychosocial objectives. Yet timing and continuity, due to volatility of the security situation, are often a challenge in these contexts.

Box 30
Art-based interventions in academic programmes

IOM includes components of art-based interventions and culture in its Master and other academic programmes on MHPSS in emergency and post-emergency settings, and includes artists among those who can attend those trainings. See, for instance, the special section of the journal *Intervention*, containing the fieldwork of some of the students to the IOM Diploma in Psychosocial Support and Conflict Transformation, organized in collaboration with the University of **Ankara**.



6.5. CHALLENGES AND CONSIDERATIONS

The most validated adaptations of arts-based practices into healing and social support programmes – such as dramatherapy, art therapy, playback theatre and the theatre of the oppressed – are largely based on Western artistic practices and traditions. Their adaptation to each and every culture can't be taken for granted, and should be attentively discussed with local practitioners and communities.

Activities should always be tailored to the needs and preferences of the target population, knowing that creativity expresses in different form in different cultures, but is present in all cultures. Adult males may not meaningfully

➔ FURTHER READING

Armaghanyan, S.

2018 *Theatre as Psychosocial Approach in Humanitarian Settings*. (Unpublished masters' thesis).

Balfour, M. (ed.)

2013 *Refugee Performance, Practical Encounters*. Intellect, Bristol, United Kingdom.

International Organization for Migration (IOM)

2001 *Archives of Memory: Supporting Traumatized Communities Through Narration and Remembrance*.

Schininà, G.

2004c Here we are. Social Theatre and Some Open Question on its Development. *The Drama Review*, 48(3):17–31.

For references see the full bibliography [here](#).



7. RITUALS AND CELEBRATIONS



→ 7.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

This chapter concerns the inclusion and promotion of collective rituals and celebrations in a CB MHPSS programme. After a brief introduction to the functions rituals and celebrations can have in a CB MHPSS programme, the chapter will provide practical information to MHPSS programme managers on how to include rituals and celebrations in MHPSS programming. While the restoration of individual and family rituals has an important role to play in terms of self-care and psychosocial well-being, this chapter concerns collective and community-based rituals and celebrations only.

Box 31

Complementary information

The UNICEF *Operational Guidelines: Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families* (UNICEF, 2018) provides guidance on support to communities to re-establish rituals or cultural events (for example, commemoration events to foster communal healing, cultural festivals or religious celebrations), along with traditional healers or leaders as **appropriate**. The information contained in this chapter complements the information contained in the UNICEF Guidelines from a programmatic point of view.

- They offer occasions for codified expression of individual negative emotions and positive emotional reactions.
- They help to overcome isolation, and help people to socialize and share.
- Making use of metaphors, images, characters rooted in traditions, they allow people to communicate negative experiences in a safer, indirect way.
- Being learned and repeated for generations, they help in contextualizing the current suffering in history and heritage, providing continuity and a perspective.
- They can provide interpretative frameworks to personal and collective predicaments. Tales, legends, staged ritual dramas, songs, proverbs and scriptures all contain elements of reflection on the human condition that can also shed light on the current problems.
- They help people to feel reconnected with themselves, their families, communities of origin and host communities.
- Rituals can represent, validate and accompany transformations. The transformative function is inherent to rituals, which often are rituals of passage – such as marriages, seasonal celebrations, initiations and funerals – which all reflect the social recognition of the change in a personal state.
- In addition, in situations characterized by disruptions that have fractured communities, they can ritualize the experiences of violence, displacement and relocation, and celebrate the resilience of communities. Celebrating arrivals in the camps, and their closure, new intercultural rituals – along with the host communities – can all contribute to the well-being of affected populations.

In the aftermath of an emergency, rituals and celebrations can perform several functions. Through codified rules and scenarios, ritualized movements, learned narratives and symbolic images and practices, they allow sharing, a sense of being supported, relief from negative feelings and strengthening of positive, culturally and religiously grounded coping mechanisms:

Box 32**Example from the Yazidi community in Iraq**

In 2015–2016, the Yazidi community in the northern part of Iraq welcomed back those Yazidi women who had been kidnapped into sexual slavery by ISIS, using traditional cleansing rituals, which allowed them to be fully reintegrated into their families, using a traditional form. This is an example of collective ritual of transition used to respond to war-related adversity ([here](#) and [here](#)).

 **7.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO**

Psychosocial programme managers are not going to perform or organize rituals and celebrations themselves. Yet they should design and implement programmes that allow for support to rituals and celebrations in various forms, which will be described below.

7.2.1 Facilitate existing or reactivate interrupted practices**7.2.1.1 Map types of rituals and celebrations with community leaders and informants**

Rituals and celebrations can be religious or non-religious. Both religious and non-religious rituals and celebrations can be daily (for example, Muslim daily prayers or flag-raising), weekly (for example, Sunday masses or elderly gatherings), yearly (for example, Eid, Christmas, Labour Day, Independence Day), occasional (for example, weddings, funerals), periodic (for example, initiations, coming-of-age processes). It is important, at the very beginning of a psychosocial support programme, to create a calendar of the rituals and celebrations that can be calendarized, to understand the scope of the necessary financial and manpower commitments. To note:

- Movements (but in some cases, also public gatherings) of refugees, IDPs and migrants outside camps and centres require authorizations and coordination with security forces that might take time and efforts to be obtained.
- Rituals and celebrations should be reviewed with community leaders, in order to identify potential human rights violations and be clear about what the programme can support or not and why.

Table 3: Examples of rituals

Examples of rituals	
Personal rituals	<ul style="list-style-type: none"> • Coffee in the morning. • Bedtime routines, like storytelling or prayers. • Personal religious practices. • Comfort rituals/stress management.
Social rituals	<ul style="list-style-type: none"> • Hospitality: Coffee ceremonies, meals, “good manners”, greetings and farewells, relations with guests. • Activities with friends: Tea and chess, bar hopping, dancing, sports. • Celebration of holidays, birthdays, name days. • Memorialization of events. • Presentation of “self” such as attitude, posture, approach to others. • Family relationships and activities.
Religious rituals	<ul style="list-style-type: none"> • Prayers and preparation for prayer. • Rituals of devotion: Fasting, abstaining from X, seclusion, paying alms, worship, special food. • Celebration of holy days, festivals. • Memorialization. • Preaching/worship. • Creation of shrines/altars/places of devotion. • Elevation of persons having certain gifts or training to be leaders for others.
Cultural rituals	<ul style="list-style-type: none"> • Initiation/membership rituals. • Group membership rituals: Political groups, gang behaviour. • Symbolic behaviour. • Clothing/hairstyle as reflective of group identification. • Citizenship or ethnic membership. • Development of arts, including song, dance, visual, crafts. • Sharing of history/narratives of group. • Passing of traditions across generations.
Rites/rituals of life events (cultural, traditional or religious)	<ul style="list-style-type: none"> • Recognition that a person has changed, therefore social position/relationships change. • Rites of passage from one state to another. Sometimes include survivorship or disaster recovery. • Births and naming. • Puberty and initiation to adulthood. • Marriage.
Rituals of grief, loss, disasters	<ul style="list-style-type: none"> • Gathering of people to mourn. • Support for friends and family of the bereaved. • Public ceremony, public demonstration of feeling, processions. • Prayers. • Lighting of candles, bringing of flowers. • Food, communal meals. • Rituals of honouring ancestors.

Box 33
Religious rituals

At the early stages of an emergency, religious rituals, such as public prayers and rituals connected with the life cycle – coming of age, marriages and, most importantly, grieving rituals – should take place. Click [here](#) for more information.

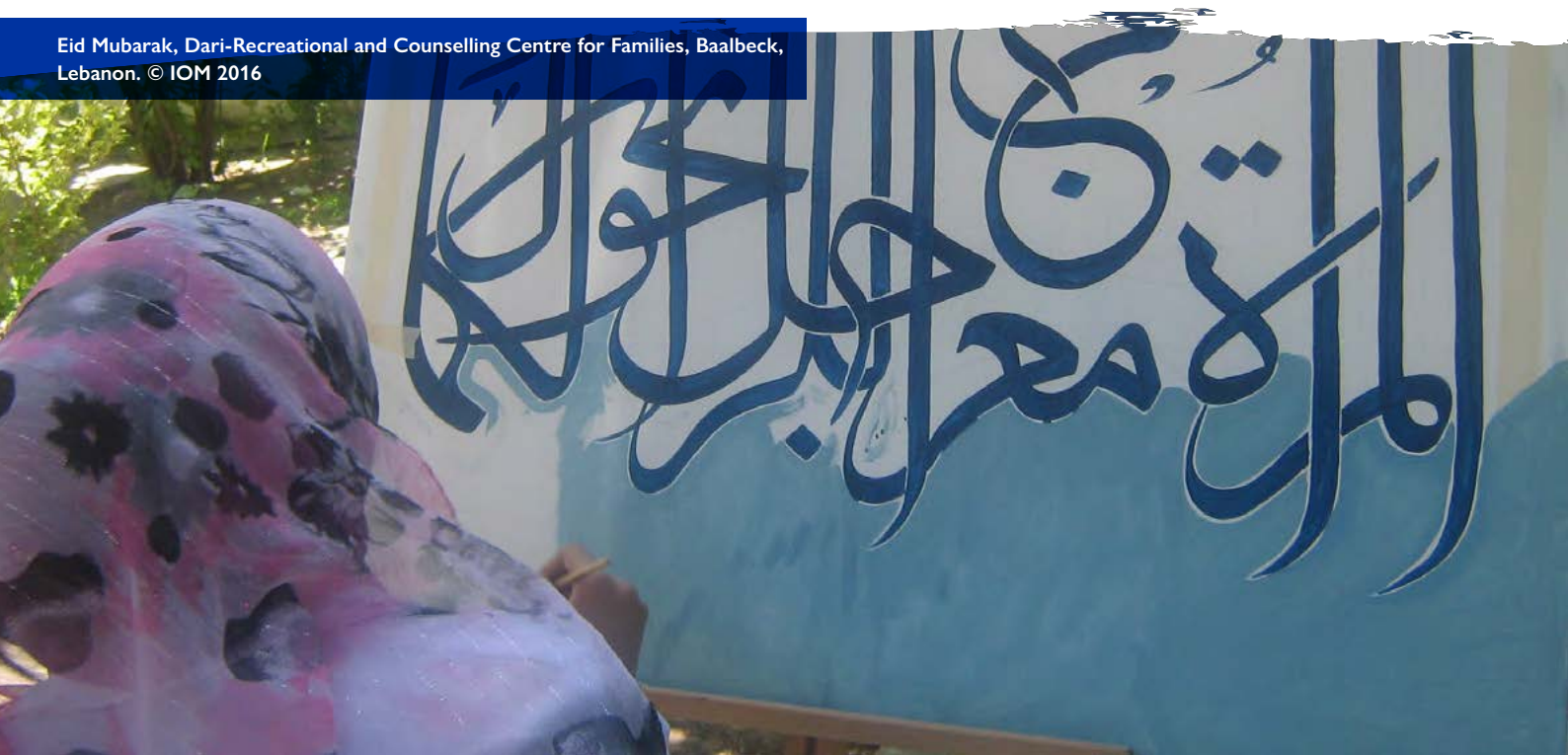
candles – might greatly support the execution of religious rituals and public gatherings in a warm and conducive atmosphere. It is important that all religious and ethnic/cultural groups present in a camp or a community be represented, always using a conflict-sensitive approach (see chapter on **Integration of mental health and psychosocial support in conflict transformation and mediation**).


7.2.1.2 Identify and refurbish (or prepare new) sites and locations

This includes, for example, mosques, churches, temples, meeting rooms, town halls, schools, museums, cinemas and theatres, where religious rituals and civic collective gatherings can be held in safe and welcoming premises. If such locations are not available in a close range, the project might consider the establishment of temporary dedicated spaces (rub halls, tents, caravans, shadings) or renting/rehabilitating available structures for the purpose. It is important to recreate a symbolic enclosure to these spaces, even with simple objects such as fences, pathways, boards, images, plants and decorations. Usually, provision of ad hoc equipment – such as data projectors, screens, sound systems, traditional instruments, stationery, chairs or necessary seating arrangements, lights and

7.2.1.3 Mapping and involving faith-based, civic and cultural organizations and their leaders

Religious leaders, artists and cultural activists, within and outside the groups of concern, who are willing to collaborate with the psychosocial project in organizing rituals and gatherings, and promoting participation, based on agreed procedures and aims, should be identified. If available, programme managers should actively search for collaboration with religious congregations, cultural centres, and faith-based and civic-based organizations to provide training on MHPSS to their staff and volunteers. These include both among the displaced and the host communities. If deemed appropriate, partnerships should be established with them to jointly carry out these activities.



7.2.1.4 Facilitate inclusion

Programme managers should facilitate inclusion of individuals and families who might have difficulties accessing public gatherings and religious places, due to disability, language capacities and/or stigma. This includes:

- Transportation;
- Accompaniment;
- Translation (including in sign language if needed);
- Refreshments;
- Ramps and other devices to reduce architectonic barriers;
- Personal assistants and health staff for the elderly, those with motor disabilities, mental disorders, as well as their caretakers.

On the occasion of civic commemorations, public campaigns or ceremonial exchanges of gifts, a mixed attendance and inclusion of different subgroups should always be pursued.

Rituals and celebrations can also be used to divide and exclude, and this needs to be evaluated at the inception of the **programme**.



7.2.1.5 Mobilize stakeholders and partners

Local authorities, camp managers, section leaders, teachers, journalists, artists and media activists should be involved from the inception of the activity. Appropriateness of the activities, designing and implementing steps, available financial and material resources, logistics support and authorizations should be discussed and coordinated with them. If deemed necessary, ad hoc committees can be established for the organization of both civic and religious rituals, but religious ones may have to follow their established procedures, particularly on the subject of inclusion. It is good practice to mobilize groups and individuals in the organization of these events (for example, youths, scouts, heads of families, women's leaders and religious actors).

Box 34

Safety and protection

Participants may need to be reassured of their safety and protection, vis-à-vis the risk of internal and external provocations. Not only should safety and security be provided, but participants should be made aware that these measures are in place.

7.2.1.6 Engage staff appropriately

Ideally among the multidisciplinary PMTs, there is a member that is tasked to learn from communities' religious and spiritual beliefs, traditional narratives and iconography, ritual and civic calendars (for example, cultural and media activists, teachers, scholars and artists). PMTs are likely to be composed of professionals with different ethno-religious backgrounds and social status, along with gender, age and political differences. Therefore, it is important as a preliminary to discuss modalities of their engagement in rituals and celebrations. Particularly for religious rituals and public gatherings, which might require the full mobilization of the team, it is important to coordinate roles and functions according to professional skills, social attitudes and cultural proximity to the affected populations. Staff members who do not feel comfortable, or perceive their presence as potentially obstructive to the smooth implementation of the activity, should be left free not to facilitate or attend. Discussions with and within the teams after the implementation of rituals and celebration activities should be encouraged by psychosocial supervisors as a good managerial practice and lessons learned exercise.



Healing Ceremony with Rohingya women in Cox' Bazar, Bangladesh. © IOM 2018

7.2.2 Promoting additional activities and new rituals and celebrations

7.2.2.1 Promoting the reactivation of rituals and celebrations

After a preliminary assessment on the most appropriate religious rituals and civic celebrations recognized by the community, according to the specific goals, stages of the emergency and target groups, different sets of activities should be identified (for example, public prayers, candlelit march, pilgrimages and visits to symbolical places, funerals, weddings, annual celebrations and commemoration, storytelling and poetry contests, radio talks and social media events) that the project aims to support directly, either because they are missing, or because they are deemed particularly important. Special attention should be paid to testing some of the assumptions on the positive effects of the specific activity on the well-being of participants through discussions with religious leaders, cultural activists and selected members of communities.



See example on community-led Iftar dinners in Turkey.

7.2.2.2 Promoting new celebrations

In strict dialogue with religious leaders and civic activists, new ritual celebrations could be promoted by the MHPSS programme, including:

- The anniversary of the day of displacement;
- The opening, anniversary or closing of a camp or transit area;
- A day celebrating the relations between the displaced and the host community;
- Interfaith celebrations based on the religious composition of the camp, displaced community and host community.

7.2.3 Links with sports, cultural creative activities and informal education

Preparation of the main celebrations and rituals can be linked to sporting events or activities, such as tournaments and contests. The ritual and the celebration can be linked to the other creative activities supported or connected to the programme. For example, one can organize seminars, drama, music, traditional and other dances shows, poem readings and storytelling, and photo and art exhibitions, during or around the celebrations. Moreover, the rituals and celebrations can be used to promote support groups and other programme activities.

7.2.4 Documentation

Many of these events might assume historical relevance and should be properly documented by the project. It is important to archive:

- Photos and videos produced by participants, PMT members and media;
- Printed materials such as brochures and posters;
- Professional documentaries.

Some of these documents will properly fill **Archives of Memory**.



→ 7.3. CASE STUDY

In the aftermath of the 2010 earthquake in Haiti, during masses, some Christian priests were blaming the earthquake on the prior behaviour of their faithfuls, characterized by a non-strict adherence to the prescriptions of the religion. By contrast, the cosmological vision of the world connected with Voodoo helped individuals and communities give a transcendental value to the earthquake, making it easier for them to attribute a meaning to its consequences. Many families believing in Voodoo were quite distressed about the impossibility to bury the roughly 80,000 corpses that could not be found, since in Voodoo, funerary rituals are extremely important in determining the well-being of the person in the afterlife, but also his or her possibility to still relate to the world of the living. For this reason, IOM, first alone and then under the umbrella of the IASC Working Group on MHPSS, promoted an interconfessional forum of religious leaders. The forum brought sensitization on the psychological consequences of blame towards priests in the country, the creation and dissemination of common supportive messaging and especially the elaboration of a guide, agreed by all, to perform funerary rituals in the absence of corpses, and to the organization of such collective rituals in several camps.



7.4. CHALLENGES AND CONSIDERATIONS

When public celebrations and religious rituals are associated with painful memories, deep resentment and contested meanings, their inclusion in a psychosocial support programme should be carefully planned, to prevent their close association with psychosocial interventions to antagonistic, partisan and politicized stances. Particularly sensitive in emergencies can be martyrs and veterans' celebrations, as well as commemorations of battles, exoduses and genocides.

Religious rituals and celebrations can be a source of conflict in some context, and this risk must be evaluated. The engagement of traditional healers and ritualists should also be done with utmost caution.

Participants might not feel comfortable having their rituals documented. As in any activity, they should be consulted before taking pictures or recording the event.

Often, rituals are used to divide and exclude, especially in conflict situations. A careful evaluation of the possible instrumental use of rituals for exacerbating conflict and exclusion needs to be carried out within an MHPSS programme before engaging with these specific celebrations. For further guidance, see [here](#).

Assessing the impact of rituals and celebrations can be challenging. Evaluation and feedback mechanisms can be used to ensure that the activity has a positive impact on the well-being of people of concern.



→ FURTHER READING

International Organization for Migration (IOM)

2018c *Psychosocial Support and Dialogue in the Syrian Arab Republic and Lebanon*. IOM, Geneva.

Schininà, G.

2004a Cursed Communities, Rituals of Separation and Communication as Vengeance. A Redefinition of Artistic Interventions in War and War-Torn Societies. In: *War Theatres and Actions for Peace* (C. Bernardi, M. Dragone and G. Schininà, eds.). Euresis, Milan.

University of Oxford Refugee Studies Centre

2013 Local faith communities and the promotion of resilience in humanitarian situations: A scoping study (E. Fiddian-Qasmiyeh and A. Ager, eds.). Working Paper No. 90.

For other references see the full bibliography [here](#).



8. SPORT AND PLAY



→ 8.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Sport and play are fully part of the cultural and relational experience of a community, and can contribute to protecting and promoting the mental health and psychosocial well-being of individuals and groups, across genders, age ranges and social statuses.

Sport and play are deeply rooted activities that are always present, in some form, in any community. As they are a part of learned interactions and behaviours, and easy to reproduce, they are often spontaneously reproduced even in emergency and displacement settings. They are therefore a powerful means to support interactions among community members in emergencies, as well as an entry to engage communities and their subgroups in **MHPSS programmes**.

Sport and play are essential for the physical and psychological development of children since, through playing, children express and externalize in a safe environment, learn how to connect and cooperate with others, and can give a symbolic structure to their experiences. Games are also spaces for exploration and problem-solving, and educational tools for adults. In this sense, sport and play can help individuals to develop their resilience ([here](#)).

Box 35

Children's well-being and resilience

Well-being describes the positive state of being when a person thrives. In children, it results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence a child's ability to grow, learn and develop to their full potential. In MHPSS work, well-being is commonly understood in terms of three domains:

- Personal well-being: Positive thoughts and emotions, such as hopefulness, calmness, self-esteem and self-confidence;
- Interpersonal well-being: Nurturing relationships, a sense of belonging, the ability to be close to others;
- Skills and knowledge: Skills to effectively interact with others, cope with distress and seek information.

Source: Children's Resilience Programme (IFRC and [Save the Children](#)).

For additional information on child development, well-being and resilience, not only in relation to sport activities, please see [here](#).

At the community level, in the humanitarian domain, evidence shows that sport and play, and other recreational and structured activities, can be powerful tools for social inclusion, social cohesion, conflict transformation and creating a strong sense of community and **togetherness**. They can also contribute to restoring a sense of normalcy, helping to maintain the developmental process.

From a psychosocial point of view, sport and play are able to work organically on several

components of mental health and psychosocial well-being, since they engage the physical, psychological, social and cultural dimensions in the same actions.

In the IASC **pyramid** of MHPSS interventions in emergencies, sport and play are usually considered at the second level of intervention (family and community support). Most spontaneous and generic sport and play activities will in fact be offered to all community members. Yet, sport and play can also be focused activities at the third level of intervention by, for instance, problem-focused play therapy workshops centred on psychological problems, or sport activities with an aim of helping the physical and psychological rehabilitation of people with amputations, among others. In some cases, sport and play can be used as a part or a complement of different forms of psychotherapy at the fourth level of intervention (which is true for mindfulness, as well as cognitive behavioural therapy, art therapy and others).



Box 36

Attention points

To increase the possibility of reaching MHPSS and protection outcomes, it is essential to have in mind, from the initial stage, several attention points, such as:

- How are sport and play perceived by the community? By children and youth? By women and men?
- Which activities used to be implemented in the past? Were these activities gender-, age- and disability-inclusive?
- Who were the main actors involved in promoting and supporting sport and playing activities (NGOs, schools, youth clubs, mosques, churches, sport and cultural centres, private institutions and/or sport federations)?
- Are there potential risks linked with supporting and stimulating games and sports (such as cultural divisions, human rights violations, gender issues, among others)?
- Are there social norms prohibiting certain groups from participating?
- Can sport and games be a possible answer to a specific community's needs?
- What are the existing resources?
- How is the emergency impacting the set-up and implementation of the planned activity (for example, see chapter on **Integration of mental health and psychosocial support in conflict transformation and mediation**)?

For more information, see [here](#).



Sport and play are strictly interconnected with rituals and cultural activities, since:

- Sport and play can be used to celebrate rituals.
- Rituals have their codified protocols that usually include play and games or representations.
- Sporting events can become rituals in their own capacity.

They are also interconnected with informal education, since:

- Informal education can regard psychomotricity and different forms of sport.
- Games and play can reinforce life skills.
- Games and play can be used as a learning method.

Finally, the relation between sport and play, and theatre and other arts-based activities, is clear-cut, since they all refer to the action of playing, of which they represent different forms and manifestations. Additional information, including the definition and operational framework for the use of sports in post-disaster settings, can be found [here](#).



8.1.1 Basic principles in organizing sport and play activities

In the design and implementation of sport activities that are structured and have specific psychosocial objectives, the MHPSS manager should embed principles found in Table 4.

Table 4: Sport and play in MHPSS principles

Meaningful participation	From a psychosocial perspective, to make participation in sport and play even more meaningful, it is important to organize before and after discussions about the changes activities have promoted at the level of the individual (self-esteem, sense of power, frustrations) and of the community (sense of playing together, exploring new rules and meanings to antagonism and cooperation). Non-meaningful participation, especially in emergency situations, would be the one that derives from focusing on antagonism.
Capacity development	Skills to facilitate sport processes, in a psychosocial programme include: <ul style="list-style-type: none"> • Personal skills; • Social skills (communication, listening; negotiation, conflict management; teamwork, empathy; motivational approaches); • Methodological skills, which encompass: <ul style="list-style-type: none"> - Knowledge of specific sport techniques; - MHPSS skills; - Pedagogical skills. In emergency situations, these skills may need to be refreshed or taught, since the challenges of the emergency context bring the need for new personal, social and technical capacities, as well as new sport practices.
Context sensitivity	Sport activities should be sensitive to the cultural and spiritual dimensions of individuals and families, the socioeconomic and political contexts of the emergency, and to subcultural and conflict dynamics.
Inclusion	In sports, inclusion is programmatically translated in a series of practices aiming at “increasing access to, participation within, and reducing exclusion from, any arena that provides sport and physical activity”. Therefore, proactive initiatives should be taken to ensure the participation of marginalized or segregated individuals, such as persons with disabilities, including children with mental, cognitive and physical impairments; women and girls; and elders and youths belonging to different subgroups. A viable methodology to grant inclusion in sport activities can be found here .
Sustainability	This is mainly measured by the degree to which the MHPSS understanding and skills have been embedded in the sport practices of a community.





Outdoor games. Dari Recreational and Social Centre, Misrata, Libya. © IOM 2013/Stefano SPESSA

8.1.2 Categories of sport and play

There are different ways to classify sport and play activities, including structured versus unstructured activities. But regardless of how one chooses to classify them, it is critical that sports and activities aim to support psychosocial well-being, and are selected and implemented in ways that consider all ranges of motions and abilities, and include considerations of age, gender, economic situation and culture, among other factors.

Games and sport training need to be organized in a programme and sessions. A suggested plan is the one that envisages a main goal for each session. In each session, the goal is discussed and agreed, then there will be a warm-up, core exercises and trainings, a cool-down, and a debate/discussion. Activities may be:

- Individual/group;
- Outdoor/indoor;
- Aerobic/non-aerobic;
- Technology-based.

Which sports activities to select should be primarily based on what is already existing within the community. However, sport and play should also be seen as an opportunity to innovate and listen to the needs and requests coming from the community. For example, skateboarding in Afghanistan has been used in a particularly innovative programme for girls' **empowerment**.



8.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

MHPSS managers are not going to directly conduct sport activities, but rather design, supervise and manage programmes that should create a space for the use of sport and play to reach psychosocially-related objectives at various levels of intervention. The activities will be mainly implemented by the PMT. The UNICEF *Operational Guidelines: Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families* (UNICEF, 2018) envisages practices for inclusion and participation of children and their families in sport activities and events. The suggestions below aim at complementing the information from a programmatic point of view and adding links to relevant tools.

As for creative and art-based activities, sport activities supported and promoted by an MHPSS programme can be divided into “community-generated”, “programme-facilitated” and “programme-generated”. For an explanation of these terms, click [here](#).

Practical steps to include sport and play activities in an MHPSS programme will include:

- (a) Mapping existing sport and play activities among the displaced and affected community, including activities they used to do but are currently unable to do due to the emergency displacement.



- (b) Mapping existing sport and play activities among the host community, including those that could easily involve the displaced, emergency-affected communities.
- (c) Identifying and selecting sport and play activities to support and engage people of concern in the programme: Support to community-generated sport and play activities can include:
 - (i) Sport materials;
 - (ii) Sport equipment;
 - (iii) Other in-kind support;
 - (iv) Training;
 - (v) Securing facilities and their access;
 - (vi) Including the sport activity in a referral mechanism;
 - (vii) Creating occasions for networking between sport activities, such as leagues, common trainings and forums.
- (d) Implementing additional programme-facilitated sport activities within the programme, enhancing the capacity of existing realities, with the specific objective to respond to identified psychosocial needs (high levels of distress, lack of social cohesion): In this case, clearly defined programme objectives will be influenced by, and will in turn influence, the type of sport/ interventions selected.
- (e) Sport activities proposed by the programme manager that are not part of the usual sport and play activities used in a community, but that respond to specific psychosocial objectives or emergency generated needs: In this case, objectives should reflect and be reflected in the type of sport, the local context, the stage of emergency, and the psychosocial needs that have been identified and prioritized through the assessments. They should be determined with a participatory approach.
- (f) Taking disability into consideration when planning sport and play activities to make them inclusive.
- (g) Including people of concern in the selection of activities and development of a schedule.

8.2.1 Capacity-building

Designing and organizing capacity-building for the identified coaches, organizers and volunteers are key steps for managers that should be implemented to support the setting up of activities, and also to maintain quality of activities, by providing ongoing support to trainees. These can be introductory or specialized, based on needs and pre-existing capacity. Training should always be accompanied by ongoing support and supervision. Table 5 is a reinterpretation of the one that can be found [here](#).

Coaches' technical skills should be developed in parallel with their MHPSS skills. The latter represent a prerequisite to reinforce the skills of others. In addition, training can vary for levels of complexity, according to the existing capacity (see Box 37).



Box 37

Training for Syrian coaches

In 2014, IOM and the NGO Sport2Build partnered on a training programme for Syrian coaches. IOM Syrian Arab Republic provided prosthetic limbs to survivors of war who had to have limbs amputated. In parallel, a group of sport coaches was identified and trained to organize specific sport activities for people with amputations and new to the use of prostheses. Since the coaches were proficient in their own sport domains and as sport trainers, the training focused on psychosocial skills, rehabilitation skills and very specific exercise and inclusion practices. The project aimed at supporting the amputees in regaining faster control over their movements, as well as a sense of self-worth and an ability to socialize. The training materials are not published and can be obtained contacting contactpss@iom.int.

Table 5: Key steps for managers to support the setting up of activities

Enrolment	Training/ongoing support	Retention
<ul style="list-style-type: none"> - Make a list of existing and required skills for coaches and facilitators. - Develop a recruitment strategy for staff involving the community. - Select coaches from the local community whenever possible. - Engage equal numbers of female and male coaches where possible. 	<ul style="list-style-type: none"> - Train all coaches/facilitators on basic MHPSS (for instance, using this tool), PFA, motivational approaches and small-scale conflict mediation (see chapter Integration of mental health and psychosocial support in conflict transformation and mediation). - Complement with sports-skills and game-skills training. - Facilitate coach/volunteers/organizers exchange platforms. - Provide mentoring and psychosocial support for coaches, volunteers and organizers during training and throughout implementation, by the dedicated resource in the PMT. - Conduct on-the-job trainings with frequent follow-up rather than one-off longer trainings. - As part of training and ongoing support, ensure there is a functional referral mechanism in place for children who need other types of support, including non-MHPSS services and specialized MHPSS. 	<ul style="list-style-type: none"> - Increase coaches' and facilitators' motivation and volunteerism by providing recognized training and certification in specific coaching/animation competencies and appropriate coaching kits. - Encourage coaches and facilitators to form peer-to-peer groups as part of ongoing support to the coaches and the activities they are implementing with the community.



Sporting Activities in Gujba, Nigeria. © IOM 2018



8.3. CASE STUDY

Egypt is home to many refugees from the Syrian Arab Republic, Sudan, Eritrea and Iraq. These refugees live in precarious conditions, and their children suffer the effects of forced displacement. Tensions between refugees and host communities are common.

In years past, Terre des Hommes developed and implemented a methodology called “Movement, Games and Sports”, which aims at improving young people’s well-being and protection. Since October 2017, a new project called “Sport for community-based protection and social inclusion” has been implemented and aims at providing sustainable sport as well as psychosocial and life skills activities that increase social inclusion and community-based protection for vulnerable children and youth.

8.3.1 Helping young people get back on their feet

Animators use football as a tool to support the children. “When they lose, refugees in particular feel as if they’ve lost everything. In their real lives, they feel they may never recover. We use activities to show them that they can get back on their feet and still make something of the situation. This applies to football and real life”, explains Pasant Aly Mokhtar, who is in charge of those running the activities.

8.3.2 Teaching key skills

One of the coaches explains: “I don’t want the children just to play. I’d like them to learn something new every day. I’d like to teach them new life skills and encourage social integration.”

8.3.3 Promoting integration

Noor, a Sudanese mother, came alone with her children to Cairo five years ago. She is afraid of making friends with strangers. To ease life for

children in this situation, they can create their teams in advance for each training, but are not allowed to separate them by nationality. This promotes integration.

8.3.4 Building self-confidence

Some individuals suffer the consequences of war or the loss of a family member. Some no longer remember their homes, but still have trouble adjusting to their new culture. The first time they take part in the activities, they’re shy. It’s the coaches’ goal to support individuals to regain elements of positive self-recognition and strengths to promote self-confidence and resilience.

8.4. CHALLENGES AND CONSIDERATIONS

Gender and disability inclusion should be mainstreamed. Activities should be culturally appropriate and respect non-discriminatory principles. For instance, girls may be at risk of bullying by taking part in a certain activity or sports that imply force and physical confrontation. It is important to offer different kinds of sports and to adapt rules and practices to make games and sports, even highly physical ones, accessible.

Communicating the objectives of the programmes to the community is essential, and illusions or disproportionate expectations should not be created to stay realistic. Sport is a tool to reach a variety of objectives but, as a stand-alone practice, its MHPSS potential has its limitations.

While sports are important, it is essential to consider food and other basic needs of participants. If food insecurity is a grave issue, one should consider delaying the start of programmes and partnering with those who are able to engage in mitigating food insecurity.

Coaches are in a unique position to be role models and mentors for young participants, but there are also stories of coaches misusing their



influence and power, harassing, bullying, manipulating and neglecting participants' safety. It is widely recognized that safeguards are necessary, and this includes putting into place safeguard **policies**.

Sport and play do not always nor automatically have a positive impact. Careful consideration should be given to potential negative effects of the intervention:

- Creating risks by empowering women or vulnerable categories in highly conservative cultures.
- Fostering negative and aggressive competition, which can validate or reactivate community tensions: Sport can be associated with political divides in conflict areas, and used as a divisive element. It is therefore important to associate planning of sport activity with a conflict-sensitive approach.
- Fostering women, girls and child abuse and intimidation.
- As sport and play are tools to reach psychosocial and protection outcomes, they should not be conceived as isolated activities but integrated into larger programmes.
- In specific cultures, participation of women can be very hard to encourage.

FURTHER READING

Alexandria University Theories and Applications the International Edition (TAIE)

2011 *Sport as an Instrument for People Development and Peace Promotion*. TAIE. Faculty of Physical Education, Abu Qir, Alexandria University, Alexandria.



Clemens Ley, C. and M. Rato Barrio

2010 Movement, Games and Sport in Psychosocial Intervention: A Critical Discussion of its Potential and Limitations within Cooperation for Development. *Intervention*, 8(2):106–120.



Harknett, S.

2013 *Sport and Play for All: A Manual on Including Children and Youth with Disabilities*. Handicap International, Colombo, Sri Lanka. Available from www.sportanddev.org/sites/default/files/downloads/sport_and_play_for_all.pdf (accessed 16 April 2019).



Huizinga, J.

1949 *Homo Ludens*. Routledge, London.



PYKKA and United Nations Children's Fund (UNICEF)

2010 *Changing Life Through the Power of Sports*. PYKKA and UNICEF, New Delhi.



Sport Inclusion Network

2012 *Inclusion of Migrants in and through Sports: A Guide to Good Practice*. Sport Inclusion Network, Vienna.



sportanddev.org

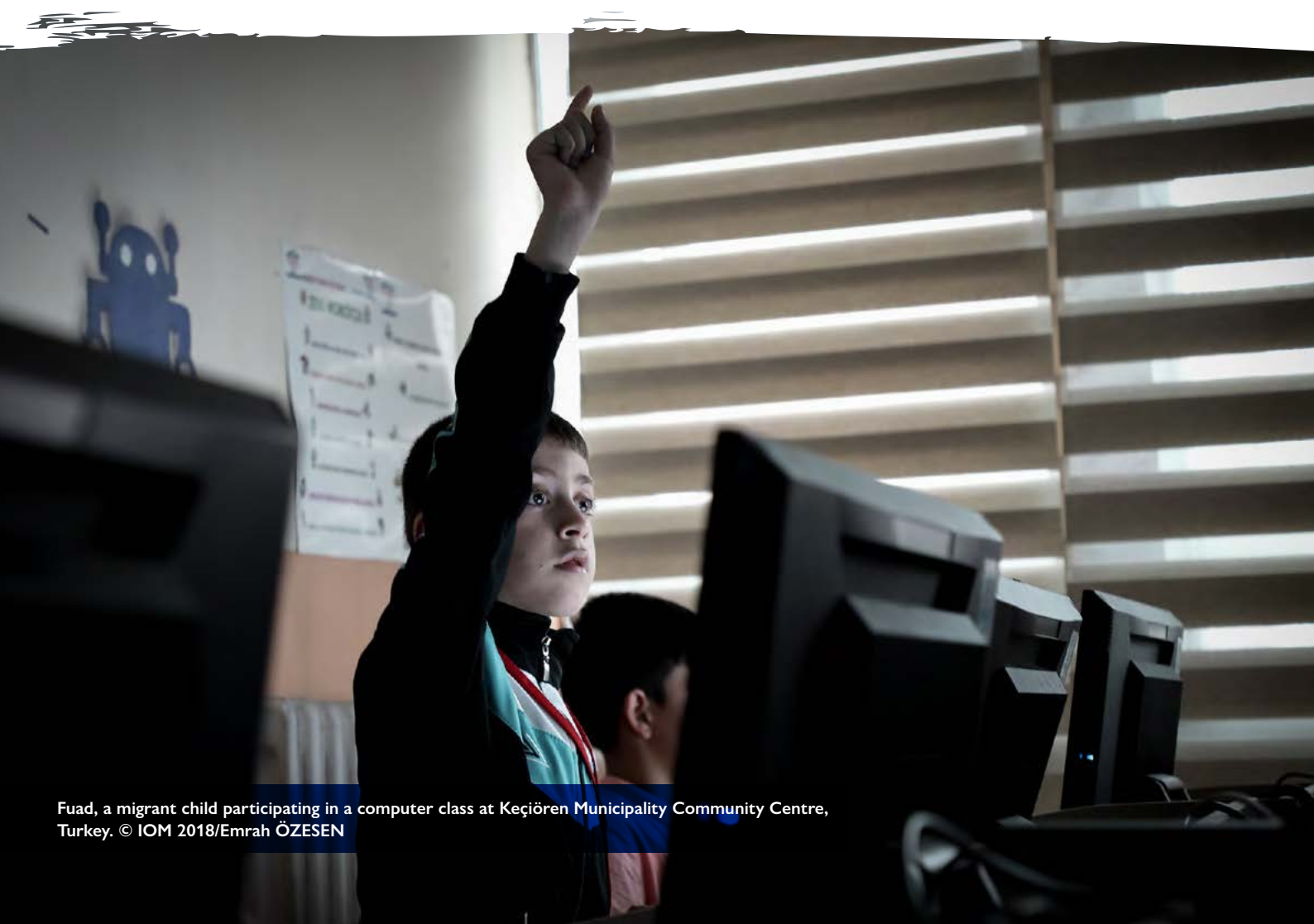
N.D. Sport as a Psychosocial Intervention.



For other references see the full bibliography [here](#).



9. NON-FORMAL EDUCATION AND INFORMAL LEARNING



9.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

In the immediate aftermath of a crisis, restoring the functioning of formal educational institutions can be difficult for both local governments and humanitarian actors. In situations of forced or mass displacement, the integration of newly arrived communities in the formal education system of the country of destination can be hampered by logistical and administrative constraints. Moreover, in displacement and migration, students, even if integrated in the education system of the host country, can struggle due to the adaptation to different curricula and pedagogical models from the ones they were used to. Therefore, such contexts call for programmes facilitating either non-formal education and/or informal learning responses, as a bridge towards or a complement to formal education. Formal education, non-formal education and informal learning are all fundamental cultural activities having to do with the consolidation of a cultural canon and the organic integration in a community. They are also an important venue to create relations and to learn how to relate to others.

It is important to understand the various definitions and differences. The International Network for Education in Emergency (INEE), provides a common framework to refer to (see Table 6).

Table 6: Common framework for education in emergencies

Education in emergencies	<ul style="list-style-type: none"> - Quality of learning opportunities for all ages in situations of crisis, including early childhood development, primary, secondary, non-formal, technical, vocational, higher and adult education. - Provides physical, psychosocial and cognitive protection that can sustain and save lives.
Formal education	<ul style="list-style-type: none"> - Usually refers to educational institutions that follow a specific curriculum developed and approved by a government with one or more final graded examination(s).
Non-formal education	<ul style="list-style-type: none"> - Takes place both within and outside educational institutions, and caters to people of all ages. - Does not always lead to certification. - Non-formal education programmes are characterized by their variety, flexibility and ability to respond quickly to new educational needs of children or adults. - Often designed for specific groups of learners, such as those who are too old for their grade level, those who do not attend formal school, or adults. - Curricula may be based on formal education or on new approaches. - Examples include accelerated “catch-up” learning, after-school programmes, literacy and numeracy. - Non-formal education may lead to late entry into formal education programmes, which are sometimes called “second-chance education”.
Informal learning	<ul style="list-style-type: none"> - “Forms of learning that are intentional or deliberate but are not institutionalized are known as informal learning. It is consequently less organized and structured than either formal or non-formal education. Informal learning may include learning activities that occur in the family, workplace, local community, and daily life, on a self-directed, family-directed, or socially-directed basis ” (United Nations Educational, Scientific and Cultural Organization (UNESCO)).



Non-formal education can target different populations, and be implemented in a specific space or not. Curricula are more or less formalized, but with no certification process nor diploma at the end. These can include language classes, uncertified literacy and numeracy courses for adults, computer literacy and psychoeducation sessions.

Informal learning is less structured than formal and non-formal education, but what differentiates it the most from other forms of education in an emergency is not the structure, but the objective. A structured sport session, for example, has objectives. A specific set of games and exercises solicits brain/muscles and is categorized as informal learning, even though it is a very structured activity. In basketball training, one has to learn how to play, and to practice a lot in order to do so. He/she will need to learn positions, targets, how to throw the ball, how to collaborate with others and how to follow rules, which all engage body–mind circuits. Yet the final objective is not the learning but the actual playing. The same happens during cultural, creative, artistic and theatrical activities illustrated in this Manual, which are not aimed specifically at education, but can have objectives related to learning (skills, attitudes, processes). The non-formal learning potential of several activities can be spontaneous or well thought out, in the sense that activities can be redesigned and structured to reach their full potential.

Non-formal education and informal learning contributes to MHPSS outcomes for different reasons (see Table 7).

Table 7: Non-formal education and informal learning as they contribute to MHPSS

MHPSS	<ul style="list-style-type: none"> - Safe schools and non-formal learning spaces are some of the most beneficial environments for children and youths during a period of uncertainty. - Intentional investment in education-based psychosocial support has proven to protect children and youths against the negative effects of disasters by creating stable routines, providing opportunities for friendship and play, fostering hope, reducing stress, encouraging self-expression and promoting collaborative behaviour (Alexander, Boothby and Wessells, 2010; Masten, Gewirtz and Sapienza, 2013).
	<ul style="list-style-type: none"> - Psychosocial well-being is a significant precursor to learning, and is essential for academic achievement; it thus has an important bearing on the future prospects of both individuals and societies.
	<ul style="list-style-type: none"> - The psychosocial support approach works best when integrated into the different spheres of young people's lives. Since education settings bring children, youths and their peers, parents, families, and communities together, they can help create a supportive environment that promotes improved psychosocial well-being. - Ideally, the education and community settings that surround each child work together to ensure that they receive the best possible care and follow-up; this includes communication between teachers and parents, and counsellors, if needed.

9.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

MHPSS managers are not providing non-formal education and non-formal training by themselves, but they need to design programmes that envisage actions and resources to promote non-formal education and non-formal learning. They will also have to select and supervise educators and teachers who are core members of the PMTs, and agree on their action plans following the steps below.

- (a) Foster the involvement of the community: Community members should be especially engaged in these activities, not only as participants but to understand priorities, identify teachers and trainers, select activities and monitor outcomes. The selection and prioritization of the activities are based on three factors:
- (i) Needs-based: Identification of needs in the community (school help, hygiene awareness, psychoeducation);
 - (ii) Resource-based: The identification of community resources whose agency can be empowered by organizing non-formal education activities for others (computer, languages, arts and crafts, music);
 - (iii) The possibility of the programme to cater for the needed materials, venues, security, among others.
- Design and implementation, adaptation, location and identification of involved persons as well as linkages with other programmes should be discussed, defined and addressed with key actors of the affected community.
- (b) Wherever possible, support pre-existing facilities in the host community (music schools, sport schools, dance schools, computer schools, language schools) rather than creating parallel structures, and

assure access (transport, payment of fees if suitable) and inclusion.

- (c) Identify people with skills they can teach to the others in the displaced community and mobilize them in organizing non-formal education for defined groups. Support these activities in kind, training and eventually stipends for the facilitators.
- (d) Analyse the non-formal education potential of other support activities organized by the programme (theatre and drama, sport), and create spaces for exchanges between the facilitators of those activities and the educators on the team to emphasize this potential through structuring, pedagogical hints, and pre- and post-workshop discussions.
- (e) Finalize a plan of non-formal education activities, dividing them in:
 - (i) Inductions and information sessions (a few hours);
 - (ii) Workshops (a few days or a week);
 - (iii) Actual educational activities (school support, language classes, numeracy classes) that should be given a set duration, number of sessions and a closure in order to maximize participation and inclusion.
- (f) Provide training to volunteers, teachers and facilitators on interactive methods to facilitate sessions and basic MHPSS:
 - (i) Promote, wherever possible, ad hoc non-formal education activities for people with severe mental disorders or disabilities.
 - (ii) Organize service evaluations, at the end of each cycle of non-formal education activities.



Table 8: Examples of activities (non-exhaustive)

Health education (WHO definition)	Any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.
Hygiene promotion (SPHERE definition)	Hygiene promotion is a planned, systematic approach that enables people to take action to prevent and/or mitigate water, sanitation and hygiene-related diseases. It can also provide a practical way to facilitate community participation, accountability and monitoring in WASH programmes.
Life skills (WHO definition)	WHO in 1999 identified five core cross-cultural areas of life skills: decision-making and problem-solving; creative thinking (see also lateral thinking) and critical thinking; communication and interpersonal skills; self-awareness and empathy; and coping with emotions and stress.
Sport education	Many life skills can be taught through sport activities that contribute to development: concentration, collaboration with others, self-confidence, strategic thinking. Specifically, games and play can foster a sense of safety and contribute to children's well-being. Moreover, they constitute tools for social inclusion that contribute to the sense of community and togetherness.
Literacy and numeracy courses (UNESCO)	Proficiency in literacy and numeracy is essential if young people are to fully develop their potential as effective members of their community and for mi-grants to integrate. Where there are low levels of literacy and numeracy in the adult population, it is an indication of low basic skills and low employment levels. Those courses can be part of a broader catch-up classes plan.
Arts and crafts	Non-formal education in arts and crafts can make people relax, connect with others through an action, enhance self-esteem and, in some cases, act as an income-generating activity (see challenges).
Mine risk education (international mine action standards)	Refers to "activities which seek to reduce the risk of injury from mines and explosive remnants of war by raising awareness and promoting behavioural change, including public information dissemination, education and training, and community mine action liaison".

Non-formal education requires a close linkage with communities and a strong involvement from the beginning to ensure that non-formal education activities are adapted to the population's needs. Lack of involvement by the affected populations and the community could negatively impact non-formal education interventions by fostering limited interest in the programme or delivering messages that are not contextualized nor adapted to the population. The contents and material should be checked and approved by community members, who acknowledge the purpose and necessity of the programme to support it.

→ 9.3. CASE STUDY: FABLAB INITIATIVE FOR EMERGENCY AND HUMANITARIAN CONTEXTS

Globally, a FabLab is defined as “a technical prototyping platform for innovation and invention, providing stimulus for local entrepreneurship. For Terre des hommes (TdH), the adaptation of this initiative to development and humanitarian contexts complements and heightens the impact of existing programming by providing an entry point to a broader package of services available within different TdH interventions adapted to needs and context.

It consists of a physical space equipped with tools (for example, 3D printers, laser cutters and circuit-makers), software (to programme the tools and support access to networks), and educational approaches and processes (for example, adapted training courses, management systems to open the space to innovators and peer-to-peer learning models). It is not simply piece(s) of equipment – rather, it is a way of engaging with children, youths and communities.

9.3.1 A new way of targeting youths, a hard-to-reach demographic

In crisis-affected areas, teenagers and youths experience significant protection risks, including but not limited to early marriage, school dropout, child labour, conflict or contact with the law, violence associated with the crisis, and association with armed conflict, including forced recruitment, and juvenile justice issues.

Despite being very frequently at risk, teenagers and youths are often extremely difficult to reach. There are few standardized approaches for engaging with teenagers and youths, and little consensus around basic issues, including what ages precisely constitute the term “youth” itself.

Attractive places for youths:

- Focus on cutting-edge yet easily accessible digital technologies, and youths have higher levels of engagement and interest in digital technologies compared with other demographic groups.
- Support creativity in a flexible and adaptable manner, which is key for a group that has fluctuating interests, capacities and needs, and whose needs are currently not sufficiently met by humanitarian responders.
- Organize time of activities considering issues such as child labour and school attendance.





English classes at Haj Ali IOM Community Center in Iraq.
© IOM 2017/Sandra BLACK

Table 9: Impact opportunities

Education	<ul style="list-style-type: none"> - Provides a good basis for provision of non-formal education, particularly in STEM (science, technology, engineering and mathematics), for the most vulnerable youths. - Enables the transfer of youths from non-formal education into formal education (university, high school or vocational training). - The safe space stimulates both learning and opportunities.
Affected populations-led participation and design	<ul style="list-style-type: none"> - Allow youth to lead and more actively participate in the development and implementation of projects and generate a tangible output. - People using FabLabs drive their own development, which gives affected populations the flexibility and the tools to design their own solutions while linking users to share experiences.
Child protection	<ul style="list-style-type: none"> - Provides an open, safe space for youths and communities in which they can build trust, work together to define their own priorities, and identify innovative solutions to their problems. - Aims to empower children and their communities to engage more effectively in dialogue and action to support child rights, leveraging digital tools and networks. - Privileged space for delivering MHPSS services and, when necessary, identifying and referring youths to TdH's other services (such as those provided by social workers and community mobilizers, among others).
Livelihood opportunities	<ul style="list-style-type: none"> - The hardware component represents an aspect of the digital economy to which few conflict-affected communities have access. - Can support vulnerable communities to engage in small-scale production and meet immediate needs in a more cost-effective and tailored fashion. - TdH FabLabs represent a valuable resource and access to livelihood for those who develop skills through the TdH FabLabs. - For the broader economy within the community, as it provides new models and a method for enhancing existing tech (and other) industries.

In conclusion, FabLab was a great opportunity of learning for youths and community members, and in the meantime to ensure high participation and involvement in the implementation to make the FabLab sustainable. It helps provide a safe place, to deliver adapted learning, to take sufficient time with youths for them to learn, to have fun, and finally to learn something around new technologies, together with other education contents (basic reading and numeracy courses, vocational training).

→ 9.4. CHALLENGES AND CONSIDERATIONS

The differentiation between the various forms of education in emergency within MHPSS programmes is very important in terms of programming and community dynamics since, often, especially in emergencies, confusion arises between formal and informal education, informal education and informal learning, and vocational and professional trainings. This leads to four series of problems:

- (a) Creative or socializing MHPSS workshops (informal learning) are often misinterpreted as non-formal education activities. For instance, a tailoring or crocheting group for women, primarily aimed at helping them gather together and express themselves, can be considered by the affected populations and at times by the project management as a non-formal course in tailoring. This can give rise to false expectations among participants and create an ambiguity in the planning of the activity, the necessary expertise of the trainer, and other things. Clarity on the nature and scope of activities needs to always be adopted in planning.
- (b) MHPSS programmes tend to certify non-formal educational activities. This is also done for very short inductions or information sessions. While this is often at the request of participants, and can represent an incentive for participation, boosting their self-esteem, it can also bring two problems. On the one hand, participants may feel these certificates capacitate them professionally. On the other hand, in a humanitarian context characterized by the necessity to hire staff in a haste, certificates can be misinterpreted in their training value. Finally, the proliferation of certifications can devalue the legitimate certifications of those who followed an official curriculum in the country, affecting community dynamics.
- (c) Non-formal education and vocational and professional training need to be kept distinct. While people can be informally educated in an art or a craft, for their own interest, vocational trainings aiming at employability and income generating based on the same skills are part of a livelihood support protocol, and need to be designed with that aim in mind. Not doing so can create future frustrations in participants. Chapter on **Integrated MHPSS and livelihood support** will describe better how this integration can happen in vocational trainings without creating confusion.
- (d) Formal education is always a primary need and should be favoured, while at times, in emergency situations, non-formal education risks being used as a substitute for formal education, even when formal education is available but (a) in remote locations, and (b) is perceived as too difficult. In those situations, if resources are scarce, transportation to formal educational facilities should be prioritized as a response, vis-à-vis the organization of informal educational activities. In addition, while informal education can keep on being offered, sensitization on the importance of formal education needs to always be organized and mainstreamed, and schools need help for children and youths to adapt to the new curricula favoured vis-à-vis other forms of non-formal education.



→ FURTHER READING

Finn Church Aid (FCA)

2018 Improving Well-being Through Education – Integrating Community Based Psychosocial Support into Education in Emergencies. FCA, Helsinki.

International Network for Education in Emergency (INEE)

2010 *Minimum Standards for Education: Preparedness, Response, Recovery* (2nd ed.). INEE, Geneva.

2016 Background Paper on Psychosocial Support and Social and Emotional Learning. INEE, Geneva.

2018 Guidance Note on Psychosocial Support. INEE, Geneva.

For other references see the full bibliography [here](#).



10. INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN CONFLICT TRANSFORMATION AND MEDIATION



➔ 10.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

One of the challenges that MHPSS teams frequently encounter in humanitarian emergencies is the pervasiveness and complexity of interpersonal and intercommunal conflicts. It is thus essential for MHPSS workers to acquire basic skills in managing and resolving conflicts. This chapter will discuss practical ways in which MHPSS workers can use their skills, resources and networks to respond to interpersonal and community-based conflicts. To this end, a brief introduction to concepts on conflict assessment is provided.

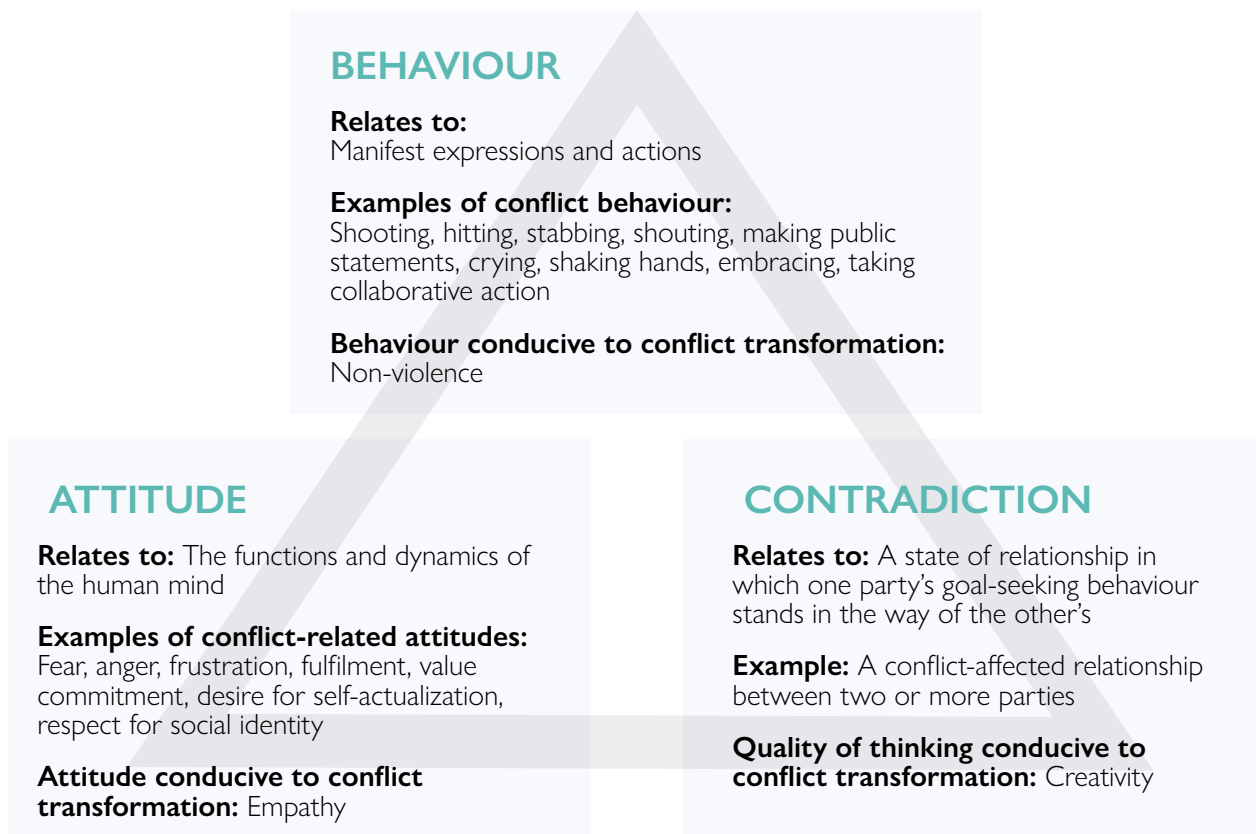
Conflict is a contradiction. It is a state of human relationships in which one side's attempt to achieve its goals stands in the way of the other side's. The following link provides a more detailed description of conflict as well as other related **concepts**.



Conflict in and of itself is neither destructive nor constructive. When parties in conflict lack capacities and means to transform their conflict, the resulting frustration and enmity can turn the conflict into a destructive experience. When the parties have the capacity and means to see their conflict as a shared challenge to be overcome, the conflict becomes an opportunity for creative problem-solving and relationship-building.

According to pioneering peace researcher Johan Galtung, a social conflict at all levels, from interpersonal to international, has three dimensions: attitude (A), behaviour (B) and contradiction (C), as summarized in Figure 10.

Figure 10: ABC triangle



Source: Based on Galtung (1958).

The ABC triangle is a useful framework to help MHPSS programme managers examine the interconnected nature of attitude, behaviour and contradiction. Their practice in counselling, for example, can help individuals and groups to restore empathy, therefore facilitating attitudinal changes, which can in turn encourage them to adopt non-violent behaviours. Furthermore, their attitudinal and behavioural changes can contribute to building constructive relationships, and exercise creative thinking necessary to resolve the incompatibility of their goals.

Humanitarian emergencies such as natural disasters, armed conflicts and migration crises make it difficult for individuals and communities to exercise empathy, non-violence and creativity. This is particularly true in cases of displacement, which often result in tensions between the displaced and host communities. MHPSS can help affected individuals and communities restore empathy with one another, promote non-violent behaviour, humanize their relationships, and encourage creative problem-solving.

Conflict transformation consists of finding a mutually acceptable solution to the underlying contradiction that strains human relationships, while promoting empathetic attitudes and non-violent behaviour. Conflict transformation contributes to building a secure and reassuring social environment in which individuals and communities affected by humanitarian emergencies can regain or develop their capacities to self-reflect, restore relationships, and seek and receive MHPSS effectively. The processes of MHPSS and conflict transformation are thus complementary and mutually reinforcing. For these reasons, MHPSS workers will find it useful to gain basic skills in conflict analysis and transformation, in order to deliver MHPSS services effectively.

Conflict transformation skills useful for MHPSS professionals working in humanitarian emergencies vary significantly depending on the circumstance in which they work. The

skills summarized in this [link](#) suggest a possible starting point, and could be used as a list for trainings that could be offered.



Box 38

Resources

Additional resources on conflict transformation may be found at the following sites (all sites accessed 17 April 2019):

- African Centre for the Constructive Resolution of Disputes (ACCORD) (www.accord.org.za);
- Beyond Intractability (www.beyondintractability.org/);
- Peace Insight (www.peaceinsight.org/);
- CDA Collaborative Learning Projects (<https://www.cdacollaborative.org/>);
- Conciliation Resources (www.c-r.org/);
- Alliance for Peacebuilding (<https://allianceforpeacebuilding.org/>);
- United Nations Mediation Resources (<https://peacemaker.un.org/resources>).



10.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

- Be sensitive to conflict at all stages of an MHPSS programme.
- Use MHPSS activities in conflict transformation efforts or programmes.
- Introduce conflict mediation and social cohesion as a component of MHPSS programmes.

A prerequisite to these tasks above is conducting conflict analysis and feasibility analysis, summarized in Box 39.

Box 39
Conflict and feasibility analysis

1. Conflict analysis

Conflict analysis is an analytical process through which to identify the sources and nature of a given social conflict systematically. Suggested steps to perform a conflict analysis include the following:

- Identify parties in conflict, defined as individuals and/or groups capable of exercising agency to develop and pursue goals.
- Learn and articulate the goals of each of the parties.
- Describe their relationships (for example, collaborating, opposing, or having no relationships).

See examples of conflict analysis. The first **example** addresses a simple two-party conflict; the second **example** analyses a more complex multiparty conflict. These examples of conflict analysis suggest opportunities for conflict transformation.

2. Feasibility analysis

This refers to an initial inquiry into the feasibility of intervention. Depending on the context of their work, MHPSS workers conducting a feasibility analysis may ask questions about the security, legal, political and institutional circumstances of the intervention. They must also examine the programme objectives, time frames, resources, expertise, availability of local partners, and other factors essential for making informed decisions about the desirability, ethicality and possible methods of intervention.



Conflict mediation training, Baalbeck, Lebanon. © IOM 2016



Findings from conflict analysis and feasibility analysis can help establish a well-informed basis for implementing each of the three suggested tasks:

- (a) Be sensitive to conflict at all stages of MHPSS programmes: Incorporating conflict sensitivity into all stages of an MHPSS programme is essential when working in conflict-affected societies. Conflict sensitivity refers to the process of (i) understanding the social context of the conflict in which an MHPSS programme is implemented, (ii) monitoring the interaction between the programme and its context, and (iii) proactively taking actions to minimize the programme's negative effects on the conflict and maximize its positive impacts. The possible actions to be taken include a suspension of the programme where its continuation is likely to exacerbate the conflict. For more information on conflict sensitivity, as well as on the “do no harm” principle closely related to conflict sensitivity, please visit this [link](#).



Conflict sensitivity is particularly important in the selection of MHPSS programme sites, affected populations, objectives, expected outcomes and staffing. With respect to staffing, the selection of PMT members requires attention to conflict sensitivity. Conflict analysis is especially important in this context, because the conflict-affected communities they serve will find it important that the team is balanced, representative and accessible to all affected populations without prejudice. For more information on the selection of PMT members, please see chapter on [Psychosocial mobile teams](#).



Box 40

Livelihood support for women

With respect to the application of conflict sensitivity to the development of programme outcomes and affected populations, livelihood support for women presents a useful example. While support for women's empowerment in family and community life is an important programme objective, its possible consequences include an increase in men's resistance and in domestic violence. Considering these challenges, MHPSS workers must consult not only the participating women but also a broader scope of stakeholders who can either support or hinder the women's activities for economic empowerment. MHPSS workers must also inform the participating women of the possible adverse consequences of their participation, as well as of the choices the women can make to continue, discontinue or seek help. The example of women's livelihood development illustrates the complexity and difficulty of activities designed to tackle deeply structural and cultural contexts of programme design. It also illustrates the role of conflict sensitivity, not only about programme effectiveness but also ethics.

- (b) Use MHPSS activities in conflict transformation efforts and programmes: MHPSS programmes, as described in [the models of work](#), address the interrelation of biopsychological, sociorelational and cultural factors of experiences. These programmes make use of recreational and [social, ritualistic, artistic, sport](#) and [educational activities](#), capable of bringing people together and fostering social cohesion. Creative activities can stimulate imaginative thinking useful for creative problem-solving. In addition, individual and group counselling, as well as psychoeducation, can help conflict-affected individuals and communities develop empathy, promote non-violence and facilitate relationship-building. Three aspects of an MHPSS programme – counselling, psychoeducation, and social and recreational activities – can make an especially important contribution.



(i) Counselling as a contribution to conflict transformation: MHPSS activities, which focus primarily on the attitudinal and behavioural dimensions of conflict, can be carried out in such a way as to help their affected populations address the underlying contradictions in conflict-affected relationships. Counselling is an especially useful method for this purpose. In north-eastern Nigeria, for example, the MHPSS staff support the reintegration of former Boko Haram members into their home communities. The staff offers counselling to the returnees whose MHPSS needs are inseparably linked to long-standing challenges about their livelihood development, self-worth, education and need for social justice. While their counselling does not aim to resolve these and other social issues that contributed to the rise of Boko Haram's insurgency, it can nevertheless help former Boko Haram members reflect on these issues and explore ways to face them constructively.

(ii) Psychoeducation as a contribution to conflict transformation: MHPSS education enables conflict-affected communities and individuals to understand how the human mind works under stress, grief and loss, and how communication can be positive in nature, and what actions can be taken to manage these. In order to address the psychosocial effects of the war and the migration crisis in the Syrian Arab Republic, IOM produced *Self-Help for Men Facing Crisis and Displacement*, a guide for adult men seeking basic knowledge on the sources of stress and the practical measures they can take to mitigate the stress. The guide is available at [this link](#).

(iii) Social and recreational activities as a contribution to conflict transformation: Social and recreational activities can bring together members of divided communities. They can humanize each other and build social cohesion. In Libya, for example, the MHPSS staff is using a community centre to bring

displaced people, migrants and local residents together. The social and recreational activities offered at the centre enable the previously divided community members to get to know each other, and build relationships and a sense of community.

While each of the above three types of MHPSS activities can make a significant contribution to conflict transformation, their effectiveness can be enhanced further by institutional partnership and collaboration. Specifically, MHPSS workers can reach out to IOM's Transition and Recovery Divisions or Stabilization Units, whose activities are more closely aligned with conflict transformation. If these units are not readily available, MHPSS workers can identify and partner with other organizations and actors with expertise and experience in conflict transformation.

(c) Introduce conflict mediation in MHPSS programmes: One of the most practical methods of conflict transformation that PMTs can learn and practice as part of their daily activities is conflict mediation. MHPSS managers can explore alternative means by which to introduce conflict mediation into their day-to-day activities. The alternative means described below are mutually supportive and complementary. They may be combined or sequenced in such a way as to maximize programme effectiveness:

- (i) Hire an experienced conflict mediator: An MHPSS programme manager can hire an experienced conflict analyst, if funding permits. The MHPSS programme in Iraq, for example, hired a conflict specialist as a member of the MHPSS team. The specialist monitors the conflict dynamics at MHPSS centres implemented within the programme, and ensures their conflict sensitivity and programme effectiveness.
- (ii) Identify and appoint a conflict mediator, as a core member of each PMT: A PMT may include a qualified team member to play the role of a conflict analyst and mediator, whose





responsibility is to monitor and work on conflict-related **issues**.

- (iii) Provide basic conflict mediation training to the whole of an MHPSS team: MHPSS workers equipped with basic conflict mediation skills can carry out MHPSS activities with greater conflict sensitivity, contributing to the management and prevention of violent conflicts, and granting effective service delivery when relationships between stakeholders are tense. The PMTs working in the aftermath of Boko Haram's insurgency in north-eastern Nigeria received trainings in the analysis and transformation of interpersonal and intercommunal conflicts. The training materials and curricula they used can be obtained by writing to contactpss@iom.int.
- (iv) Provide advanced trainings to selected PMT members to enable them to become conflict mediation focal points: Some of the PMT members may receive more advanced mediation trainings, gain practical experiences and become mediation focal points. The MHPSS staff in South Sudan adapted this strategy to its distinct programme needs. Together with selected community members, South Sudan's MHPSS staff members received advanced conflict mediation training. Based on the training, they became conflict mediation focal points in IDP camps. The training increased their capacity to address community conflicts on their own. The skills they gained contributed to creating both formal and informal structures of conflict management. The training materials and curricula can be obtained by writing to: contactpss@iom.int.
- (v) Identify and empower qualified community members to become conflict mediation focal points.

MHPSS teams can find trusted community members with conflict mediation skills, and support them to become focal points who can partner with the PMT. These local focal points may receive customized skill-building training. In addition, or

alternatively, they can be included in the trainings for the PMT described in points (iii) and (iv) above. In Iraq, for example, IOM's MHPSS activities empower community members through intensive conflict mediation trainings, facilitate community members' participation in dialogue and leadership groups, and carry out youth peacebuilding activities. Through these IOM-sponsored activities, trained and qualified Iraqis have come to serve as conflict mediation focal points working side by side with the **PMTs**.



10.2.1 PMT members as mediators

PMT members and MHPSS workers in general can serve as conflict mediators in humanitarian emergencies. In many contexts of MHPSS activities in which MHPSS workers perform mediation, they do not hold the title of a mediator, nor do community members recognize MHPSS workers as mediators. Under these circumstances, MHPSS workers practice emergent mediation, defined as an informal, spontaneous process of assisted negotiation and problem-solving for which there is no formal mediation contract expected.

Emergent mediation can be initiated by casual conversations with clients of MHPSS services. Questions such as "Is there anything I can do to help you think through this relationship challenge together?" and "Would you mind telling me why you and the other person are refusing to communicate?" can serve as an invitation to emergent mediation.

Defining emergent mediation broadly, MHPSS workers can perform mediation in the following ways:

- (a) One-on-one dialogues: in addition to what presented [here](#), the chapter on **Counselling** offers useful insights into one-on-one dialogues.
- (b) **Mediation between two or more parties.**
- (c) Support for social, ritual, educational, recreational and artistic activities that promote relationship-building and problem-solving (See Box 41).



The three methods are usually applied to regular MHPSS activities in which relationship-building is important. They are complementary and mutually supportive. Two or more methods can be combined and performed simultaneously or sequentially, depending on the needs and contexts of the MHPSS activities.

Box 41
Linkages with prior chapters

Social, ritual, educational, recreational, artistic community-based activities, described in prior chapters, refer to a broad range of familiar community practices that can bring a larger number of people together to meet the community's shared needs and purposes. The people brought together for community-based activities may come from the same community or from different communities. When organized purposefully, community-based activities can help people from different sides of a conflict to humanize each other and build trust, and encourage them to overcome the underlying reasons for the conflict. MHPSS workers can offer community leaders the support they need to effectively utilize community-based activities in such a way as to address conflict issues and relationship challenges constructively. Illustrative examples of such community-based activities include:

- Traditional healing and reconciliation rituals;
- Wedding, funeral and naming ceremonies;
- Religious services and religious study sessions;
- Interfaith prayers for a common cause;
- Intercommunal markets and trade;
- Intercommunal collaboration for farming, animal rearing, fishing and forestry use;
- Cooperatives for intercommunal livelihood development;
- Community festivals;
- Intercommunal sports activities;
- Community theatre;
- Intercommunal disaster relief;
- Intercommunal neighbourhood clean-up, tree planting and environmental protection;
- Purposeful use of the media and social media for community-building;
- Curriculum development, teacher training and language instruction that promote community cohesion and intercommunal coexistence;
- Intercommunity dialogue sessions or meetings;
- Group support sessions.

For information on how to organize these activities, see the prior chapters



Box 42

Application of conflict analysis and transformation skills



Click [here](#) for case studies on how to apply skills in conflict analysis and transformation into real-world contexts of humanitarian emergency.

10.2.2 MHPSS workers' training needs in conflict transformation and mediation

The concepts, skills and methods of practice outlined in the preceding sections of this chapter suggest a range of topics that MHPSS workers can study to expand their capacity to address interpersonal and community-based conflicts in humanitarian emergencies. For information about what training curricula different IOM missions have used, please contact the IOM MHPSS Section at contactps@iom.int. A concise summary of suggested topics can be found [here](#).



10.3. CHALLENGES AND CONSIDERATIONS

While an analysis of the relational, cultural and structural dimensions of conflict require highly abstract thinking, recognition of conflict behaviour does not require much abstraction, because behaviour is usually visible and tangible. When faced with violence and human suffering, the rational thinking necessary to grasp the complexity of the conflict is compromised, and fundamental elements of the conflict – such as its history, the cause–effect relationships brought to the violence, and other factors – are set aside. In the face of violence and humanitarian emergency, people tend to distance themselves from the kind of abstract analytical thinking necessary to understand complex causal chains of action and reaction that led to the outbreak of the violence, to focus on an immediate evaluation of the resulting violent behaviours. Keeping the attitude–behaviour–contradiction (ABC) triangle in mind, MHPSS workers can help individuals and communities in conflict restore

a holistic, multidimensional image of Self and Other. Through such a process of sustained public education and dialogue, MHPSS workers can help parties in conflict and stakeholders regain a self-reflective capacity and psychosocial readiness to analyse conflict and prevent violence.

Violence makes parties in conflict pessimistic about their future possibilities. It discourages them from believing and investing in creative problem-solving. Under such circumstances of pessimism and hopelessness, MHPSS workers can help parties in conflict and community members restore creativity. Concretely, MHPSS workers can introduce successful examples and best practices of creative problem-solving from the parties' own communities, as well as from other credible sources. MHPSS workers can also share with the parties such skills and methods of conflict transformation and mediation as the ones described in this chapter, so they can expand their toolbox to tackle their conflicts constructively and creatively.

→ FURTHER READING

Arai, T.

2009 *Creativity and Conflict Resolution: Alternative Pathways to Peace*. Routledge, London.

2017 *Promoting Interreligious Harmony in Myanmar: A Guide to Training and Dialogue*. Peaceful Myanmar Initiatives, Yangon, Myanmar.

Barsky, A.E.

2014 *Conflict Resolution for the Helping Professions*. Oxford University Press, New York.

Beer, J.E. and C.C. Packard, with E. Stief

2012 *The Mediator's Handbook*. New Society Publishers, Gabriola Island, B.C., Canada.

Conflict Sensitivity Consortium

2012 *How to Guide to Conflict Sensitivity*.

Galtung, J.

2000 *Transcend and Transform: An Introduction to Conflict Work*. Paradigm Publishers Boulder, Colorado, United States.

For other references see full bibliography [here](#).



11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT



→ 11.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

11.1.1 What is a livelihood?

Simply defined, a livelihood comprises the capabilities, assets and activities required for making a living. This may include subsistence strategies, income-earning activities, formal or informal employment, or a combination of all of these.

Livelihoods represent much more than income or employment. Livelihoods comprise individuals' spiritual, humane, social, political, financial, natural and physical capital or assets. What we do to earn a living often determines who we are in society, and the relationships we will have with others. It may define the opportunities we can access and the quality of life we can expect. Understood in this way, livelihoods are a fundamental component of overall psychosocial well-being.

In the humanitarian context, it is common to define a livelihood programming purely in terms of the economic reinforcement it offers to help people weather a crisis. In order to be sustainable, livelihood support needs to help individuals, families and communities withstand and recover from a shock with the same or improved capabilities as before the shock/crisis, without further threatening the natural resource base. See Box 43.

Box 43

Sustainable livelihoods

- Do not undermine the long-term availability of natural resources;
- Do not threaten the livelihoods of others;
- Are not dependent on outside resources, such as external funding.

11.1.2 Why to combine livelihoods programming with MHPSS

In emergency settings, people's access to livelihoods is often disrupted. There may be increased difficulties for the means of a livelihood, with inherent stress. Moreover, the loss of livelihood can often be one of the greatest impactors on both an individual's sense of social status and their individual sense of control. This can be particularly acute when a household head become a net "recipient" of aid support, rather than playing the breadwinner role they played before the crisis. To learn more about the relationships between access to livelihoods and mental health and psychosocial well-being, and better understand this chapter, see a series of [short videos](#) here, especially those from James Walsh, Guglielmo Schininà and Elisabeth Babcock.

The rationale for including livelihood support within MHPSS programme centres on two points. First, by promoting economic security, livelihood programming can help address the stressor of financial and material insecurity in emergency settings. This stressor is identified consistently by populations in a diverse array of settings. For example, rapid MHPSS needs assessments undertaken by IOM in different countries all indicated that insecure access to livelihoods comprised one of the greatest causes of distress and other negative feelings. Livelihood programmes help alleviate this stress ([Howe et al., 2018](#); Jalal, Frongillo and Warren, 2015).

Second, access to secure livelihoods can strengthen the protective factors that buffer against stress and promote agency. For example, being able to provide for oneself and one's family fosters a sense of self-efficacy. Livelihoods also may offer opportunities for skill-building, which can improve overall functioning and contribute to greater self-esteem. Quality employment can help reduce depression symptoms by fostering a greater sense of agency (Butterworth et al., 2011; van der Noordt et al., 2014). Additionally, the social connection that livelihoods often offer



can contribute to a greater sense of belonging and help counteract stigma.

MHPSS interventions can also be integrated into existing livelihood programmes with the same benefits. It is particularly indicated when people or communities have been severely affected by the crisis. They might experience difficulties functioning and struggle to start or maintain livelihood activities without appropriate MHPSS. In this case, the existing programme should follow the presented structure, and an assessment must be done on how to better integrate MHPSS aspects to support affected people.

Box 44

To learn more about the assessments, select any location below

- **North-east Nigeria;**
- **South Sudan;**
- **Post-earthquake Haiti;**
- **Urban areas of Lebanon with large populations of Iraqi refugees.**

11.1.3 What the evidence base tells us

Livelihood programming is not a panacea, and practitioners should not expect that simply adding a livelihood component to an MHPSS programme will automatically enhance outcomes, or vice versa.

While there are volumes of literature on livelihood programmes, the evidence base on programmes that combine livelihood support with MHPSS programming is quite limited, because many livelihood programmes are not designed with mental health or psychosocial well-being impacts in mind, and/or are not evaluated on these dimensions. Even fewer have been implemented in emergency settings. A systematic review by **Lund et al.** (2012) included only five evaluations of programmes that included indicators for both livelihoods and MHPSS outcomes, while that by Kumar and Willman (2017) found eight, with none having been done in situations considered emergencies.

Still, there is promising evidence from other contexts to allow for identifying some guiding principles to orient livelihood programming within MHPSS programmes in emergency settings. These are covered in the following section.



11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT



11.1.4 Guiding considerations for designing livelihood interventions to boost MHPSS

Interventions claiming the title “livelihood support” vary enormously in their objectives, design and scope. They range from cash-transfer and social insurance programmes to job training, entrepreneurship support and market facilitation activities. Even within particular categories of livelihood programmes, there is great diversity. A cash-transfer programme might be aimed strictly at boosting incomes, or it may have broader social objectives, such as empowering women or youths, restoring a sense of normalcy, or even reducing violence.

Moreover, the type of livelihood intervention options available will vary greatly with the degree of stability in a given context. In highly volatile situations, interventions are focused on saving lives: for example, through distribution of food, seeds or tools such as grinding machines. In more stable environments, interventions can focus on building assets, employment support or entrepreneurship. Ultimately, sustainability of livelihoods depends on people gaining access to markets so that they no longer rely on external support, which is often beyond the reach of MHPSS programmes in emergency settings. Livelihood programmes should be included from the onset of the emergency, but intervention options need to be tailored to the specific contextual situation.

There is no single design or “how to” guide that can cover the great diversity of livelihood programming. Because livelihoods are defined by local conditions, the choice and design of programmes should emerge from knowledge of the programme context. Camp contexts often present particular challenges for developing livelihoods. In particular, livelihoods thrive on stability (commonly lacking in camps), and the close concentration of people with limited means can limit opportunities.

This section is not intended to be comprehensive, but to serve as an orientation to some important

considerations. It builds on the **Minimum Economic Recovery Standards of the Small Enterprise Education and Promotion Network**, which presents minimum standards to facilitate economic recovery in crisis situations, providing guidance on what to consider when planning livelihood activities.

Livelihood interventions that work to alleviate sources of stress and strengthen protective factors have been most effective in boosting mental health and psychosocial well-being. For this, it is helpful to:

- Keep expectations realistic: Start small, and be honest with affected populations about the objectives and constraints.
- Avoid adding more stress: Keep projects simple and sensitive to the stresses people already are facing.
- Focus on building assets to enhance people's ability to weather shocks over time.
- Alleviate key stressors such as food insecurity or social tensions.
- Connect to social relationships where safe/ possible, to build on sources of resilience (existing support groups, local procurement systems).
- Match needs and capacities with markets to set people up for success: Be sure to conduct a market systems assessment (see 11.2.3 for details). Link the human capital identified in the affected populations with the need for financial capital in the market. Social capital and networks among people in the affected population and host communities should be explored and taken into consideration to develop an effective intervention.
- Consider sensitivities of targeting. Consult with stakeholders to ensure that targeting does not privilege certain groups, and that decisions are communicated clearly.

For more information on the above-mentioned points check [here](#)):



11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

→ 11.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

11.2.1 Assess whether the agency is already running a livelihood programme

If the agency is already running a livelihood programme, managers should provide their assistance in:

- Raising awareness among colleagues working in livelihood support on the MHPSS aspects of their work, using the following online **training**.
- Looking at possible synergies between the MHPSS programme and livelihood programmes, which can include:
 - Inclusion of MHPSS components (discussion groups, group sessions, individual counselling) in livelihood support programmes;
 - Targeting the same communities with coordinated interventions;
 - Sharing information on vulnerabilities and resources identified in the community.

11.2.2 Include a livelihoods specialist as part of the team and train livelihood-related staff

Few people can be expected to be conversant in both the MHPSS and livelihood fields. For this reason, in case livelihood experts are not already present in their agency/mission, teams would contract a livelihoods specialist to design and deliver the activities as part of a broader programme of MHPSS. S/he should also be responsible for training short-term team members in these new areas. Ideally, this person would be recruited locally in order to have a strong knowledge of the context, but could be recruited internationally, depending on the scale of the programme. S/he should have

in-depth knowledge of the context and market, and some experience in conducting market system assessments and overseeing livelihood programmes. S/he should also be trained in basic MHPSS concepts. At a minimum, s/he could take this **online training** course and learn relevant chapters of *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007)*.

Local talent can often be recruited to support specific livelihood activities. For example, if the livelihood interventions linked with MHPSS will deliver trainings in trades such as tailoring or carpentry, local tradespeople can help lead trainings and mentor project participants.

Livelihood staff and implementing partners – including trainers, instructors and facilitators – should be trained in (a) basic MHPSS considerations, (b) the effect of toxic levels of stress on livelihood programmes, (c) how to account for toxic levels of stress in the devising and implementation of livelihood opportunities, and (d) referral mechanisms and identification of protection and MHPSS risks.

Such trainings can be derived from:

- Elizabeth Babcock’s video **here**;
- The comprehensive IUSP training on livelihood and **MHPSS**;
- Contacting **contactpss@iom.int**.

11.2.3 Assess market systems to match livelihood support with demand

A market system is made up of the producers, suppliers, traders and consumers that match the supply of goods and services with demand. These systems are critical in emergency settings because they help people meet basic needs and protect livelihoods. Markets can be particularly important to consider, given the variability of camp/non-camp settings. Camps often are detached from local markets, but conversely offer unique opportunities of concentrated

11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT



demand. For more guidance on how to conduct a market assessment, see [here](#).

From an MHPSS perspective, it is important to match the information derived from the market analysis, with the expectations of the people involved in the programmes, their skills and objectives. It is indeed important to respect people's existing coping mechanisms and expectations, while offering suitable marketable options. Programme design needs to balance these two elements, as explained in the following section.



11.2.4 Explore trade-offs

Using the market systems assessment, it is possible to explore potential options and trade-offs in order to decide what type of livelihood intervention may have the most MHPSS impact. The trade-offs do not imply that the interventions are not worth pursuing; only that mitigation measures might be needed to address potential negative impacts.

Some important trade-offs to consider are:

- Adding versus alleviating distress: All interventions introduce some distress. It is important to understand what this distress might look like, and how/whether it can be mitigated by the benefits of the intervention. Will the distress of, say, a microcredit loan outweigh the potential benefits in savings/income? In an MHPSS programme, one would avoid any livelihood activity likely to add additional stress into the life of affected populations.
- Targeting the most vulnerable versus more likely to succeed: Because resources are often limited and risks are high in emergency settings, programmes can't address everyone's needs all at once. An important trade-off arises between targeting individuals who are already doing well, such that they can then contribute more to local economies, versus targeting the most vulnerable for more potential social impact. This is important to consider in MHPSS programmes addressed to the most vulnerable populations.



Hairdressing class at the protection of Civilian site in Bor, South Sudan. © IOM 2013

- Short-term versus long-term/systemic benefit: How will the programme balance the need to respond to people's urgent needs today with the importance of investing in more systemic change? For example, a cash-for-work programme could provide a needed boost to the local economy, but its sustainability will be limited if people confront structural barriers, such as exclusion from markets because of migrant status or gender.
- Targeting specific groups versus a territorial approach: Emergency settings are often contexts of social instability and division. Interventions that target a particular group – refugees or migrants – can improve the well-being of that group, but may also risk contributing to tensions with other groups, including host communities. Decisions need to be made about whether to prioritize the well-being of a smaller group versus interventions that serve a broader group – for example, all those living in a defined geographic area.
- Boosting local economies versus distorting markets: One of the critical questions in many livelihood programmes – especially cash-for-work and cash transfers – is how big the stipend or transfer should be. If it is too small, its impact will be limited or even negligible. Too big, and it can create the wrong incentives – for example, hoarding of food/goods bought with the cash, or dissuading people from other income-earning opportunities that are not dependent on external support. Likewise, programmes that provide livestock run some risk of distorting the market prices for that livestock simply by increasing supply, though most programmes are too small-scale for this to be a key concern.
- Detracting from other MHPSS interventions: Livelihood initiatives are likely to offer great appeal to certain groups, particularly if cash or asset transfers are involved. When introducing such initiatives, it is critical to coordinate with other service providers

to ensure that this does not compete with or detract from other critical MHPSS interventions. This could involve coordinating activity schedules accordingly to enable participants to attend both types of activities, or requiring participation as a prerequisite for livelihood support.

11.2.5 Continually assess risks, especially risks to personal safety

Bringing resources into a community can expose people to new threats and risks. It can attract crime or increase household conflict by altering the balance of control over finances between men and women, or across generations. Activities that challenge social norms – for example, job training for women in non-traditional fields – can inadvertently increase risk for the people who access them (**Women's Refugee Commission, 2015**). **Here** is a useful framework for understanding and assessing risks in emergency settings.

These risks need to be assessed initially and monitored throughout implementation. Managers should ask people what kinds of considerations could be helpful: for example, locating trainings or meetings nearer where people live, holding events during daylight hours, or including meetings with families/households to help partners feel included and see the benefits of the programme. This will reduce the risk of experiencing distress associated with taking part in livelihood activities such as those related to walking to the venue at night or family disagreement regarding participation.





Computer courses at Haj Ali Camp, Iraq. © IOM 2015/Aziz RABER

11.2.6 Evaluate the advantages and potential drawbacks of different types of programmes

Using the information gathered in the assessment and the analysis of trade-offs, one can evaluate the suitability of different types of livelihood programmes. Table 10 presents some of the key advantages and disadvantages of different types of interventions, which could also be combined as different activities of one programme. There is no accepted rule on which interventions work better in camps or non-camp contexts. This is one of the many variables that needs to be ascertained from the needs assessment. However, these examples have been structured based on the likelihood of them being implemented in a camp context. This table is not exhaustive of all the options, but gives examples of some of the trade-offs outlined above:

Table 10: Advantages and drawbacks of different forms of livelihood support from an MHPSS angle

Livelihood Program	Description	Advantages/drawbacks
	Direct transfers	
Social direct cash transfers	Cash – either directly, or as vouchers – is given to participants with few or no conditions. If the objective is to enable people to buy basic goods, transfer amount is low. If the objective is to promote economic security, transfer amount is typically much greater than average.	<p><i>Livelihood advantages</i> Where access to credit and capital is the main constraint to accessing livelihoods, cash transfers can provide needed capital for investments (materials, tools, training) to promote financial security and stimulate local economies.</p> <p><i>MHPSS advantages</i> Allow people to self-prioritize their own needs and can target the most vulnerable.</p> <p><i>Potential drawbacks</i> Limited impact where other barriers to financial security predominate (social norms or disrupted access to markets, for example). Can drive increased inflation, or distort local markets and power relations if amount of the transfer is too large and/or risk mitigation measures are inadequate. Can reduce the sense of agency and be a source of social shame.</p>

11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

<p>Food for work or cash for work</p>	<p>Participants receive food aid or cash in exchange for work, usually on public works projects (building or restoring infrastructure, trash pickup, among others).</p>	<p><i>Livelihood advantages</i> Promotes food security, helps prevent people selling off assets and helps stimulate local economy.</p> <p><i>MHPSS advantages</i> Food for work and cash for work can incorporate skill-building and can connect people to productive activities. Labour can be used to rehabilitate community assets/infrastructure, which can boost community sense of a return to normalcy, as well as an increase the sense of purpose.</p> <p><i>Potential drawbacks</i> Estimating the appropriate amount of food or cash is critical to avoid distorting markets, and overly disturbing power dynamics. Can contribute to dependency. Privileges the able-bodied. The work can be demeaning, is often short term, and therefore may not help build sustainable livelihoods. Community infrastructure projects to be worked on need to be well thought out. For example, could the choice of public works to be rehabilitated exacerbate tensions between individuals/groups?</p>
<p>Employment and job training</p>		
<p>Wage employment within emergency response</p>	<p>Identify opportunities for employment within the emergency response, from delivery of direct services to affected population, to the supportive and administrative structures.</p>	<p><i>MHPSS advantages</i> Can provide meaning and purpose to affected populations and improve their perception within the community. Promotes activated development and sense of agency. Can be combined with skill training. It is a common form of livelihood support in MHPSS programmes.</p> <p><i>Potential drawbacks</i> Can create resentment in socially complex contexts, and/or be complex to implement in an egalitarian way. A market analysis is needed to avoid it. Engaging underqualified individuals, who may be dealing with their own stresses, can undermine the response and the psychosocial well-being of affected populations.</p>
<p>Job/skills training and placement</p>	<p>Programmes that seek to equip individuals for waged jobs based on market opportunities. Provision of training in basic job skills.</p>	<p><i>Livelihood advantages</i> Creates portable assets. If training is matched to available labour market opportunities, can stimulate labour market and promote economic security. Can promote activated development and sense of agency.</p> <p><i>MHPSS advantages</i> Can contribute to promoting self-esteem and self-efficacy. Can help establish social networks.</p> <p><i>Potential drawbacks</i> Few jobs (formal or informal) available in crisis contexts. Training without placement may lead to raised expectations, or lack of applicability to real world of work. May be difficult if training is not matched to available job opportunities, or participants are not legally able to work. Can create resentment if local labour is displaced.</p>

11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

<p>Access to information and communication technologies</p>	<p>With potential to connect to wider MHPSS offerings, information resource or IT centres can be used to provide access to online courses, get information on market prices or demand, or even (in rare cases) access online employment opportunities.</p>	<p><i>Livelihood advantages</i> In very high-capacity contexts, opportunity to earn income through freelancing and connection to global markets.</p> <p><i>MHPSS advantages</i> Low risk. Allows individuals to get what they need and chart their own journey.</p> <p><i>Potential drawbacks</i> Unlikely to have significant impact on livelihoods in the short term, unless combined with other activities. High set-up costs unless integrated with other camp interventions (for instance, safe spaces). It discriminates against persons who are illiterate.</p>
<p>Assets for generating income</p>		
<p>Income-generating activities – group agricultural support</p>	<p>Grants or materials (seeds, tools) are provided to support/re-establish group business. This may be in agriculture – crop production – but could also exist in livestock/fishing or non-agricultural businesses, such as sewing clothes or bakeries.</p>	<p><i>Livelihood advantages</i> Can mobilize the skills people bring with them, produce needed goods, stimulate local economy. Agricultural interventions can promote food security, stimulate local economy if people produce enough for sale.</p> <p><i>MHPSS advantages</i> Can build a sense of community between group members who have access to markets. Can incorporate training and skill-building. Favours group work, which can build a sense of community.</p> <p><i>Potential drawbacks</i> Could privilege able-bodied people, or those who are more natural entrepreneurs. Potential to distort market prices for assets or livestock provided by the programme. Can contribute to competition for resources and degradation of environment. Asset replacement projects can be hard to assess accurately, and may privilege those who had more to start with. It can increase stress and anxieties and bring frustration.</p>
<p>Income-generating activities – individual livestock or fishing support</p>	<p>Provision of livestock, or materials to support small business or income-generating activities such as livestock or fishing (water, food, veterinary care, nets). Used to build assets and income, and promote food security. Can also involve asset replacement after a disaster.</p>	<p><i>Livelihood advantages</i> Can contribute to income generation. Can promote food security, build assets and increase food security. The assets may be port-able if affected people were displaced and return home.</p> <p><i>MHPSS advantages</i> Can incorporate training and skill-building. Can increase interaction with host communities as customers/vendors, allowing displaced people to extend their network. Can promote activated development and sense of agency.</p> <p><i>Potential drawbacks</i> Could privilege able-bodied people, or those who are more natural entrepreneurs. Potential to distort market prices for assets or livestock provided by the programme. Can contribute to competition for resources and degradation of environment. Asset replacement projects can be hard to assess accurately and may privilege those who had more to begin with. It can increase stress and anxieties and bring frustrations.</p>

Other common types of livelihood programmes, such as village savings and loans and microcredits, are not considered in this chapter, as they are beyond the scope of MHPSS programmes.

11. INTEGRATED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, AND LIVELIHOOD SUPPORT

11.2.7 Identify facilitative partners where possible

Given the importance of connections to the market, programme managers should seek to identify market actors to partner with where possible. Do seeds need to be given out, or can suppliers be invited to establish themselves in the location or camp to distribute them in return for cash or vouchers? Can a financial services provider be engaged to manage cash transfers, which will convert into personal accounts after the intervention ends? This creates greater opportunity for sustainability and long-term economic relationships to be built. Similarly, simply negotiating greater access to local and regional markets for target populations, particularly those in camps, can function as a major intervention in itself. Market actors can be targeted with awareness of the MHPSS needs of affected populations, especially when working with groups with vulnerabilities.

11.2.8 Develop clear transition strategies

In engaging with communities, it is critical to set a clear end point for livelihood interventions, so that affected populations are able to plan for the future. This must be communicated clearly in community outreach, as well as part of any trainings provided. Clear communication prevents stress and supports affected people to gain self-reliance and recover their sense of hope.

11.2.9 Build integrated monitoring and evaluation processes

Given the importance of market suitability, a monitoring and evaluation (M&E) system needs to continually monitor not only the impact of the interventions on the target group, but the evolving changes in the market (which are likely to experience significant flux, particularly in the early post-crisis period). An intervention may need to be adapted to keep up with market changes. Most importantly for MHPSS

programming, the intervention should always be monitored and evaluated in relation to the MHPSS objectives set by the programme, for which people can refer to chapter on **Monitoring and evaluation**. Given the trade-offs outlined above, an M&E framework which also looks for risk of negative impacts on other members of the community can also be important. An example can be found [here](#).



11.2.10 Consider supplementing the “core” intervention with additional support for certain groups

Some subsets of the affected population may need additional support to benefit from the intervention. It could be that certain groups are more illiterate, have roles within the community that forbid them from certain activities, or are less physically able. This may require offering adapted interventions, or supplementary supports, to help them get the most out of the support. For instance, this can include reducing physical barriers to access livelihood opportunities, raising awareness in the community to facilitate access to specific activities, offering leadership courses to empower certain groups or courses on specific abilities required to have access to livelihoods. This could be language classes, literacy classes, learning how to navigate in a new environment or how recruitment processes work in a new location.

→ 11.3. CASE STUDY

As an example of a livelihood programme adopting MHPSS considerations, see the Nigeria, Community-Based Conflict Management and Cooperative Use of Resources (CONCUR) [here](#).



➔ 11.4. CHALLENGES AND CONSIDERATIONS

Challenges are identified in section **11.2.4** on trade-offs, and in section **11.2.6** on benefits and drawbacks, which should be read.



➔ FURTHER READING

Blattman, C., J. Jamison and M. Sheridan

2015 Reducing Crime and Violence: Experimental Evidence on Adult Non-Cognitive Investments in Liberia. Working Paper No. 21204, National Bureau of Economic Research, Cambridge, Massachusetts, United States.



Butterworth, P., L. Leach, L. Strazdins, S. Olesen, B. Rodgers and D. Broom

2011 The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results from a Longitudinal National Household Panel Survey. *Occupational and Environmental Medicine*, 68(11):806–812.



Jalal, C.S., E. Frongillo and A. Warren

2015 Food Insecurity Mediates the Effect of a Poverty Alleviation Programme on Psychosocial Health Among the Ultra-Poor in Bangladesh. *The Journal of Nutrition*, 145:1934–1941, doi:10.3945/jn.115.210799.



Mani, A., S. Mullainathan, E. Sharif and J. Zhao

2013 Poverty Impedes Cognitive Function. *Science*, 341:76–80.



For more references, see the full bibliography [here](#).



12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

➔ 12.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

The Inter-Agency Standing Committee (IASC) defines protection as:

All activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law, i.e. human rights law (IHRL), international humanitarian law (IHL), international refugee law (IRL) (**IASC, 2016**).



Protection is the responsibility of all actors intervening in a humanitarian setting (see Box 44 and IASC, 2016), and it is particularly so for MHPSS actors, since “an intimate relationship exists between the promotion of mental health and psychosocial well-being and the protection and promotion of human rights”, as stated in *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (**IASC, 2007**). Accordingly, human rights and equity are the first core MHPSS principles promoted by the Guidelines (see Box 45), and three action sheets (3.1, 3.2, 3.3) are dedicated to the relation between MHPSS interventions and human rights violations and **protection**.



Box 45

The Centrality of Protection in Humanitarian Action – Statement by the IASC Principals (IASC, 2013)

Protection of all persons affected and at risk must inform humanitarian decision-making and response, including engagement with States and non-State parties to conflict. It must be central to our preparedness efforts, as part of immediate and life-saving activities, and throughout the duration of humanitarian response and beyond. In practical terms, this means identifying who is at risk, how and why at the very outset of a crisis and thereafter; taking into account the specific vulnerabilities that underlie these risks, including those experienced by men, women, girls and boys, and groups such as internally displaced persons, older persons, persons with disabilities, and persons belonging to sexual and other **minorities**.



Human rights are founded on the respect of the dignity and worth of each individual with his/her unique characteristics, capacities and resilience. In emergencies, and resulting migration and displacement, individuals are more likely to:

- Be at risk for their lives;
- Lose a sense of dignity;
- Be deliberately targeted or threatened with violence, abuse and exploitation;
- Be discriminated against in their access to food and water, shelter, health care and other basic needs;
- Find obstacles in accessing education or civil documentation.

States are responsible for promoting, respecting and protecting human rights for all, without discrimination as to “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”, including migratory status. This is in compliance with the humanitarian principles of humanity, neutrality, impartiality and **independence**.



12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

More practically, four key elements of protection mainstreaming into other sectors have been identified to operationalize the protection principles of the Sphere Standards. These are:

- Enhance the safety, dignity and rights of people, and avoid exposing them to harm.
- Ensure people's access to assistance according to need and without discrimination.
- Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation.
- Help people claim their **rights**.

The interrelatedness of these factors can be illustrated through the equation at figure 11.

Figure 11: The protection equation

$$\text{RISK} = \frac{\text{THREATS} \times \text{VULNERABILITIES}}{\text{CAPACITIES}}$$

Source: DG ECHO (2016).

Although this evaluation of factors remains highly contextual and can't always be generalized in categories that fit all emergency situations, individuals who may require specialized protective measures, especially in relation to the protection of their mental and psychosocial well-being, could include:

- Survivors of GBV;
- Survivors of trafficking;
- Unaccompanied and separated children;
- Persons with disabilities;
- Individuals with mental, neurological and substance use disorders;
- Chronically ill patients;
- Stranded or detained migrants;
- **Other groups to be determined based on context.**

Box 46

IASC principles

Principle 1: Human rights and equity

Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations. Humanitarian actors should also promote equity and non-discrimination. That is, they should aim to maximize fairness in the availability and accessibility of mental health and psychosocial support among affected populations, across gender, age groups, language groups, ethnic groups and localities, according to identified needs (IASC, 2007: 9).

12.1.1 Who might be in need of protection

In its **Principles for Humanitarian Action**, IOM (2015b) identifies four interrelated vulnerability factors that determine the need for protection: (a) individual characteristics; (b) pre-existing social, economic, environmental and political conditions; (c) external disruptive factors induced, or resulting from, forced migration; (d) the specific situation of displacement or migration (section IV.4).

The list is not exhaustive, but it offers a basis for prioritizing specific groups of people in relation to their vulnerability to specific threats, within IOM's operations.

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

Box 47

Protection in IOM

IOM is committed to mainstreaming protection in all its activities in humanitarian settings, in ways that seek to do no harm, prioritize safety and dignity, foster empowerment and participation, and are non-discriminatory and based on needs. In addition, IOM works across all commonly accepted dimensions of protection.

IOM policy on humanitarian principles formalizes the organization's adherence to the IASC humanitarian principles and can be found [here](#).

IOM protection mainstreaming in emergencies schematizes how IOM engages with protection and can be found [here](#).



12.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

MHPSS is understood to be a specialized and integral part of protection and complementary activities, and close collaboration between MHPSS programmes and protection programmes should be the norm in the field. MHPSS programmes should contribute to diminishing the protection risks, strengthening existing capacities, and mitigating threats and vulnerabilities (see Box 48). They should provide MHPSS for identified protection cases, and refer to protection actors MHPSS clients who are also in need of protection assistance. MHPSS activities can therefore contribute to different positive protection outcomes within the protection egg (see Figure 12), which extends to the fact that they can contribute to the empowerment and increased resilience of affected individuals and communities to reclaim their rights, participate actively in the decision-making processes of their communities, and resort to positive coping mechanisms when faced with crises, thus contributing to increasing their protection.

Synergies and coordinated actions should be implemented throughout the whole project's cycles, as depicted in the following seven-step operational framework.

12.2.1 How to include protection concerns in MHPSS programming

12.2.1.1 Context analysis

MHPSS programme managers should have an understanding of the general protection context, and be aware of existing protection risk analysis, when devising responses to the actual and potential impact of violations and abuses on mental health and psychosocial well-being of vulnerable populations. In most humanitarian contexts, this information can be obtained from:

- (a) The protection cluster and its sub-clusters:
 - (i) Child protection;
 - (ii) GBV;
 - (iii) Housing land and property.
- (b) The MHPSS working group where there is one.
- (c) The United Nations Country Team/ Humanitarian Country Team strategy.
- (d) The Humanitarian Response Planning.
- (e) The Humanitarian Need Overview.

Thus, for an MHPSS manager, participation of the protection cluster and relevant sub-clusters and regular exchanges with protection actors is critical.

The understanding of the protection context and risk analysis will feed into the MHPSS **needs assessments** to guide a better response.



12.2.1.2 Coordination and partnership

Given the complementariness of their objectives and principles, MHPSS and protection actors should coordinate activities to ensure that they

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

are effectively and efficiently working jointly towards protection outcomes and, finally, the respect of the rights of the affected populations. This implies that MHPSS programme managers should make sure that:

- (a) Protection referral pathways are known to the MHPSS teams, which includes knowing and understanding the available services and their nature.
- (b) MHPSS is included in the referral pathways of protection teams and actors.
- (c) Both MHPSS teams and protection actors are aware of their respective identification indicators for referral.
- (d) There is an agreement on informed consent, data sharing, data protection and confidentiality principles and procedures for mutual referral throughout the period of care.
- (e) Referrals of MHPSS clients to protection actors should be followed up and documented, and respect the basis of need to know of the principle of confidentiality.
- (f) An MHPSS staff member will be in charge of liaising with external organizations to ensure consistency of the referral pathways of protection cases and timely communication among partners. In the PMTs, this will be the social worker.
- (g) Dissemination of information on existing MHPSS referral pathways for protection cases is agreed upon with relevant protection actors.
- (h) Joint projects and programmes can maximize financial and human resources, and help to advocate for unified messages.

12.2.1.3 Capacity-building

MHPSS teams, including PMTs, should be trained in:

- (a) General protection.
- (b) Operational standards and procedures used

by the protection actors in specific areas (for example, child protection, GBV or counter-trafficking).

- (c) Specific MHPSS needs and best practices for response for specific protection cases of IOM concern:
 - (i) Survivors of GBV;
 - (ii) Displaced populations and vulnerable migrants;
 - (iii) Survivors of trafficking;
 - (iv) Migrants in detention;
 - (v) Unaccompanied and separated children;
 - (vi) The protection dimension of assisting people with mental, neurological and substance use disorders;
 - (vii) Elderly, especially if unaccompanied.
- (d) Psychoeducation of families.

MHPSS teams should offer trainings to protection actors, as follows:

- (a) General MHPSS and the IASC Guidelines (IASC, 2007).
- (b) MHPSS services available in the given emergency.
- (c) Impact of violence on mental health and psychosocial well-being.
- (d) The protection dimension of assisting people with mental, neurological and substance use disorders.
- (e) PFA and positive communication.
- (f) Identifying people in need of MHPSS referral.
- (g) Psychological consequences of:
 - (i) Displacement;
 - (ii) Trafficking;
 - (iii) Administrative detention;
 - (iv) GBV;
 - (v) Travelling unaccompanied and separated children.

All the above-mentioned trainings, both for MHPSS teams and protection actors, are available by contacting the IOM MHPSS Section at contactpss@iom.int. Some of them can be

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

offered jointly to MHPSS and protection actors/ teams, based on professional background and other determinants. Community members can be added to the trainings, since they have an essential function in granting and promoting protection and well-being. This includes civil society and human rights organizations.

MHPSS staff, especially when working in close collaboration with protection actors, can be included in protection-specific trainings on issues pertaining to their context, such as child protection, GBV, human trafficking and detention.

Similarly, protection actors often conduct activities that need psychosocial competencies, such as building community-based protection networks or committees, launching awareness campaigns, interviewing potential victims of human rights violations, and conducting focus group discussions with various categories of the population. Moreover, they are often in direct communication with persons going through distressing situations. They can be included in trainings in counselling skills, and community mobilization, conflict sensitivity, mediation and others usually offered to PMTs.

Training is not the only way to reinforce partnership, and MHPSS programme managers should be proactive in identifying manners to reinforce or complement current protection activities.

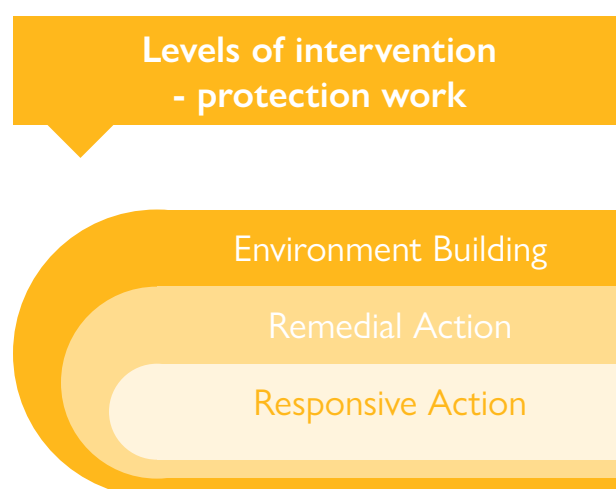
12.2.1.4 Multi-layered response.

Cases referred to MHPSS programmes by protection actors should receive services at all levels of the IASC pyramid of MHPSS. While usually referral tends to happen only for those with severe mental disorders or in need of more focused counselling, PMTs should as much as possible include clients in all activities that the programme proposes, including socializing and recreational activities, if and when appropriate in terms of general and psychological safety.

In addition, services should not be segregated, especially in the first stages of assistance. This means, for instance, that a counselling centre for survivors of GBV is to be avoided in a camp. By contrast, dedicated protocols and methods can be used to provide counselling to survivors of specific human rights violations, such as the Solution-Focused Brief Therapy model for survivors of GBV or **torture**. Existing staff working in camps or displacement areas should be trained in those methods, to be able to provide the necessary assistance when needed, avoiding, however, the certainty of separate facilities. Moreover, specific socializing activities, as well as peer-support or dedicated support groups, could be offered to specific categories of victims and survivors, based on their identified common needs and resources (see, for example, the testimonial theater activities proposed in chapter on Creative and art-based activities). Survivors of violence might choose to engage in the community or in public debates, campaigns and sensitization activities as part of their personal resilient and restorative psychosocial path (for example, acceptance, self-confidence, agency and activism).



Figure 12: MHPSS activities contributing to different positive protection outcomes within the protection egg



Source: **Based on ICRC (2001).**



12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

Box 48

Targeting subgroups

Avoid singling out or targeting specific subgroups for assistance, unless this is critical and justified in the specific context to prevent further harm. Integrated support helps to reduce discrimination and may build social connectedness. Consider, for example, providing women's groups rather than groups for women who have been raped (IASC, 2007:61).

12.2.1.5 Safe locations

While MHPSS activities in emergencies usually take place in a variety of settings, counselling of persons with protection needs should happen in a setting that guarantees privacy, security, confidentiality and safety, and yet is not stigmatizing. The space should contain visuals with positive images or messages in local languages, and message boards with updated information on referral systems, services and useful contacts. The counselling space should not contain physical, verbal or symbolic cues that could trigger negative emotions.

12.2.1.6 Social, art-based and recreational activities

CB MHPSS programmes as explained in this Manual include socializing, sport, theatre, and arts-based and ritual activities. These can be important venues not only to promote psychosocial well-being of survivors of human rights violations: they can also be considered ways to promote human rights messages and concepts; for identifying persons with specific protection needs to be referred; and for understanding trends of human rights violations or patterns linked to a lack of respect or knowledge on human rights

topics, which can guide further awareness or empowering activities. In some circumstances, these activities can be purposively organized with a more explicit protection objective in mind, involving protection actors. Such joint activities that involve specific community leaders and members could reduce human rights violations and abusive behaviour, while increasing collective awareness on rights and standards of protection. See, for example:

- (a) A booklet on domestic violence elaborated by IOM **Iraq**;
- (b) The **Girl Effect programme**, and its creative use of media for girls' empowerment and protection in various African countries.



12.2.1.7 Monitoring and evaluation indicators

For **monitoring and evaluation** activities, including those related to protection, see chapter on Creative and art-based activities. The following indicators identified in *IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings* (IASC, 2017), are related to protection:



- (a) Number of reported human rights violations, where possible and required;
- (b) Percentage of target communities with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women and people with severe mental disorders);
- (c) Percentage of target communities where representatives of target groups are included in decision-making processes on their safety;
- (d) Percentage of target group members who, after training, use new skills and knowledge for prevention of risks and referral;

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

- (e) Number of members of at-risk groups (such as children or survivors of sexual violence) who use safe spaces;
- (f) Percentage of target group members (such as the general population or at-risk groups) who feel safe;
- (g) Number of protection mechanisms (such as social services or community protection networks) and/or number of people who receive help from formal and informal protection mechanisms;
- (h) Number of people who have reported human rights violations and perceptions about **the responses of institutions addressing their case.**



Indicators should be identified through participatory exercises in the target groups and subgroups. Indeed, a common understanding of abuses and threats should be at the basis of this exercise and may need prior work on language and culturally appropriate methodologies.

Box 49

IOM safe locations in South Sudan

In Wau, South Sudan, the counselling rooms are located inside IOM clinics. They provide a quiet and private space for those who are seeking counselling, including caregivers, clients and people referred from protection actors: for instance, survivors of sexual and gender-based violence or people living with HIV/AIDS. Counsellors who work inside the clinics can receive those needing support in collaboration with the health workers who have been trained in MHPSS. In addition, an on-call counsellor and team leader are designated on shifts to ensure the timely provision of support, whether they are at the clinic or in the vicinity of the **community.**





There is also at least a counselling space available in the psychosocial support resource centres. In the centres, there are rooms that can be used for group activities or for counselling. When the room is needed for counselling, the PMTs are alerted on the schedule. The counselling space is prepared and maintained clean and available at all times. Often there are counselling sessions that need follow-up after group activities; therefore, it is necessary to have a private space available for use.

Protective factors are also included in the design of the space. The spaces for activities are free from possible hazards, ventilated and with semi-transparent parts on the walls, for people to see that social activities are safely taking place (especially activities for children). The composition of PMTs in each activity also matters; they should not dominate in numbers. If the activities (individual or group) are done outside of the centre, the same principles about having safe locations are applied.

Consultations with communities on their concept of “safe places” are very important when planning or designing activities, or when identifying venues or physical structures to be constructed or rehabilitated.

12. STRENGTHENING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE FRAMEWORK OF PROTECTION

➔ 12.3. CHALLENGES AND CONSIDERATIONS

- (a) Humanitarian organizations and national institutions may operationally frame protective interventions as individually-centred and normative-based approaches, which make coordination and joint programming with community-based MHPSS programmes either ineffective, or even antagonistic. In this respect, capacity-building and mutual referral can be efficacious tools to find common grounds.
- (b) New protection measures and safety networks are at times introduced without properly considering pre-existing ones. This can reduce the capacity of the affected communities to protect themselves. The mainstreaming and collaboration of MHPSS programmes with protection programmes will still be coordinated with the community programme steering **committee**, and subject to community feedback. In addition, MHPSS assessments are usually able to identify existing practices and networks, which need to be factored into these collaborations. The “do no harm” principle must be considered in all interventions. 
- (c) People can cope with crises by resorting to pre-existing social or traditional harmful practices and/or they can develop new crisis-induced negative coping mechanisms (female genital mutilation, early marriage, child labour, marginalization of persons with disabilities, segregation or forced institutionalization of persons with mental, neurological and substance use disorders). These might not comply with human rights and humanitarian standards, and eradicating them may require longer-term social, cultural and structural changes at the community level. MHPSS activities should be inscribed within a multilayered, longer-term strategy, with increased coordination with transition and development actors, whenever present.
- (d) Human rights violations can also be perpetrated by humanitarian staff, and IOM has taken specific measures to prevent sexual abuse by humanitarian staff in its policy on Protection against Sexual Exploitation and Abuse and staff standards of **conduct**, in line with the inter-agency policies on the issue. 
- (e) There could be the tendency to overrefer “cases”, congesting some organizations and reducing their capacities to provide quality services to the ones most in need. There are also often challenges of overidentifying when there are no specific services available (for example, identifying unaccompanied and separated children, or specifically street children, when no actor actually provides alternative care, protection, access to health care or other services to them). The identification of a group or individual at risk brings an ethical duty to provide care and follow-up. This means that the MHPSS actor should refer to protection services and, where no services are available, to inform responsible or relevant actors, or duty bearers, of the particular issue or the cases, while respecting data protection, consent and confidentiality principles, and keeping the security of the persons or group as the primary consideration. This should be done within the protection cluster or/and its sub-clusters, or in liaison with protection actors.

Box 50
Reporting human rights and other violations

MHPSS staff will invariably witness the disclosure of abuses that could be classed as human rights violations, while providing assistance to affected individuals. It is not the function of MHPSS workers to investigate allegations of abuse, but they can certainly play a key role in supporting survivors in accessing justice where possible.

Where a MHPSS worker is told about an abuse by a client, he-she should continue providing care and not interrupting it and, upon receiving consent to do so, refer the case for additional support to:

- a) an IOM protection officer if s/he exists; OR
- b) ask the manager to consult the Protection Cluster Coordinator for the appropriate referral entry point, based on the survivor's wishes, his or her immediate and long-term needs, and the type of abuse. For example, the referral procedure for a case of suspected child abuse will vary significantly from an allegation of torture made by an adult male in detention. Referral options may include the provision of immediate medical or protection assistance, or legal, livelihood and reintegration support. Referrals should not be made to service providers, who are linked to alleged perpetrators.

Notwithstanding the advice provided by the Protection Cluster or other similar bodies, MHPSS practitioners should at minimum be familiar with, and where existent and possible, integrate into, the existing working groups and / or referral pathways for the following types of abuse:

- Sexual and gender-based violence (SGBV);
- Forced recruitment / trafficking;
- Child abuse
- The six grave violations against **children**;
- Attacks on civilians;
- Torture and ill-treatment;
- Enforced disappearance

All referrals should be made in line with respect for survivor autonomy, which means respecting survivor choices, upholding full and informed consent, and respecting the principle of confidentiality where possible. MHPSS staff should know that not all help professional categories are protected from court-ordered requests to disclose information about survivors. Before promising full confidentiality, staff should understand the limits of what they can guarantee.



FURTHER READING

The Alliance for Child Protection in Humanitarian Settings

2018b *Child Neglect in Humanitarian Settings*. The Alliance for Child Protection in Humanitarian Settings, Geneva.



Inter-Agency Standing Committee (IASC) Task Force on Humanitarian Action and Human Rights

2004 *FAQ on IHL, IHRL and IRL*. IASC, Geneva.



International Committee of the Red Cross (ICRC)

2018 *Professional Standards for Protection Work* (3rd ed.). ICRC, Geneva.



International Organization for Migration (IOM)

2009b *Caring for Trafficked Persons: Guidance for Health Providers*. IOM, Geneva.



2010b *Data Protection Manual*. IOM, Geneva.



Office of the United Nations High Commissioner for Refugees (UNHCR)

2011 *Age, Gender and Diversity Policy: Working with People for Equality and Protection*. UNHCR, Geneva.



2014a *Child Protection Issue Brief: Mental Health and Psychosocial Well-being of Children*. UNHCR, Geneva.



2014b *Understanding Community-Based Protection*. UNHCR, Geneva.



United Nations Office of the High Commissioner for Human Rights (OHCHR)

2011 *International Legal Protection of Human Rights in Armed Conflict*. OHCHR, Geneva



For other references see the full bibliography [here](#).



13. COUNSELLING



13.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Managers of MHPSS programmes are not directly providing counselling services, but they design programmes and take implementation decisions that regard counselling. These have to do with selecting which counselling models and tools to use in the programme, based on contextual capacities and needs. MHPSS programme managers have to:

- Identify, alone or together with the technical supervisor, training programmes that are suitable to enhance the existing counselling capacities in the given context.
- Consider issues of scalability, adaptation and training, when devising counselling interventions in emergencies.
- Consider the issue of squared cultural and linguistic differences and, at times, of working with interpreters, when offering counselling to migrants.
- Monitor adherence to adopted methodologies. Organizing and supervising the technical supervision is also part of the manager’s duties.

This chapter therefore serves as a guide to better understand the definition, practices and modalities around the provision of counselling services in an emergency, with particular regard to those methods that better serve a community-based approach, such as one that empowers and entitles communities in finding their own responses. In order to understand the definitions of counselling, resilience and other terms used in the chapter, see [here](#).

13.1.2 Concepts

13.1.2.1 Counselling

Counselling is a supportive conversation. There are many types of conversations that take place between community members that may have a therapeutic benefit. These can range from spontaneous, mutually supportive conversations, to problem-solving associated with particular activities. In this Manual, counselling refers to those structured conversations that may take place with individuals and groups, that have a **therapeutic outcome** as their goal.

Counselling is a rich and diverse field, which may also be practiced by other disciplines, such as social work and clinical psychology. The hallmark of counselling is its particular emphasis on mobilizing suffering persons’ resilience (Fraenkel, 2014). Of great importance in counselling is how to create and maintain healing and ethically sound relationships between the counsellor and those being counselled.

Features that stand out in a contextually-sensitive counselling approach are:

- Mobilizing suffering persons’ resilience, and their psychological and relational strengths and resources, in order to solve their problems: This will often include facilitating the collective capacities for resilience that reside in family and community relationships, and that are drawn from cultural and religious traditions.
- Effective counselling: This involves teaching important skills, such as active listening, respect and avoiding causing emotional harm. Effective counselling is enhanced by the social–emotional and relational intelligence of the practitioner and client, as well as other supportive members of the community.
- Counselling for many, and particularly for those who have been displaced from home, family, and community, which creates a space of “protected intimacy”: An important capacity for preventing a sense of psychological homelessness (Saul, 2018).

A number of recent studies support the importance of counselling in emergency settings (Jordans, Pigott, and Tol, 2016; Patel, 2012; Murray et al., 2014; Ramaswamy et al., 2018; Tol, et al., 2011; Watters, 2017). These MHPSS interventions can build healing connections that may both reduce ongoing distress and prevent future mental health difficulties.

At a most basic level, counselling helps re-establish connections between people, so that one is not alone struggling with adversity in isolation – a serious risk factor for mental health difficulties. Since humanitarian emergencies are so destabilizing and often unpredictable, the connection with others can help in gaining perspective and composure, and support the shoring up of resilience: for example, recognizing and accessing resources important for adaptation and problem-solving.

Active and perceived social support has been found to be the most important protective factor in highly stressful situations, such as during and following emergencies, since both giving and receiving help are adaptive activities (Hobfoll et al., 2007). Following a disaster, there is an evolutionarily-based biological capacity for people to come together and bond. This natural healing process may be supported through counselling at the individual and communal levels, particularly when it helps restore connections that may have been broken, as well as build new ones.



In the IASC pyramid of MHPSS intervention in emergencies, the counselling techniques and models described in this chapter are included at the third level (focused interventions), even though they require different levels of specialization.

13.1.2.2 Community-based counselling

While there are many approaches to counselling, community-based counselling has the advantage of addressing not only psychological issues resulting from stress, grief, loss, depression and other individual mental health difficulties, but also the psychosocial impacts and challenges

resulting from the collective injuries to families and communities. These approaches are aimed at strengthening collective resilience and social capital, and mobilizing the community's engaged action and response. Community-based approaches aim at understanding the sociocultural and physical environmental parameters that both hinder and promote the kinds of interactions and conversations that lead to well-being. This includes the relationships between people and between groups; their culture; and existing structural inequalities based on race, ethnicity, gender, class, and the physical, political and economic environment. This approach also includes a historical understanding of the narratives that have shaped identities and the current situation or crisis.

A community-based approach is particularly relevant in crisis situations, where not only individual clients, but their families and communities, are affected, directly or indirectly, by stressful and disruptive events. Counsellors, too, are part of the system. They are affected by their work, which includes reciprocal interactions with clients, with their own work teams and organizations, and with their own families and communities. “Vulnerability” and “resilience” are concepts that apply to counsellors as well as those they seek to help.

Community-based approaches isolate problematic behaviours or feelings not only in the individual, but also in the web of relationships in which a person is embedded. The problems will always have both an individual and relational or collective dimension. Counsellors will therefore understand the context and meaning of counselling in particular situations – for instance, does having a counsellor from outside the family or community intervening to help solve the problems of children in some way undermine the parents' authority and competency? For example, does it send the message “You can't do it yourself, we must help you”? This problem often presents itself when counsellors work directly with children and ignore the competencies of parents.

Table 11 clarifies principles for community-based counselling. While many counselling approaches focus primarily on the individual, and not every approach is reflective and responsive to the community, a standard can be set in which any individual and group counselling approach can be adapted to make it more contextually and community-based.

Table 11: Community-based counselling approaches – minimum and optimal standards

Minimum standards	Optimal standards
Programmes are often provider-driven, with participation of community leaders and members to aid in programme implementation.	Programmes engage the community's participation at all stages – planning, assessment, prioritizing, implementation, evaluation and dissemination. Programmes may fall along a continuum of outside provider/inside community-driven programme development.
Primary focus on screening for and addressing multiple mental health problems as well as specific diagnosable disorders. Symptomatology, idioms and constricts are validated with the community.	There is an assessment of needs, challenges and priorities of the target population to determine the most effective and appropriate counselling approach.
Primary focus is on treatment of individuals and reduction of psychological symptoms. Tools are translated.	Focus may be on addressing the particular challenges in families, in the community as a whole, or groups and organizations within the community. The emphasis is on relational repair as much as symptom relief.
Exploration of culture and context to understand how best to implement and scale up interventions.	An initial assessment is made of culture and context, to understand individual and collective strengths, resources and coping capacities, as well as problems. Culture is central to determining local understandings, priorities and meanings of potential interventions (see IASC, 2007:38–48). Care is taken not to undermine local meanings, re-sources and coping capacities at the levels of individual, family and community.
Adapt evidence-based programmes developed in other contexts to current context. The particularities of context and culture are explored to facilitate implementation.	Programme development is an iterative process based on ongoing community input, revision and approval. Cultural meanings are central to determining priorities, available resources and preferred ways of addressing distress or challenges, using participatory methods as above (Bragin, 2014).
Criteria for programme success are determined by established indicators developed in testing programmes, and in solution-focused counselling in client-identified goal setting and steps.	The criteria for success in evaluating a programme are determined by client-identified goals and in collaboration between outside providers and the community.



Some types of counselling approaches used in emergency situations – including cognitive behavioural approaches, narrative exposure therapy, eye movement desensitization and reprocessing, Rogerian approaches, some art therapy and dramatherapy techniques – tend not to take into consideration the social and ecological context of the person(s) being counselled, nor the context of the counsellors and the counselling situation itself. There are, however, counselling approaches, such as strength-based **solution therapy approaches**, that are grounded in a social ecological approach (see models of **work**). Furthermore, the above-





mentioned counselling approaches, although not being community-based in themselves, can be integrated into a more socially and ecologically contextual approach and programme, contributing to its overall objectives.

13.1.2.3 The counselling process

The counselling process is determined by the context in which therapeutic interactions take place, as well as the particular theoretical model of the counselling approach, usually in structured multimeeting programmes. Counselling may take place in professional spaces or MHPSS centres – such as IOM’s recreational and counselling centres and **hubs**, other **safe spaces**, health centres, or in communal or cultural spaces that have been identified – where an individual would go in need of guidance and support (Abramowitz, 2010; Chibanda et al., 2016). Counselling may take the form of accompaniment: for instance, by a volunteer who helps a client navigate to resources in new and unfamiliar situations – a popular approach in Latin America (Valdivieso and Andersson, 2017; Pinheiro, 2017), which builds on social work approaches to case management.



The process of counselling most often includes an initial stage of joining or gathering, and various forms of listening and speaking:

- Some of these conversations may have particular culture-based guidelines about how to speak and who can speak with whom and in what order.
- There may be cultural conventions or restrictions on the giving and receiving of advice (in traditional communities, married couples experiencing difficulty will meet with the in-laws to help resolve marital conflict or solve problems).
- There may be cultural prohibitions on speaking to strangers outside the family.
- Counselling may be directive or non-directive, and may focus primarily on providing emotional support or giving advice.
- It may focus on solving problems or finding solutions, exploring painful feelings or strengthening the coping capacities of individuals, families or groups.
- Many counselling approaches, especially in emergency situations, will involve some form of strengthening of emotional regulation skills, through training in relaxation or mindfulness techniques, or physical exercise and movement (Wessells, 2009).

The counselling process can vary due to the types of people who are meeting, whether the groups are facilitated by professionals or trained paraprofessionals, or follow culturally prescribed ritual guidelines around life transitions and crises.

Box 51

What distinguishes a more systems- or community-oriented approach to counselling from more individually oriented approach

- Rather than exclusively focusing on internal psychological processes, it attends to patterns in relationships among people in families, couples, groups and in the community, through community approaches.
- It attributes psychological and social dysfunction to problems lying not solely within the individual, but also in larger systems.
- It pays attention to structural issues of race, ethnicity, religion, class and gender as social determinants of mental health difficulties. It is structurally competent.
- It acknowledges that the problems of individuals and groups always occur within context, and so do the solutions, which must be meaningful and acceptable in the person's social context – family, friends, peer groups, faith-based groups and organizations.
- It sees the social context as not only sustaining problems, but also as the source for solutions. To ignore both is to narrow the scope and potential effectiveness of counselling. For instance, if a child who is exhibiting problem behaviour is removed from his social context to solve his problem, when he is returned to that context he is also returning to the relational forces in the family or school that may have sustained the problem in the first place.
- It can be more challenging with highly mobile populations – such as refugees and migrants, or with displaced persons, whose sense of community has been fractured – and more difficult to reproduce/scale up.

Group counselling session. © IOM 2015





Male support Group, Erbil IDP site, Iraq. © IOM 2017

➔ 13.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

The decision about what kind of counselling programme(s) to implement in an emergency situation may be guided by the three core principles:

13.2.1 Understanding the complexity of the situation in which counselling is being provided

The basic starting point for understanding the complexity of the situation is a descriptive account of the humanitarian emergency, the population affected, how many, where they are from, how many health and mental health professionals are available, when they arrived, what has been their journey, and so on. This “thick description” (Geertz, 1973) may serve as a first step on which a “situation analysis” can be made: that is, a tool for creating a detailed understanding of an interpersonal episode or complex state of affairs (the situation) in the context of the larger narrative of which it is a part (the embedding drama). “Situation analysis creates a detailed description of the situation and links that particular situation to the larger drama of which it is a part in order to

identify the factors driving the situation, as well as to highlight the most useful points for intervention” (Green-Rennis et al., 2013).

An important part of understanding the complexity of the situation is to describe the structural factors at play. These structural factors could be at the level of community, neighbourhood, institution (housing, schools, corrections, clinical services), and at the policy level (State policy on housing, policies of international aid groups, the impact of war and political violence). Referred to as “structural competency”, this approach to clinical training and practice addresses the social and political aspects of mental health and psychosocial well-being. Focusing on structure can promote a more collaborative approach that makes use of local resources. This is in lieu of an approach that venerates individual behaviour change in the face of overwhelming environmental adversity (Metzl and Hansen, 2014). This recognition of larger social forces is essential to understanding the social disparities in global mental health. Inequalities based on race, ethnicity, gender and social class are major drivers of poor mental health outcomes.

Other important questions to ask are: What are the complexities of the stories? How do narratives shape the experience of the

population, the providers and the developing collaboration – and the way the manager thinks about designing interventions?

13.2.2 Recognizing existing individual and collective processes and resources for recovery

Through interviews and observations, it is important to understand the positive social processes that have already been taking place in the target population and the humanitarian environment, which may be considered forms of counselling and may serve as the foundation for the further development of counselling approaches for a community. The aim is not to undermine already-existing resources and resilience processes important for recovery. An understanding of these resources will provide important information on the preferred help-seeking patterns in a population, and help identify leadership capacities, skill sets and motivated community members, who may be important collaborators in developing counselling programmes.

Resilience has now emerged as a new paradigm in the fields of development and mental health (Ager et al., 2013). What is distinctive about a resilience-based approach is:

- An emphasis on strengths, resources and capacities rather than deficits;
- Anticipation of actions that reduce the impact of adversity;
- Attention to multiple levels of influence, ranging from the structural and cultural through to the community, family and the individual;
- Mapping influences within ecologically-nested systems (ibid.).

Influences are bidirectional, in that an individual's resilience is fostered by family, social and cultural resources embedded in one's social ecology, as well as the collective capacities or ways that

families and communities exhibit resilience themselves in response to stress and challenges. This may involve adjustments and adaptations of subsystems within the community – that is, individuals, groups and organizations – or it may involve the interactions of the entire community with its environment, including other social, economic and political entities (Kirmayer et al., 2009).

Approaches to resource mapping have been presented in previous sections of this Manual. Here we may add that, in developing resilience-based approaches to counselling, mapping sources of resilience at different systemic levels will be important in determining points of intervention. A variety of maps have been developed (see Landau and Weaver (2006) later in this chapter) that will be helpful to programme planners as a kind of checklist of the potential points of intervention.

13.2.3 Enhancing and building on what already exists

In collaboration with community representatives, it is important to understand which existing processes could benefit from support by providers. For example, a group of volunteer parents running a sports programme for youths might request help from counsellors to address some of the MHPSS needs of programme participants that come up in the groups they are facilitating. This non-stigmatizing site may be an important place to offer information on understanding stress reactions and tools to cope with stress, anger management and routes to other forms of counselling, if needed. The sports group itself may have the capacity to function as a kind of peer support group with the aid of a psychosocial counsellor.

In trying to determine what types of counselling may need to be added to what already exists, it will be important to understand the different effects or impacts of migration and displacement at different levels. Often, when looking at a counselling approach, one can find his or her

approach to counselling in individual level factors (symptoms, mental health disorders), but not the disruptions that take place at the level of the family and the level of the community. One needs to be able to consider interventions that not only strengthen family and community supports, but address the impact that stress, grief, transition and loss can have on family and community interactions.

Multilevel approaches to determining which counselling methods to use do consider the impacts of expressed community needs at multiple systemic levels.

Family stress needs to be addressed at the family level, often with community support. When determining what needs to be strengthened, enhanced or added to the community's counselling efforts, it must first be established with the community its desired goals and priorities for counselling efforts. Based on this vision of recovery, one can then explore with the community the different options for counselling as a part of the process of developing a strategic plan for a set of counselling interventions that are the most important for this early phase of intervention.

What is the process for establishing the priorities and how are these priorities negotiated among community members and with providers? That process may include a discussion of different types of counselling approaches that are traditionally utilized or preferred by the community, what may be limitations of these approaches, and what additional approaches are needed to complement existing services in order to address the unique challenges of the current emergency situation. It also needs to be determined what resources are available – for example, trained community members, available for training as paraprofessionals. In the process of negotiating priorities, the following principles may be useful in guiding that process:

- Provide preventive value – to the extent that the counselling approaches strengthen protective factors (such as promoting social support and problem-solving).
- Address the most vulnerable and high-risk community members.
- Promote social cohesion and be effective in promoting cross-community communication and preventing communal fragmentation.
- Acknowledge the diversity of needs and determine which counselling interventions will most likely lead to practical success and thus increase the efficacy of the community.
- The development of the priority must respect or take into consideration the power dynamics in the community. The issue of sharing and distributing resources in a fair and equitable way brings in a more ethical dimension for how priorities are established.
- It is important for practitioners to be both culturally and structurally competent in facilitating this process of negotiation.

In the context of understanding the community situation and broadly assessing its needs and resources, the goal is then to determine which counselling approaches would be most desirable, feasible and viable in the situation. A framework is recommended here that is based on relationally-oriented design thinking adapted from IDEO U (2016) and Bava (2017).

The choice of particular counselling approaches should be determined by the goals and priorities articulated by the community. Then the community may explore with provider organizations which counselling options may be available, feasible to implement and most viable. The needs of the community don't

always coincide with the resources that are being offered by humanitarian organizations. The community would benefit from knowing about counselling programmes that most closely fit their goals, so that trainers in these particular approaches may be sought. This determination is accomplished by interviewing community members, stakeholders and provider organizations. Some of the options for community-based counselling approaches at different levels are presented below.

→ 13.3. OVERVIEW OF COMMUNITY-BASED COUNSELLING INTERVENTIONS

Ideally, a counselling programme in emergencies for IOM should not follow a precise and predetermined intervention protocol, but should be based on a solid foundation of skills of the counsellors, and the sensitivities and competences described beforehand in the chapter. A group of trained counsellors, constantly retrained and supervised, should be allowed to adopt flexible approaches in intervening with groups and individuals, while adhering to precise ethical principles and overarching models of work.

However, various community-based counselling interventions – or psychological interventions, as some call them – have been developed at the level of the individual, family, groups and communities as a whole in humanitarian settings. Others have been developed in a variety of other settings, but have the potential to be implemented in emergency humanitarian contexts. These are more structured and validated, and are therefore potentially easier to scale, in the case of a lack of resources or foundation capacity.

During the initial months of a humanitarian emergency, it is important to allow some time

for people to access on their own the coping strategies they find most useful, so as not to interfere with or undermine a population's natural coping capacities. It will be important to wait before offering counselling that targets specific mental health difficulties that only become apparent months after an initial crisis. However, in this initial stage, counselling may be useful that addresses the immediate impact of a crisis, such as:

- Practical problem solving and problem management (see PM+, section 13.4.1 below);
- Ambiguous loss groups (see section 13.6 below);
- LINC Community Resilience Model (Landau and Weaver, 2006);
- Socioterapy (see [section 13.3.3 below](#)).

At a second stage, more approaches can be used, including the ones above.

13.3.1 Individual level counselling approaches

Problem Management Plus: PM+, in individual and group format, is an innovative psychological intervention that provides clients with skills to improve their management of practical problems (unemployment, interpersonal conflict, among others) and associated common mental health problems, via the provision of four strategies: problem-solving counselling, stress management, behavioural activation and strengthening social support.

13.3.2 Peer-support counselling programmes

Friendship Bench Programme in Zimbabwe: Located in the grounds of health clinics around Harare and other major cities in Zimbabwe, the practitioners are lay health workers known as community “Grandmothers”, trained to listen





Lay Counselling at the Protection of Civilians site in Malakal, South Sudan. © IOM 2018



to and support patients living with anxiety, depression and other common mental disorders (see “**Friendship Bench**”).

Being Buddies – IOM Nigeria: The buddy system is an intervention similar to peer-to-peer counselling, which consists of the identification, training and constant supervision by professional counsellors of various community members who can provide support to their peers in the neighbourhood, families, workplaces and groups. It was originally developed in non-emergency contexts, in settings such as workplaces or schools. In schools, programmes have been put in place to promote students’ psychosocial well-being through buddy support, with the idea that students would be more responsive to receiving support from their peers, to whom they could relate more, than from a school staff member. Such approaches have proved particularly relevant in some emergency settings, such as north-eastern Nigeria. In this context, counsellors and psychologists are scarce. Moreover, seeking assistance from a counsellor or psychologist is quite the exception, whereas

most affected individuals would seek assistance through other support systems, friends, neighbours and colleagues, which would be perceived as more effective and appropriate by them.

This methodology puts both participants in a more equal position. In humanitarian settings, very often, affected populations are seen as passive recipients of assistance. The buddy system approach allows for a different view and promotes a different self-identification, because affected individuals become both providers and receivers of such services. Through the buddy system approach, a positive sense of identity is encouraged, providing affected individuals with an opportunity to become positive role models.

In emergency and displacement settings, neighbourhood support structures are often broken down, and the buddy system can help weave and strengthen the social fabric. By encouraging interactions through “buddies”, groups can be created at the grass-roots level to recreate neighbourhood or problem-based **support**.



Through the buddy systems approach, individuals are equipped with MHPSS skills, so they can provide effective support to their peers. They can pair up with individuals needing more support. The MHPSS manager and supervisor's role is to build capacity of the buddies, provide guidance and ensure that they do no harm. Buddies should be provided with supervision, to explore any challenges they may encounter, and reflect on their practices and experiences. Finally, in emergency settings and particularly in protracted crises, populations can experience numerous displacements. With the buddy system approach, the trained individuals will be moving with the affected population and still be able to render MHPSS, even in situations where humanitarian actors may not be able to reach the affected population.

13.3.3 Group counselling

Group interpersonal therapy (IPT) was originally developed in the United States as an individual treatment for unipolar, non-psychotic depression (Klerman et al., 1984). In treating depression, IPT targets the connection between the onset of symptoms and current interpersonal problems. The IPT therapist begins with a systematic diagnostic assessment, explains the diagnosis, and works with the patient to identify the problem areas associated with the onset of the current symptoms. Difficulties in four interpersonal areas are considered triggers of depressive episodes and become the focus of treatment: grief (due to death of a loved one), interpersonal disputes (disagreements with important people in one's life), role transitions (changes in life circumstances, negative as well as positive) and deficits (persistent problems in initiating or sustaining relationships).

IPT is specified in a manual, has been tested in numerous randomized controlled trials, and is efficacious for a number of mood and non-mood disorders (depressive and bipolar disorder, post-traumatic stress disorder (PTSD), eating disorders,

among others), age groups (adolescent, adult and geriatric populations), settings (outpatient mental health facilities, primary care, school-based clinics, community settings, among others), and modalities (for example, individual, group and telephone).

There is a growing body of evidence showing the effectiveness of IPT in low-resource regions and settings. IPT was used in a group format, was culturally adapted, and showed efficacy for depressed adults and adolescents in both southern and northern Ugandan communities; for depressed primary care patients in Goa, India and Ethiopia; and with women with post-partum depression in China and Kenya. The last group was HIV positive and included survivors of intimate partner violence. Group IPT was adapted for global dissemination by **WHO**.



Sociotherapy is a therapeutic system with strong theoretical and historical links to Sociology. This approach to therapy emphasizes social, cultural, environmental and interpersonal factors, taking into account the living environment of groups of clients to support their interpersonal adjustment and reach treatment objectives. While psychotherapy is centred on the individual, sociotherapy considers that individual psychological concerns frequently have social or environmental causes that limit the effectiveness of psychotherapy. Sociotherapy intends to provide substantial solutions to sociopsychological problems, helping clients to regain harmony with their community.

Sociotherapy targets groups of clients, using interaction and socialization as a way to collect information on client's limitations and as a therapeutic tool. Clients learn roles and adequate interpersonal behaviour through the experiencing of social interactions (Whiteley, 1986); relearning established roles and problematic behaviours in a safe environment. Thoughts and feelings on the process are discussed with all group members and the sociotherapists, who support the group to adjust to their daily lives in their specific social context.



Richters (2010) states that “sociotherapy helps people to regain self-respect, rebuild trust, feel safe again, overcome unjustified self-blame, re-establish a moral equilibrium, have hope, live without terror, forgive those who have harmed them, apologize to those whom they have wronged, and regain their rightful place in the community”. This approach had been successfully used in different contexts, for more information please see examples of its use in Rwanda, where it has been used since 2005 to support communities after the war and 1994 genocide ([here](#) and [here](#)).



13.3.4 Family counselling, Ambiguous loss – Working with families with missing members

Counselling approaches that work with families struggling with ambiguous loss are important in humanitarian emergencies. Boss (2004) defines ambiguous loss as “an unclear loss – a loved one missing either physically or psychologically. It results from various situations of not knowing if a person is dead or alive, absent or present, permanently lost or coming back.”

The issues that families with a missing member(s) must contend with are multiple, and need counsellors who understand the impact this kind of temporal dislocation and uncertainty can have on a family system. Counsellors will need strategies for preventing and addressing the polarization and conflict that can occur in families when coping with a situation of a missing member(s). Family reunification programmes are also important in this phase and go hand in hand with programmes that address ambiguous loss (Boss, 2018; IFRC, 2001, 2014; Killian, 2016; Robbins, 2013). For practical guidance see [here](#) and [here](#).



The collaborative family programme development model is a collaborative research-based approach to creating community-based programmes for families. In this approach, families are viewed as experts on the nature of their challenges and on what they desire in a programme. This approach

is particularly useful in developing programmes for families who have experienced social oppression and who may have been reluctant to participate in programmes created for them by professionals without their consultation. In contrast, when professionals adopt the stance of respectful learners, families respond by actively engaging in the programme development research and in the programme created from it. This article describes the nature and complexities of a collaborative programme development stance (Fraenkel, 2006).

13.3.5 Technological and social media-based counselling approaches

Social media-based counselling approaches are a new field of development. Although best reproducible practices could not be identified at the moment, a series of readings is recommended for inspiration: Ungar et al. (2013), Ruzek et al. (2016), and Ruzek and Yeager (2017).

13.3.6 Self help tools

Often, in emergency situations, access to most vulnerable populations is not to be given for granted. Lack of access jeopardize the possibility to offer direct counselling services from the one side, and to present and promote online mechanisms of distant counselling on the other. In these situations, IOM uses self-help printed and online tools that can be included in distribution packages, or other primary good distributions. The process to create these tools is 4 folded.

- Focus groups are conducted with relatable groups who are accessible to identify main stressors and concerns and viable solutions
- A mixed group of psychologists, anthropologists and visual artists create self help tools on the identified issues and building on identified resilience factors, that are conversational in tone and include visuals.

- The resulting messages and pictures are validated in new focus groups.
- The final booklets are printed and included in distribution packages, health facilities, educational kits and made available online.



See [here](#) the English version booklet *Self Help for Men in Crises and Displacement*, specifically tailored in 2015 for Syrian men living in unaccessible areas in the Syrian Arab Republic. The booklet has since been distributed and downloaded in tens of thousands of copies, translated and adapted, and used, as well, as supporting material in face to face and group counselling sessions for men in several countries.

13.3.7 Other focused psychosocial supports

Other forms of focused psychosocial support are presented in this Manual, as follows:

- Problem-based, programme-generated support groups and peer support **groups**;
- Problem-based and programme-generated art-based interventions (dramatherapy, social theatre, art therapy and **others**).



In addition, *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007) include PFA as a third-level intervention. See Box 52 for the presentation and discussion of PFA.

13.4. ADAPTATION, TRANSLATION, TRAINING AND CULTURAL COMPLEXITIES IN WORKING WITH MIGRANTS

The mentioned existing counselling interventions can be used within a CB MHPSS programme. Yet these interventions, in order to be adapted and scaled up, will require:

- A meaningful selection of the best intervention for the context;
- The adaptation and translation of the relevant tools in the new language, if necessary;
- Training of the counsellors on the method and protocols.

For how to choose the best intervention for a specific setting and to adapt and translate the model accordingly, please refer to the following chapters of the forthcoming WHO *Psychological Interventions Operational Manual: Integrating Psychological Interventions in Existing Services*:

- Chapter 2 – Choosing the best intervention for a specific setting;
- Chapter 3 – Translation and adaptation of psychological interventions.

The forthcoming WHO manual will be found here in the online version of the present Manual, as soon as it will be published.

When working with migrants and displaced populations, and their host communities, the issues related to adaptation and translation become more complex and three-tiered.

The translation of the tool in the mainstream language, which is well captured in the WHO operational manual, may not be enough, because migrants and displaced people come from other cultures and may speak one or more different languages. One possible solution is to adapt and translate the protocols,

tools, training modules and supporting materials in more languages. But this is not always feasible, since several languages can be at play, and the process can become lengthy and costly.

Increasingly more often, especially in sudden onsets of emergencies, but also in protracted situations – such as the ones of the refugee camps in Greece or in Kenya – it is necessary to envisage ways that allow the counsellors to work, with the help of translators, with a client who does not speak his/her same language and comes from a different culture. This is never a neutral process, because all counselling models and psychological interventions are based on a one-to-one relationship or a one-to-a-group relationship, and the presence of a third person in the equation needs to be carefully planned and requires special safeguards that include:

- Training the counsellors in providing counselling through translation.
- Training the identified translators, who often are not professional translators, in how to translate in a counselling setting, and on basic confidentiality and active listening skills.
- Providing for the salary or in-kind support of the translator.
- Educating the counsellors in cultural diversity management. This includes two kinds of trainings, one more specific to the cultural dos and don'ts of the culture of the client, and one more on how to address the key issue of cultural diversity in the counselling session.

To receive guidance in the organization of these trainings, please contact contactpss@iom.int.

13.5 Challenges and considerations

Some of the most common issues facing non-specialists working in such situations is that these community members often share the same kinds of challenges as those they may be counselling. Personal reactions may make it difficult to provide effective counselling, requiring

a structure to be put in place for initial and ongoing training, and ongoing monitoring and **supervision**.

It is important to have a code of conduct that include guidelines for maintaining professional relationships. **Wessells (2009)**, describes the following principles for maintaining a “do no harm” approach:

- Allow time for critical reflection on ethical issues before, during and after each emergency response in order to mitigate or minimize harm.
- Develop and provide specific ethical guidelines with regard to appropriate conduct in international emergencies.
- Document and improve efficacy of MHPSS interventions in emergency contexts.
- Ensure preparedness of MHPSS workers in international emergencies.

Limited resources and capacities will determine the types of counselling programmes to be implemented, but in these situations a great deal of creativity and ingenuity often take place, and sometimes even the most useful resources and hidden capacities might emerge.

This chapter provides a broader perspective than is usually attributed to an individual model of counselling in its attention to situational and contextual factors that need to be addressed in a counselling situation, in the multiplicity of spaces and interactions in which counselling may take place, and that more informal types of counselling are often taking place spontaneously and on a regular basis. In communities, these natural processes should not be harmed and the programme shall even enhance the opportunities for these interactions to take place when possible.

Providing support (for staff welfare) and technical supervision to counsellors is important and challenging. This is addressed in the **chapter on Technical supervision**.



Box 52**Psychological first aid**

Psychological first aid (PFA) is an evidence-based approach that involves humane, supportive and practical help to fellow human beings suffering serious crisis events, provided by people in a position to help others who have experienced a distressing event. PFA was conceived as an alternative to critical incident psychological debriefing and other forms of one-off psychological interventions after disruptive events that focused on trauma paradigms and retelling. These interventions have been proved to be harmful in the medium term and are discouraged by several agencies, including IOM. PFA allows providing emotional comfort and practical support, without leading people to tell what happened to them.

It gives a framework to immediately support people in ways that respect their dignity, culture and abilities. PFA is short one-off supportive intervention and cannot be considered a counselling method or a service that can be offered several times to the same individual. If more than PFA is needed, it should be addressed with **referral**.

PFA entails different components, including initial contact with the affected person, providing safety and comfort, emotional stabilization, providing information and practical help, connecting the person with their social network, connecting the person with available services, and providing information. The PFA providers must always ensure protection from further harm for themselves and the supported people, and be prepared for the intervention, analysing the situation and gathering information beforehand.

Despite the fact that *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007) place this intervention on the third level of the intervention pyramid (focused support), for IOM PFA should be used at all levels:

- First level of intervention – basic services and security: Camp coordination and camp management (CCCM), Health and Emergency response staff, among others, should be trained in PFA, as they are commonly the first respondents in an emergency. PFA allows them to provide information and support the affected population in an effective way, preventing humanitarian intervention-induced distress.
- Second level of intervention – community and family support: PFA can be used at the community level. Groups of volunteers in the local population interested in supporting others can be trained in PFA to support their peers experiencing highly distressful event.
- Third level of intervention – focused supports: PFA is usually the first intervention for people in need of support after an emergency. MHPSS workers must be trained in PFA to help stabilize affected people before determining if further counselling or social support is needed through referral.
- Fourth level of intervention – specialized services: PFA can, in certain circumstances, be useful to offer initial support to people with pre-existing or emerging mental disorders, and their families and caregivers.

All MHPSS workers must be trained in PFA. The most common tools used for training are WHO's *Psychological first aid: Guide for field workers* (WHO, 2011) and *Psychological first aid: facilitator's manual for orienting field workers* (WHO, 2013). Additional tools can be used depending on the context ([here](#), [here](#) and [here](#)).

Although no specific MHPSS background is needed to be trained on PFA, some basic skills are necessary, such as active listening, compassion and flexibility.



FURTHER READING

Betancourt, T. S., S.E. Meyers-Ohki, A.P. Charrow and W.A. Tol

2013 Interventions for Children Affected by War: An Ecological Perspective on Psychosocial Support and Mental Health Care. *Harvard Review of Psychiatry*, 21(2):70–91.



Bragin, M.

2014 Clinical social work with survivors of disaster and terrorism: A social ecological approach. In: *Essentials of Clinical Social Work* (2nd ed.) (J. Brandell, ed.). Sage, Thousand Oaks, CA, pp. 366–401.



Nicolas, G., B. Schwartz and E. Pierre

2009 Weathering the Storms Like Bamboo: The Strengths of Haitians in Coping with Natural Disasters. In: *International Handbook of Emotional Healing: Rituals and Practices for Resilience after Mass Trauma* (A. Kalayjian, D. Eugene and G. Reyes, eds.). Greenwood Publishing Group, Inc., Westport, CT, pp. 96–106.



Nordbrandt, M.S., J. Carlsson, L.G. Lindberg, H. Sandahl and E.L. Mortensen

2015 Treatment of Traumatized Refugees with Basic Body Awareness Therapy Versus Mixed Physical Activity as Add-On Treatment: Study Protocol of a Randomised Controlled Trial. *Trials*, 16(1).



Patel V. et al.

2018 *Where There is no Psychiatrist*. Royal College of Psychiatrists.



Scholte, W. F. and A.K. Ager

2014 Social Capital and Mental Health. *Intervention*, 12(2):210–218.



For other references, see the full bibliography [here](#).



14. COMMUNITY-BASED SUPPORT FOR PEOPLE WITH SEVERE MENTAL DISORDERS



Support group for persons with disabilities at the Protection of Civilians site in Wau, South Sudan. © IOM 2018

➔ 14.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Mental disorders have a range of manifestations, but are most commonly characterized by a combination of distorted thoughts, perceptions, beliefs, emotions, behaviours and relationships with others (WHO, 2018b). When these problems last for long and/or are very pronounced, they strongly impact the life of affected persons and significantly decrease their ability to function. These are termed “severe mental disorders” and require high levels of care.

Typical examples of severe mental disorders are:

- Psychotic disorders of all kinds (including manic psychosis);
- Severely disabling presentations of mood and anxiety disorders (including severely disabling presentations of depression, bipolar disorder and PTSD);
- Severe clinical conditions due to the use of alcohol or other psychoactive substances;
- See [here](#) for more information.



The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007) also note that many of the actions to be taken to protect and support people with severe mental disorders apply for people suffering from other severe disorders and conditions, such as:

- Severe developmental disabilities (such as autism);
- Neurological disorders and neuropsychiatric conditions such as epilepsy, delirium and dementia;
- Locally defined severe mental health conditions;

- Risk behaviours commonly associated with mental disorder (such as suicidal feelings, self-harm).

According to WHO (2018b), the determinants of mental health and disorder include, “not only individual attributes such as the ability to manage one’s thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, standards of living, working conditions, and community support.”

During emergencies, according to some estimates, the percentage of people with a severe mental disorder increases from a baseline of 2–3 per cent, to 3–4 per cent (WHO and UNHCR, 2012). Emergencies not only lead to an increase in the number of people who are affected by a severe mental disorder, but the conditions of those who already had such a disorder often deteriorate (see Weissbecker et al., 2019). In addition to destabilizing existing health and mental health services, the emergency situations can deprive people of social supports and other means of coping that had previously sustained them. Families can be distressed by the burden of care, and be more stigmatized or alienated in their own communities than before the emergency. This puts people with severe mental disorders at an elevated risk of abandonment or neglect during emergencies (Jones et al., 2009).

People on the move face several stressors that can cause high levels of distress and worsen their mental well-being. Some reports in the popular media and research suggest a very high prevalence of mental disorder in migrants and refugees, with some even assuming that most migrants and refugees have mental disorders. However, the evidence base for such claims is contested because of methodological limits, and the tendency to conflate all emotional distress with



mental disorder (Rodin and Van Ommeren, 2009; **Schininà and Zanghellini, 2018**).

In fact, critical and systematic research on the prevalence and incidence of mental disorders among migrant and non-migrant populations in European studies did not find substantial differences between migrants, including refugees and non-migrants (Priebe et al., 2016). Worldwide, research suggests a higher prevalence of psychotic disorders in migrants, although the differences are generally marginal (Hollander et al., 2016). Public narratives on migration are certainly dominated by the discourse on migrants' vulnerability – how vulnerable migrants are, and how vulnerable they make societies – and such discourse may itself serve to compound the psychological problems of migrants (**Schininà and Zanghellini, 2018**).



The United Nations special rapporteur on the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health (2018) cautions against the use of “alarming statistics related to the scale of mental disorders of migrants since this can route problems in a biomedical model which may lead to less focus on policy, empowerment and investing in enabling conditions, and more on treating individual conditions, leading to ineffective and potentially harmful outcomes”.

IOM MHPSS programmes should not reinforce unhelpful and incorrect ideas that all or most migrant and displaced populations suffer from severe mental disorders or psychological problems. Words matter, and it is important for MHPSS programme managers and teams not to use language that pathologizes the psychosocial difficulties faced by migrants and crisis-affected populations, and erroneously labels a whole group as mentally ill. However, in situations of armed conflicts, natural disasters, mass displacement and migration crisis, the relatively small number of people with severe mental disorders are among the most vulnerable.

IOM MHPSS managers should therefore prioritize the responses for this group, both in terms of access to clinical care, and in other protection, such as strengthening protection measures.

The causes of most severe mental disorders are not known. Discussion on the complex interplay between biological factors and factors within the social environment in determining severe mental disorders can be found at greater length in WHO (2014) and Patel et al. (2018). As a consequence, treatment and support of people with severe mental disorders typically includes a combination of biological, social and psychological interventions. Even where pharmacological medication is prescribed, this should never be in isolation of other forms of individual and social support. Many people with mental disorders (depression, anxiety, PTSD) can be helped with psychological and social interventions alone, without medication. During emergencies, there is a well-documented risk of both undertreating and/or overmedicalizing severe mental disorders. Those with severe mental disorders need to receive appropriate care, and this care is better offered in a community-based fashion, such as:

- Avoiding hospitalization in dedicated institutions;
- Providing mental health care that is integrated in general and primary health care;
- Involving the family and other caregivers in the treatment;
- Focusing on improving social and occupational functioning of the person, if possible.

14.1.1 Global developments and best practices

A number of global guidelines strive to improve care for people with severe mental

disorders in emergencies, and these have a primary focus on facility-based care for individuals.

The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007) **Action Sheet 6.2** includes:

- Ensuring essential psychotropic medications are in emergency medical kits;
- Enabling at least one member of the emergency primary health-care team to be able to provide frontline mental health care;
- Training and supervising available primary health-care staff without overburdening them;
- Establishing mental health-care at logical points of access (in health facilities, but this can also be **through home visits or in schools and child-friendly spaces**);
- Avoiding the creation of parallel structures;
- **Informing populations about the availability of mental health services;**
- **Working with local community structures to discover, visit and assist people with severe mental disorder.**

Action Sheet 6.2 advocates strongly for integration within existing health structures and in order to do this well, community-based approaches are important (these are flagged in bold in the list above).

The WHO Mental Health Gap Action Programme (mhGAP) aims at scaling up services for mental, neurological and substance use (MNS) disorders, especially in low- and middle-income countries. The **mhGAP Humanitarian Intervention Guide (mhGAP-HIG)** contains first-line management recommendations for MNS conditions for use in humanitarian emergencies (WHO and UNHCR, 2015). It recommends that non-specialist health-care providers in primary health facilities are trained to identify and manage common

mental health conditions. The package is focused on the use of pharmacological treatment for certain disorders, but it also contains non-pharmacological elements, including brief psychotherapies and strengthening social support. The emphasis is on providing both pharmacological and non-pharmacological elements. One risk with mhGAP implementation is that these psychosocial elements may be easily ignored – because staff has limited time or training to do these interventions, leading to overemphasis on pharmacological approaches (Ventevogel, 2014). The mhGAP package is facility-based; however, trained community health workers and other volunteers can have important roles, including:

- Community engagement activities, including providing mental health awareness;
- Identification and referral of people with mental health conditions;
- Follow-up of people with severe mental disorders through home visits and practical and emotional support;
- Organizing support groups: for example, for people with epilepsy, parents of children with intellectual disabilities, and people with severe mental disorders;
- With adequate training and supervision: Providing scalable psychological interventions, such as:
 - **Problem Management Plus (PM+);**
 - **Thinking Healthy;**
 - **Group Interpersonal Therapy.**

These scalable psychological interventions are reviewed in the chapter on **Counselling**.



Box 53

Liaison with IOM emergency health teams

IOM MHPSS programme managers in the field should liaise with IOM emergency health teams to make sure that:

- IOM-run or partners' emergency primary health-care teams include a member able to provide mental health care;
- IOM-run or partners' emergency primary health-care teams are trained in PFA, and included in existing mhGAP–HIG trainings;
- Based on the existing national humanitarian mechanisms, IOM pharmacies or identified pharmacies and facilities have enough essential drugs for MNS conditions (see the full list [here](#)).



The recently revised Mental Health standard in the **Sphere Handbook** (Sphere Association, 2018) refers to the mhGAP–HIG, and emphasizes the training of health workers, provision of essential psychotropic medications and monitoring of human rights issues. The standards also recommend working with community members, including marginalized people, to strengthen community self-help and social support, and to organize a referral mechanism between health-care providers and community-based support.

14.1.2 Why a community-based approach

Global guidelines for severe mental disorders tend to focus on facility-based health care for individuals, with limited emphasis on community-based approaches. However, communities are crucial to the care and support for people with severe mental disorders and their caregivers. Two overarching principles are important:

- Taking a person focus: An individual is more than their mental health condition or diagnosis, and their individual needs and strengths remain central. When taking a community-based approach, inputs from families and the wider community are used to create effective change within individuals.
- Taking a community focus: It is also necessary to directly address the wider community system in order to protect and promote well-being, and to reduce stigma and the severity of mental disorders.

These two concepts define community-based approaches to supporting people with severe mental disorders, which include the following:

 **14.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO**

The approach and actions that need to be taken to promote community-based forms of support to people with severe mental disorders can be summarized in eight steps:

- (a) Meet lived realities at the community level through participatory, culturally-relevant assessments;
- (b) Map and build on existing community-based knowledge and resources;
- (c) Include people with severe mental disorders and their families and caregivers in planning and implementation of MHPSS programmes;

- (d) Establish community-driven referrals and follow-up (from community to health services and vice versa);
- (e) Inform the wider population about the availability of services;
- (f) Cover the full spectrum of MHPSS needs, including making sure that people with severe mental disorders and their caregivers access basic needs and community-based supports;
- (g) Actively involve community members in clinical intervention (including peer support, caregiver interventions and civil society groups);
- (h) Promote recovery at the community level.

These eight elements will be described through the course of this chapter.

14.2.1 Meet lived realities at the community level through participatory, culturally-relevant assessments



See chapter on [Engaging with communities](#).

14.2.2 Map and build on existing community-based knowledge and resources



For these items, see the dedicated section of chapter on Engaging with communities, [here](#).

In addition, while conducting mapping, it is important from the one side to look at traditional and religious systems, and on the other to make sure that mapping is accompanied by an evaluation of the human rights compliance and quality of the existing clinical services. This will include working with traditional and faith based systems, for more information, click [here](#).



14.2.2.1 Human rights and quality standards

People with severe mental disorders may be at particularly high risk of human rights violations, through abuse and exploitation, especially in emergencies. It is the responsibility of all humanitarian actors to intervene. Taking a community approach may reveal more of these violations, either in institutions, facilities or within the community. At the same time, community approaches can help key people better understand human rights of people with severe mental disorders and can reduce human rights violations. Strategies can be found at the community level to end discrimination, ill treatment or violence, and promote the right to health, education and freedom from discrimination.

Assessment and mapping of existing services and resources must include their respect of human rights and quality standards. Before starting a referral system towards an institution or service, a **WHO Quality Rights** assessment is strongly recommended, ([see assessment toolkit here](#)). IOM does not promote or facilitate referrals to institutions or services that do not respect basic quality criteria and human rights standards.

In addition, IOM MHPSS programmes do not promote or facilitate referrals to institutions or services using inhumane forms of treatment and constriction, such as chaining patients. Electroconvulsive therapy has been harshly criticized by patients' associations and human rights groups for years. In certain clinical contexts, it is accepted if provided under anaesthesia and after receiving full consent from the clients. However, in many places, these conditions are not met. In the typical displacement and migration context, in addition, it is often challenging to obtain full consent because of issues related to language difficulties, cultural misunderstanding, lack of





Support Group Session with families of people with severe mental disorders at the Protection of Civilians site in Bentiu, South Sudan. © IOM 2017

psychoeducation, referrals happening mainly in an emergency fashion, poor guardianship mechanisms, absence of families and the power inequalities often inherent in health care for migrants. In practice, therefore, IOM avoids referral of people with severe mental disorders to health-care centres that practice electroconvulsive therapy.

All the above-mentioned conditions need to be ascertained before the referrals start, during mapping, through a quality-rights and additional assessments. If a service or existing resource does not comply, IOM can start a series of capacity-building actions to bring the facility up to these standards, but must not use it in the interim. Tools 4 and 5 of the **WHO and UNHCR Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings (WHO and UNHCR, 2012)** can support processes for modifying practices to be in line with human rights principles.

14.2.3 Include people with severe mental disorders and their families and caregivers in planning and implementation of MHPSS programmes

It is necessary to continue to actively involve people with severe mental disorders, families and caregivers in the process of designing and modifying interventions and programmes. This involvement should be maintained throughout the project cycle and should be participatory in nature, and include mechanisms for ongoing dialogue already identified in the chapter on **Engaging with communities**, such as local programme committees.

14.2.4 Establish community-driven referrals and follow-up

Many people with severe mental disorders fail to come for formal treatment, or drop out of treatment, because of isolation, stigma,





fear, self-neglect, disability, poor access or because services are perceived as socially or culturally inappropriate (IASC, 2007). Once existing attitudes, sources of care and resources are well understood, it is possible for programmers to develop and agree on effective mechanisms to support people to access care.

Robust referral and follow-up mechanisms can be established with identified community personnel, including resource persons, traditional/hybrid and faith-based healers and other influential persons. Interventions may choose to establish more “formal” referral and follow-up mechanisms that are community-based but act as an extension of facility-based interventions: for example, health-care workers themselves, trained community-based workers or volunteers providing home visits and/or supporting home-based care.

Two-way referral pathways (for example, community–facility and facility–community) can also be agreed with community-based resources, working with traditional and faith-based healing systems. Facility-to-community referral pathways are a necessary component of the mhGAP–HIG. Cross-cutting the treatment guidelines is the need to refer to community-based social or protection services, shelter, food and non-food items, community centres, self-help and support groups, income-generating activities and other vocational activities, formal/informal education and child-friendly spaces or other structured activities (WHO and UNHCR, 2015).

Families, peers, and the wider community are also crucial points of referral, and are necessary for effective follow-up for those with severe mental disorders.

composed of a psychiatric nurse, a social worker and a driver, or similar professionals or activists who are appropriately trained and supervised. Team members are usually sourced from the affected communities and therefore can act as community catalysts for referrals. **These teams** may include translators or cultural mediators during migration crises. They are tasked with:

- (a) Identifying people with severe mental disorders;
- (b) Receiving referrals of people with severe mental disorders from the PMTs, families and/or other partners;
- (c) Facilitating appointments for people with severe mental disorders to the closest care facility, avoiding institutionalization to the extent possible, always preferring outpatient care, and limiting inpatient care to the minimum when the conditions of the client or the logistics of the movement do not allow outpatient care;
- (d) Following up with the client in the community, especially:
 - (i) Checking on whether medication protocols are being followed;
 - (ii) Supporting social needs through referral;
 - (iii) Supporting caregivers in their role, through psychoeducation and counselling;
 - (iv) Making sure that a continuum of care is granted, linking the client and the caregivers with the various activities offered by the PMTs at recreational, socialization, artistic and counselling levels;
 - (v) Organizing peer-support for caregivers ((iii), (iv) and (v) are discussed further below).



The IOM **PMT model** should include, when resources allow, separate and dedicated Referral Teams. Referral Teams are usually

Box 54
People living in institutions in emergencies

Emergency contexts can affect the integrity of existing institutions. As the IASC MHPSS Guidelines highlight: “Some people with severe mental disorders living in institutions are (too) dependent on institutionalised care to easily go elsewhere during an emergency.”

In emergencies, those previously living in institutions may find themselves in the community once again. Key recommended steps from **Action Sheet 6.3** include:

- Make sure one agency takes responsibility, ideally in supporting the government, for supporting people living in institutions.
- If they remain open, protect the dignity and rights of the people there (see section 14.4.2.2) and ensure that ongoing basic health and mental health care is available.
- If temporarily closed (because of, for example, an earthquake) or abandoned by health-care workers, mobilize community resources by discussing with community leaders the responsibilities of the community in providing a supportive and protective network, which may include health-care workers, community health workers, informal health providers (such as religious leaders, traditional healers), social workers, community groups and family members.
- Provide these community networks with basic training and close ongoing supervision on, for example, crisis management and ethical use of constraints.

In certain situations, psychiatric institutions may remain open, even if damaged, and people with severe mental disorders, further disabled by long stays in these often-residential facilities, may remain to live in the damaged premises. As such, they will be in need of shelter, food, water, sanitation, clothing and essential medical and psychiatric care.

In Haiti, following the 2010 earthquake, residential psychiatric facilities physically collapsed, but a sizeable number of residents remained inside living inside the ruins. Most service providers could not reach the facility for days. In such situations, IOM would consider the psychiatric facility area as a camp, extending to the residents all services provided in priority camps under the Camp Coordination and Camp Management Framework, until other more sustainable solutions are found.


14.2.5 Inform the wider population about the availability of services

For referrals, awareness must be raised with the wider community about the content and availability of services.

Community resources may be used in the dissemination of this information, as information coming from a trusted source is more likely to be believed and acted upon. In IOM, the dedicated Referral Teams can organize sensitization and information workshops, the PMT will provide this information during workshop and events, and clear information about existing mental health services for people with severe mental disorders will always be visible at the MHPSS hubs. More information on raising awareness and advocacy can be found in the **WHO mhGAP Operations Manual** (WHO, 2018e).

Box 55
Availability of services

Sensitization around the availability of services should be carried out with consideration to “supply” meeting “demand”, to avoid frustration and, more importantly, inconsistent access to treatment. Community- and facility-based approaches therefore complement each other.

14.2.6 Cover the full spectrum of MHPSS needs

In humanitarian settings, basic services, social structures, family life and security are often disrupted. People with severe mental disorders are often confronted with these extra challenges to their daily routines and basic self-care. The physical health needs of people with severe mental disorders can often be ignored, despite evidence that they can live 10–20 years less than the rest of the population (WHO, 2018a). Therefore, all layers of the IASC MHPSS Guidelines (IASC, 2007) pyramid are crucial to consider, and special considerations are likely necessary for the bottom layers – access to and social considerations of basic services and security, and strengthening family/community supports (which are largely community-based in approach) – to be adequately met.

The mhGAP–HIG highlights the need to support people with severe mental disorders to safely access services necessary for survival and for a dignified way of living – such as water, sanitation, food aid, shelter, livelihood support – through the following actions:

- Advise about the availability and location of basic services and security mechanisms;
- Advise about basic self-care (nutrition, physical);
- Actively refer and work with the social sector to connect people to social services (such as social work-type case management);
- Advise about security issues when the person

is not sufficiently aware of threats to security (WHO and UNHCR, 2015).

People with severe mental disorders may also require additional help to access culturally appropriate community and family support, which is well covered in this chapter. Participation in mainstream programmes should be enabled, and recreational activities, other sporting activities, and computer and literacy classes can be provided (UNHCR, 2018a).

The above should be supported by IOM PMTs for people with severe mental disorders, including through social work-oriented case management and referral to other activities organized by the PMTs. The IOM PMTs model should be tasked with making sure that a continuum of care is provided when linking client and caregivers with the various activities offered by the PMTs at the recreational, socialization, artistic and counselling level.

14.2.7 Actively involve community members in clinical intervention

A number of intervention models for severe mental disorders are community-based, actively involve community members and are appropriate for use in emergency settings. Three examples are given below with reference, where possible, to useful toolkits for implementation. In addition, please click [here](#) to know more on how to engage spiritual and traditional leaders in the provision of CB support for people with severe mental disorders.


14.2.7.1 Peer support

Peer support has been widely used in mental health, as it (a) creates a safe environment to freely express and share emotions and thoughts about one’s current situation and challenges; (b) allows one to learn from other similar situations; (c) creates the occasion to build new relationships and reinforce social support networks; and (d)

helps group members to access resources and support (WHO, 2017a).

For peer support groups for people with severe mental disorders, see [WHO, Creating peer support groups in mental health and related areas](#) (ibid.).

Individualized peer support is a form of one-to-one support provided by a peer with the experience of having a mental health problem and of recovery, to another peer who would like to benefit from this experience and support (ibid.). Guidelines for providing individualized peer support can be found [here](#).

UNHCR (2017) describes engaging individual refugees as volunteers to support other refugees. With adequate training, supervision and support, refugees can successfully provide culturally appropriate support, given their deep knowledge of their communities. The Guidelines describe how “the engagement of refugees is also key to building their own self-esteem and dignity, and strengthens their ability to cope with their own problem”, and can be found [here](#).

Box 56

Cross-cutting issue – Stigma and discrimination

Community-level stigma and discrimination create additional barriers for people with severe mental disorders, with negative effects on their mental health. This stigma at times includes biased discourses that consider people with severe mental disorders evil, dangerous, criminal and so on. Since migrants and refugees are often stigmatized as such, severe mental disorders in refugees and migrants can cause stigmatization and prevent affected people and their caregivers from seeking help. One could have several strategies to combat stigma.

For guidelines around managing stigma, [The International Federation of Anti-Leprosy Associations](#) has developed [a series of guides](#) for managers, health workers and social workers, which have been applied for use in mental health.

Other strategies involve:

- Ensuring that community members are actively involved: As described throughout this chapter, this can increase understanding and produce more “mental health advocates”.
- Awareness-raising: [The WHO campaigns on depression](#) can be considered a valid tool in this respect.
- Involving people with lived experience of severe mental disorders.

IOM PMTs should address the stigmatization of mental disorders through:

- Including people with severe mental disorders in their [livelihood](#), [sociocultural](#) and recreational and [sport and play](#) activities;
- Organizing anti-stigmatization campaigns and talks in the community, especially following reports or incidents of stigmatization;
- Ad hoc events, such as the celebration of Mental Health Day in Nigeria.

Sourcing team members from both the host and the displaced community can help incorporate local knowledge to address stigma and to avoid socially inappropriate discourses.

Box 57
Language and cultural considerations in specialized mental health care

Cultural considerations in globally recognized focused and specialized interventions must be strengthened, especially when working with migrants and displaced populations who speak different languages and come from very different cultural backgrounds. Models such as mhGAP, when culturally adapted in a country (see the [mhGAP Operations Manual](#) (WHO, 2018e)) will usually be adapted to the mainstream culture of that country, not considering the squared cultural complications of working with minorities, subgroups and migrants who do not speak the local language or share the local culture. Those delivering focused and specialized interventions may not be equipped to appreciate that cultural expressions of mental disorder can vary and are easily misinterpreted, especially during emergencies, or to work through an interpreter–translator.

MHPSS programme managers should consider the following activities based on needs:

- Including a module, in coordination with WHO and UNHCR on working with migrants and in translation within the mhGAP–HIG trainings.
- Organizing short trainings in mental health and population mobility, and working with translators for existing mental health services in the referral mechanism: For training content, contact the IOM MHPSS Section at contactpss@iom.int.
- Training a group of migrants with knowledge of both the origin and the local language as mental health mediators: For training content, contact the IOM MHPSS Section at contactpss@iom.int.
- Adding a translator to the dedicated referral teams or directly seconded to mental health services mostly used by certain populations of migrants.
- Working with translators is neither easy nor neutral, and requires preparation and safeguards. For more information see [here](#).


14.2.7.2 Caregiver interventions

Families and caregivers are crucial to the well-being of individuals with severe mental disorders. Considering this crucial role, there is space to build their support capacity. For reference, see WHO (2015b), [Caregiver skills training for the management of developmental disorders](#).

The UNICEF (2018) Operational Guidelines: *Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families* (field test version) also offers guidance for supporting parents and caregivers.

The tasks of dedicated referral teams within the IOM PMT model should include, when resources allow:

- Supporting caregivers in their role, through psychoeducation, support groups and counselling;
- Organizing individual and peer support for caregivers themselves.

In terms of support directed at the caregivers themselves, the mhGAP–HIG recommends the following steps:



- Ask the caregiver(s) about their concerns, capacities, physical and psychological well-being, and their own social support system.
- Give them information on relevant community services and supports, and discuss respite care (another family member or a suitable person can take over the care of the person temporarily).
- Refer them to PMTs to offer basic stress management, and encourage them to access their social support or, if needed, provide more focused support.
- Acknowledge that it is stressful to care for people, but stress to them that it is important to continue doing so (WHO and UNHCR, 2015).

Box 58
Peer support in Kenyan refugee camps

Previous patients of the hospital's mental health clinic signed up as "volunteer refugee workers" to support follow-up of current patients. They were of special value when individuals and families disengaged with treatment by making home visits to collect and address concerns, offer basic social and emotional support, and act as a bridge between the health facility and the community. They also served as a powerful "anti-stigma" tool by providing an example that individuals are more than their mental health condition, and that working productively and living well is possible.

14.2.7.3 Multifamily psychoeducation groups

One of the most promising evidence-based counselling approaches is the multifamily psychoeducational group. One example of this family and community resilience-based approach was implemented in post-war Kosovo¹ during the months following the cessation of conflict. The Kosovo Family Professional Educational Collaborative, a team of mental health professionals from the University of Pristina School of Medicine and the American Family Therapy Academy, developed a multifamily psychoeducational approach focused on allowing people with severe mental disorders to live in the community under the care and supervision of family members. The groups strengthened the capacities of families to care for members with severe mental disorders by helping them understand the nature of mental disorders and develop skills to provide home care. They also helped the families develop a support system by meeting with other families who were faced with similar challenges. The multifamily groups included presentations on psychiatric symptoms and the clinical course of chronic mental disorders, medication use and side effects, the role of psychosocial factors in precipitating or preventing relapse, responses to common problems and crises, and resilience-building approaches to severe mental illness. **See Weine, Ukshini, Griffith, Agani et al. (2005)** for further details on the group process and session topics.


14.3.8 Promote recovery at the community level

The meaning of "recovery" from a mental disorder can vary among different people. For many, it is not only about being "cured", but "regaining control of their identity and life, having hope for their life


¹ References to Kosovo shall be understood to be in the context of United Nations Security Council resolution 1244 (1999).


and living a life that has meaning for them, whether that be through work, relationships, community engagement or some or all of these” (WHO, 2017).

Key components of recovery can include inclusion, relationships, meaning and purpose, dreams and aspirations, control and choice, managing ups and downs, and positive risk-taking (WHO, 2015c).

Activities that promote recovery may be most effective when delivered at the community level. Two examples are given below.


14.3.8.1 Vocational and economic inclusion

Different types of interventions that enhance vocational inclusion and employment are often labelled as “recovery-orientated” (Slade et al. 2014). **Livelihood interventions** have also been used for people with mental disorders. 

WHO (2015c) concludes that recovery-oriented strategies enhancing vocational and economic inclusion should be contextualized to their social and cultural environment. For more information, [see hyperlink](#). 


14.3.8.2 Independent living

People with psychotic disorders have a high risk of homelessness and housing instability (Fazel et al., 2008). The facilitation of assisted living, independent living and supported housing can act as a base from which people with severe mental disorders can achieve numerous recovery goals (Slade et al., 2014).


WHO (2015d) advises that interventions are culturally and contextually appropriate, consider local resources and local cultural norms, and involve people, their families/caregivers and wider community in their design and implementation. For more information, [see link](#). 

FURTHER READING


Jones, L., J.B. Asare, M. El Masri, A. Mohanraj, H. Sherief and M. Van Ommeren

2009 Severe mental disorders in complex emergencies. *The Lancet*, 374(9690):654–661. 

Tungpunkom, P.


2012 Life skills programmes for chronic mental illnesses. *Cochrane Database Systematic Review* (1). 

Weissbecker, I., F. Hanna, M. El Shazly, J. Gao and P. Ventevogel

2019 Integrative Mental Health and Psychosocial Support Interventions for Refugees in Humanitarian Crisis Settings. In: *Uncertain safety. Understanding and assisting the 21st century refugees* (T. Wenzel and B. Drozdek, eds.). Springer, New York, pp. 117–153. 

World Health Organization (WHO)

2018b *Mental Disorders*. WHO, Geneva. 

For other references, see the full bibliography [here](#). 

15. TECHNICAL SUPERVISION AND TRAINING



I. TECHNICAL SUPERVISION

→ 15.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

In IOM MHPSS programmes, “technical supervision” refers to bringing skilled supervisors, PMTs and other MHPSS teams together, in order to reflect upon the work. It is a process of support and reflection, and is separate from managerial performance appraisal. It is about empowerment and relationship, not control. In this sense, it is different from the way in which “technical supervision” is understood in other fields, where it includes a component of monitoring programme standards.

The overarching principle guiding technical supervision in the field of CB MHPSS is that of improving the quality of the offered services and preventing harm to affected individuals and communities receiving those services, as well as to the staff involved. Technical supervision addresses the intersection of the personal and professional development of the **supervised staff**. Technical supervision must be coordinated and integrated with managerial supervision, in order to maintain a functional programme.

- Staff support: The MHPSS teams are given the opportunity to talk about their difficulties on the job. It is important to remember that, in emergencies, some MHPSS staff experience a formal role of helper for the first time. Even when they are experienced helpers, they are confronted with new factors, and are continually hearing stories of difficult experiences that are new to them.

Box 59

Staff care

Members of the MHPSS teams might be survivors themselves or might face contextual challenges similar to the ones their clients are experiencing. For personal support to the staff, supervisors should coordinate with the managers and the Staff Care Unit of the Organization. IOM staff can refer to the Organization’s Occupational Health Unit at swo@iom.int. Technical supervision is indeed an essential part of staff care, but it is not the only element of holistic staff care in emergencies, which is also based on human resources policies and personal support.

15.1.2 Whom technical supervision is for

Technical supervision is necessary for both new and experienced MHPSS staff, ideally at all levels (service providers and supervisors themselves). Many staff are living a double role, being helpers (work life) as well as people affected by the emergency (personal life). Providing supervision at all levels ensures support to MHPSS teams and improves skill levels, but it also demonstrates a culture of learning and self-reflection when supervision is for everyone.

15.1.1 The objectives of technical supervision

Technical supervision pursues two main objectives:

- Professional standards: Supervisors assist the PMTs and MHPSS teams to learn from their experiences and to progress in expertise, as well as to ensure quality service provision to the individuals to whom they offer services. This includes both skill development and ethical accountability. This way of providing technical supervision is linked to individual staff well-being, and can help ensure better client outcomes.

15.1.3 What technical supervision is about

In practical terms, technical supervision consists of MHPSS teams meeting regularly with a skilled supervisor to discuss individual clients, groups, community-based interventions and any other MHPSS activities they perform, in a **structured** way. It also includes on-the-job training. Supervision should be considered a mutual sharing of questions, observations and speculation to aid in the selection of alternatives to apply in practice. The MHPSS teams can bring up questions about the cases (which may be individual clients, families, groups or communities), or activities they are having difficulties with, and about how the assistance they are providing can be improved. Likewise, the supervisor can bring questions that can help the MHPSS staff to critically review and analyse what they are doing in their practice, with an aim to strengthen services. In addition, the supervisor will collaborate with the managers in designing a training plan for the team that results from the gaps and problems that emerged during the supervision.



More specifically, the supervision may focus on:

- The methods and modalities of the MHPSS work;
- Concerns the MHPSS teams have in relation to any aspect of an MHPSS activity;
- Lack of progress or difficulties with a case activity;
- Awareness of the potential impact of the MHPSS team members' personal values on their practice;
- Identification of any negative impact on the MHPSS teams from a case they are managing, and self-care strategies;
- Issues related to establishing and maintaining appropriate boundaries with the affected population;
- Issues related to team dynamics;
- Ethical and professional practice and compliance with codes of conduct;
- Professional identity and role development;
- Skill and knowledge development.

It is important to differentiate between technical support and personal support in the supervision process. It can still be helpful for workers to seek their own personal support, but it is important to be clear that the technical supervision process is related to work issues. This is due to a number of reasons, including respecting the workers' personal boundaries and avoiding dual relationships; the power dynamics of potentially fearing losing one's job due to personal issues; and the fact that staff care should be considered an organizational duty and not a responsibility of each project or programme, which may create an unequal offer of personal support opportunities among staff members working for different programmes in the same **mission**.



15.1.4 Technical supervision: What it is and what it is not

Figure 13 shows what technical supervision is and what it is not.

15.1.5 Requirements of technical supervision

The requirements of technical supervision include the following:

(a) Technical supervision is embedded in a culture of respect and support: It is important to clarify that the objective of supervision is grounded in the organizational responsibility to support the worker and the client in providing and receiving a service that is more likely to meet quality standards and avoid harm, rather than serving as a way to criticize or check somebody's work. Technical supervision, as pointed out before, inscribes itself in the broader context of staff care and staff development, which represent an organizational responsibility.

(b) Technical supervision provides a learning environment: It becomes by default a way to educate staff on the job in a participatory fashion. In addition, through the supervision, the technical supervisor can identify gaps in knowledge or skills that the teams need to fill, and suggest that management organize additional training or education accordingly.

(c) Technical supervision is a space to grant fidelity and innovation to the model: Supervision can ensure that the MHPSS teams provide the intended interventions. There are reasons that the intervention is structured the way it is, and it can be important for the worker to provide the essential components in specific ways. This is a part of ensuring the quality of services for the clients. However, it is also often necessary and helpful to adapt the intervention based on the client's needs or the MHPSS staff skills. If there are new techniques that the MHPSS staff members have learned or prefer implementing, or if there are

Figure 13: Yes and no of technical supervision

What technical supervision IS	What technical supervision is NOT
It should aim to create a safe place, where MHPSS staff can feel comfortable to talk about the technical aspects of their jobs, discussing freely any challenges they might be having. It should be a support-ive and encouraging space that facilitates growth and allows mistakes.	It is NOT a performance management tool that will be used to evaluate performance in managerial terms.
It should be entirely dedicated to the technical aspects of the work and how they affect the staff well-being.	It is NOT a space spent on administrative issues and complaints such as pay raises, days off, disciplinary actions or dead-lines.
It is time spent discussing the difficulties associated with the role of the MHPSS team members, especially for those cases where the professional side cannot be easily separated from personal issues, such as when a staff knows its clients privately outside of work. Technical supervision diminishes the possibility that difficulties and dilemmas will affect the personal well-being of the MHPSS team member.	It is NOT in itself a space to discuss personal issues that are unrelated to the cases or the MHPSS activities.

ways of acting within the community that they have been taught, technical supervision helps to ascertain that the learned services are correctly incorporated into the service or intervention. Additionally, technical supervision can serve as a place for feedback on the intervention model itself. The model can be questioned as to whether it is a true reflection of the needs encountered in the field, or if it is a best fit in the experience of the teams. This is an ethical dilemma that, if emerged, needs to be addressed at different levels, and in conjunction with feedback from the monitoring and evaluation system. The manager and the supervisor should establish a mechanism for feedback that is responsive to potential changes and can inform management decisions and future project development.

15.2 WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

Programme managers should address the following:

- (a) **Accountability:** Technical supervision should be kept distinct from management supervision. This means that, while designing a project, a position should be created for a technical supervisor. In IOM, the technical supervisor responds to but is distinct from the project manager. For some other agencies, often for budgetary reasons, this can be a unique professional covering the two roles. Supervisory sessions will also concern managerial aspects and administrative issues.
- (b) **International or national supervisors?** Depending on the size of the operation, the supervisor can be a dedicated international professional or a dedicated national expert, or a team of national experts. When the size of the project allows the hiring of an international expert, it may be good to pair him or her with a national expert who can bring a more culturally apt perspective to the supervision. Nevertheless, this cannot be the standard approach, because in some contexts – such as situations of civil and tribal conflict, conflictual community dynamics, or discrimination or mistrust within the community – PMTs and MHPSS teams may perceive an international supervisor as more neutral and trustworthy. In case the size and budget of the operations or other logistical constraints do not allow the deployment of supervisors, the option of remote supervision (for example, by Skype) should be considered ideally accompanied by an inception and closing face-to-face meeting.
- (c) **One or more supervisors?** The principal supervisor can coordinate other technical supervisors who are more specifically competent in certain models or practices engaged by the programme. As already mentioned, the supervisor will collaborate with the managers in designing a training plan for the team that results from the gaps and problems emerged during the supervision. In this sense, he or she will support and coordinate the identified expert trainers in devising a contextualized **plan**.



Box 60
How to structure a technical supervision meeting

Plan and notify in advance the supervision meeting, inviting the participants according to the chosen model – individual, group, peer – and the form, in person or remotely. In case of individual supervision, collect in advance if possible all the information about the case the psychosocial support worker wants to discuss. In case of group supervision, choose or verify that the location can be sufficiently spacious and free of distraction. Place a number of chairs in circle according to the number of the participants. In case of peer supervision, decide who is going to manage the flow of the meeting.

Physical set-up:

In case of individual supervision: A room, two chairs placed equally. In case of remote supervision, ask the supervisee to limit all distractions, and provide PCs, connection to the Internet and a Skype-like programme.

In case of group supervision: A room, chairs, white papers, a clipboard. In case of remote supervision, a widescreen PC, connection to the Internet and a Skype-like programme.

In case of peer supervision: It is the same as for groups.

Time required (approximately):

From a minimum of one hour to a maximum of two hours.

One time per week, or once every other week at a mutually scheduled, predetermined time.

Flow of the meeting:

The supervisor invites the participant or one of the participants to share the information about a work case in a narrative form. He/she then invites the participants to comment on what has been heard and provides comments on the roles and the actions performed, and the effectiveness of the choices that have been made, and proposes alternatives in a judgeless way.

Important concepts to maintain throughout the technical supervision:

- “Do no harm”;
- Non-judgement;
- Empowerment;
- Self-care.

Sample of a supervision session breakdown:

- Brief introduction of the supervisor and of the supervisees;
- Brief check-ins or small talk to create the atmosphere;
- Link to the previous supervision session, if necessary;
- Invitation to bring up a question, dilemma or specific work case;
- Invitation for the participant/s to comment;
- Paraphrasing what has been told;
- Evaluation of the actions taken;
- Proposition of alternative views and actions;
- Invitation to ask questions and answer the questions, promoting interaction;
- Recap of the most important points;
- Closure of the supervision session;
- Planning of the following session.



15.2.1 Modalities of technical supervision

Technical supervision must be flexible in order to meet the needs of MHPSS teams, also considering the different stages of their work experience. It can be provided mainly in **individual or group settings**:

- (a) Individual supervision: It can be offered at a regularly scheduled time, or when a specific need emerges for it. It gives full attention to the MHPSS worker and affords more time to discuss specific issues, particularly how a specific case affects the worker.
- (b) Group supervision: This is often offered at a regularly scheduled time. The entire supervised group is present, and the supervision is offered to all members of the group or, conversely, teams can be offered supervision being divided per location, or per role within the team (for example, counsellors by themselves, or educators by themselves). This allows the MHPSS workers to know what others besides themselves are also facing, and thus bring in the sense of confidence that he/she is not alone. Supervision provided in a group promotes peer learning and support.

Box 61

Technical supervision of PMTs in IOM Nigeria

In north-eastern Nigeria, technical supervision is provided to IOM MHPSS mobile teams on a weekly basis. Due to the large number of MHPSS teams, with 120 members deployed in three of the most affected states – Borno, Adamawa and Yobe – technical supervision is provided by one international and two national MHPSS specialists. Standardization and the quality of the supervision among the supervisors are ensured by the international supervisor, who has the role of supervising the other supervisors, with support from the MHPSS programme manager, who is an experienced MHPSS expert. Technical supervision is also offered by IOM specialized staff or expert network on specific themes or models of work, upon request of the MHPSS supervisor.

The supervision sessions are provided on a weekly basis (every Friday) for a period of two to three hours, depending on the number of team members involved in the specific session, and the relevance of the issues presented or raised for discussion by the teams or the supervisors. The location is usually an IOM office meeting room, where flip charts, markers, paper and notebooks are available to facilitate the discussion.

The supervisor starts the session by emphasizing self-care, confidentiality and “do no harm” principles for the discussion. He or she then introduces and explores the main subject of the session, which can be a case, an activity or a dynamic that emerged the prior week. The subject of the session is chosen by the supervisor based on the written reports received the week before from each team. On some occasions, the same subject can take up to three supervisory sessions. In this case, the team members provide an update on how the issue is progressing, also based on changes implemented based on the supervision. Staff members are asked to prepare the discussion of the cases–activities beforehand, in order to maximize the support they can receive. The session has plenary and group work components, and sensitive issues may be further discussed in smaller groups. This forum is important for all teams to interact, learn, suggest alternative views and enhance their skills. A part of the session is dedicated to feedback on main challenges faced in the field the current week. A recap of the main points discussed and a few updates close the session. Skills gaps and training needs are identified by the technical supervisors, discussed every third session with the teams, and then shared with the programme manager to inform training plans.

- (c) Peer supervision: This is a form of supervision where the participants have the same role and approximately the same expertise. The group is not directed by a supervisor and so this kind of supervision works well with “mature teams” that have worked together for a certain period. It should never be the first choice, as individual and group supervision are to be preferred for the first stages.
- (d) Remote supervision: Although face-to-face clinical supervision is the preferred method of delivery, other methods of clinical supervision delivery – including email, video, audio recording or teleconferencing – may be employed where necessary. The use of these alternative methods may be particularly necessary for MHPSS teams working in rural and remote locations. The frequency of remote supervision sessions should be the same as in the face-to-face modality.

Box 62

Remote supervision

In case face-to-face supervision is logistically impossible, or additional supervisors who are located elsewhere need to be consulted, remote supervision by **Skype**, Phone, Bluejeans, or other Internet-based solutions, can be offered as a viable alternative.



15.2.2 Frequency of technical supervision

Technical supervision should be offered at the following frequency:

- (a) Individual supervision: At a regularly scheduled interval, and/or every time a need emerges. Duration: 1–1.5 hours.
- (b) Group supervision: Every week at the beginning and every second week after the initial phase. Duration: 1.5–2 hours.
- (c) Peer supervision: It is up to the group to choose the frequency of what can also be

termed “intervision” meetings. It is suggested at least every second week. Duration: 1.5–2 hours.

15.2.3 Competencies of technical supervisors

Becoming an effective and fully competent technical supervisor is a developmental process. The competencies of supervisors must include:

- Skills:
 - Demonstrated mastery of the intervention being provided;
 - Communication;
 - Conflict resolution;
 - Group facilitation;
 - Supervision techniques;
 - Team-building;
 - Development of the supervisory relationship;
 - Responsiveness to changing needs of supervisees;
 - Compassion and supportiveness.
- Knowledge:
 - Group dynamics;
 - Ethical regulatory issues;
 - Evaluation tools and processes;
 - Supervision methods;
 - Conflict resolution and facilitation;
 - Self-care competences.
- Attitudes:
 - “Do no harm” approach;
 - Non-judgmental;
 - Empowering and strengths-based;
 - Patient and empathetic;
 - Open to receiving feedback;
 - Open to **improving skills**.

More specifically, a technical supervisor in the MHPSS field should know how to leverage diversity to be able to create an inclusive environment, manage conflicts in order to keep people in dialogue as means to build trust and unity, and balance between methodological adherence and emerging needs.



15.2.4 Supervision approaches

In the context of community-based projects, two efficacious supervisory approaches are:

(a) Systemic supervision is based on the system approach to supervision, which is derived from social work models of supervision in non-humanitarian settings. It identifies different dimensions of supervision:

- The supervisor;
- The supervisees;
- The organization;
- The affected population;
- The supervisor's functions;
- The learning tasks of the supervisees.

The model encourages supervisors to recognize and to show the supervisees the importance of cultural factors, and draw attention to how they interact with other contextual factors. The supervisor's main tasks are:

- Technical counselling;
- Case conceptualization;

- Supporting in finding a solution;
- Instructing and advising;
- Consulting and exploring.

During the supervision session, space is given to sharing beliefs, feelings and thoughts of the supervisees, and to the search for practical solutions to concrete issues. For a theoretical view of the system approach to supervision, see the book *Clinical Supervision Essentials*.



(b) Consensus methodologies build on the awareness that valuable knowledge is gained by supporting the reflection process of professionals. It is based on experiential, reflective learning as an important source for developing professional expertise. This form of supervision is valuable for more mature groups, and is not the first option. See a case study on best practice in care and protection of children in crisis-affected settings.



15.2.5 How are the supervisors trained and supervised

The supervision of supervisors assists technical supervisors to meet their learning, accountability and support needs. It should be provided by one or more individuals who have a high level of demonstrated competence in the contents of the programme as well as in the provision of practical supervision. In IOM, technical supervisors are managerially accountable to the project managers of the relevant MHPSS project, who are technically accountable to the global MHPSS Section, which will provide supervision directly and through referral to its international expert network.

PMT leaders can be trained by technical supervisors to supervise the teams more closely at the field level, especially in areas where access is limited. The technical supervisor tasks include the identification of the training needs of team leaders and the organization of **training sessions** for them.



Box 63

Systems model of staff stress management

Humanitarian work presents an array of different stressors. There are inherent stressors reflecting the content of the work, such as exposure to gruesome sites, onsite dangers, and powerlessness in not being able to apply the level of help needed. Non-inherent stressors occur at the team and managerial levels, including: lack of skills or training needed to do the job, poor role definitions/unclear expectations, unnecessarily bureaucratic agency policies, and conflict and mistrust within the team. Particularly, national staff commonly work at the intersection of these multilevel stressors, which often remain overlooked by the organizational strategies. Thus, in order to address these various levels of stressors, a non-traditional stress management model is needed that looks beyond individual self-care. The systems model of staff stress management is both systematic and multisystemic, focusing on building resilience across three dimensions. The first dimension builds a response across all the stages of stress over time: prior to the stressor occurring, when it occurs, and after the stressor has ended. This response may work to prevent or reduce the intensity of the stressors through decreasing workloads, reduce the vulnerability through training workers or developing team cohesion, and improve coping mechanisms. Second, the model works to build resilience across all socioecological levels – individual, family, team, agency and the larger community – as a systemic policy, not just a series of actions. The third dimension of stress and risk reduction applies to those working on interventions at each phase of deployment, including careful staff selection, predeployment training, in-field support, transitional support, technical supervision and follow-up support postdeployment. Technical supervision is a part of a systems model of staff care, but only a part of it (Saul and Simon, 2016; Antares Foundation, 2005).

Figure 14: Systems model of staff stress management: Dimensions



II TRAINING

15.3. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

The subjects of specific training programmes related with each of the activities presented in this manual are discussed in the respective chapters. This chapter will instead describe the process of designing trainings within a CB MHPSS programme in IOM. Training is a necessary component of a CB MHPSS programme in any emergency situation. This is true on the short term, since people in emergency are usually asked to respond to situations that are novel to them, and that challenge their existing capacities. In addition, in the specific field of MHPSS, the emergency may catalyse needs and therefore may require capacities that were not present altogether before the crisis took place. In order to be able to respond with quality, helpers, including those with MHPSS functions, often need training and technical support.

Training and capacity-building offered during the emergency phase are a programmatic necessity on the short term, but they do provide the nexus between emergency humanitarian response, preparedness and long-term development, because they create skills that can be reactivated on the mid-term, and contribute to the overall resilience of a community, including long-term mental health system strengthening. Training indeed focusses on supporting the agency of affected people. The success of an international CB MHPSS intervention in an emergency is determined by the quality and scope of technical knowledge and support the relevant programme is able provide to local formal and informal respondents, both those employed or engaged by the organization's MHPSS programme, and those in the larger community of practice.

Training can indeed play a double role in CB MHPSS programmes. From the one side it is addressed to those working on the programme, being part of the organizational implementation process; on the other, training addressed to external actors can be a programmatic activity or a specific deliverable of the programme.

Process training that is part of the process of implementing a CB MHPSS programme include:

- Training for the staff of the programme;
- Training for other units of the organization, whose job is connected with the CB MHPSS one;
- Training for implementers and partners on how to (better) perform activities to deliver under the programme;
- Training for the sector under which the programme is implemented;
- Training for the technical supervisors;
- Training for MHPSS programme managers.

Training that is delivered as an activity or a deliverable of the programme, includes, for example.

- The organization of Master's, Diploma, Certificate programmes on MHPSS related disciplines and capacities for a wider community of practice in a country;
- The organization of trainings in a certain counselling method, in a psychological intervention or an art-based MHPSS technique, to enhance the general capacity of a community to respond to a situation;
- MHgap **trainings** for health workers in certain areas;
- **PFA trainings** for professional associations or humanitarian sectors not directly involved in the programme activities as agents;
- Transcultural trainings for psychiatrists in high migration or high displacement areas.

This differentiation is not necessarily rigid.



Internal trainings for the staff of the programme can be opened to the staff of government institutions, partner organizations, civil society actors and activists, whenever this is appropriate, reaching a wider impact. Likewise, trainings implemented as an activity of the programme, can involve a defined number of internal MHPSS programme staff on top of the external participants, enhancing the programme's capacity to respond.

Process trainings tend to be focused on the capacity-building necessities of a programme as it was designed, while trainings as programme activities are designed to reach a wider capacity-building objective aimed at covering important capacity gaps in the countrywide MHPSS response systems, identified through needs assessments and mapping.

Of importance, a community-based approach to training in MHPSS does not aim to impose hierarchical practices or ready-made tools, but to create new models of collaborative intervention between the organization, the expert trainers and the students-practitioners, that need to be participatory and adapted to the specific situation. Local, community-based ownership and a sustainable approach stem from this basic model of work.

The range of what is usually included under the vast definition of training goes from inductions of a few hours, aimed at passing essential procedural, professional or academic information, to Executive Master programmes, that engage participants for several months on a subject matter, building their skills, understanding and capacity to operate in a specific technical domain of MHPSS.

It is impossible to account for all the modalities of trainings one can employ in a MHPSS programme in this manual. These will be largely determined by a combination of various factors including duration, scope, available resources, existing skills on which the training builds on, and others. In general, it is important to be

aware, while designing MHPSS programmes of the relation between training objectives, methodology and duration. By instance, if one works in a locality where none has been ever trained in MHPSS-related disciplines and no foundation skills exist, and programme resources allow to organize one day of training only, then this can be a training on PFA, but not on counselling skills. Yet, if the programme aims at providing counselling services, in the same situation, then proper, longer term training should be included in the programme design. Moreover, trainings that aim at passing skills to be duplicated or employed directly in the field need always to be organized in 3 steps:

- (a) Passing of information-knowledge-procedure;
- (b) Testing the acquired skills in a protected space, which can be done through simulations, role plays, intervision or others;
- (c) Testing the acquired skills in the real world, under supervision.

This is valid for all trainings of the sort, no matter how short/long and how focused/general they are.

For IOM, trainings both for internal MHPSS staff and for external students and experts follow this logic, whereas point (b) is resolved with the teaching methodology and point (c) by technical supervision for internal staff, and mentoring and supervised fieldwork for trainings offered to the wider community of practice.

On-the-job training, due to the specificities of an emergency situations, can be the most efficacious way to build capacity without slowing down the response. This is a training that is provided during working hours, with the trainers joining the teams during field activities. Even on-the-job training, however, should encompass the three steps to be efficacious and safe.

In terms of process training, such as training for the staff and functions of a CB MHPSS programme, the scope of training will be inversely proportional to the foundation skills

existing in the given emergency context. As mentioned, in some situations the programme will need to create the foundation of certain skills in its staff, while in others, staff may be already proficient and training will be mainly dedicated to harmonization of practices, extra skills and emerging needs identified through technical **supervision**.



The following chapter will give practical indications on how to organize both process training and activity training within a CB MHPSS programme.

→ 15.4. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

15.4.1 Mapping and partnership

Assessment and mapping should include an evaluation of existing capacities and gaps, including existing training needs and training resources in the country in the various facets of a MHPSS **programme**. The resulting analysis will help in determining:



- The expectable capacities of the PMTs members, and their training needs;
- Existing training capacities in the country, mapped versus needs;
- Identify which training capacities are lacking in the country;
- Budget the training accordingly in project planning;
- Identify trainers and supervisors.

15.4.2 Process training

15.4.2.1 Training for the staff of the programme

Based on the existing foundation skills of the staff members and the PMTs, a training plan will be envisaged for the staff. In addition to weekly technical supervision, the staff will be trained monthly, first on a core curriculum established at inception, and afterwards to respond to emerging needs identified through the technical supervision sessions. The monthly trainings will be provided either on the job or in the form of a workshop, and will be delivered by national, or international trainers, in coordination with the programme manager and the technical supervisor. Trainings will be organized for all the staff, or with a differential approach, in which members of the teams can be grouped and trained by function (all counsellors, all community mobilizers, etc.). More information on essential training can be found in the chapter on **Psychosocial mobile teams**. More information on additional trainings on specific activities can be found in the respective chapters.



15.4.2.2 Training for other units of the organization

This is specific to each organization. In IOM, MHPSS programmes aim to train:

- Colleagues working in DTM in PFA;
- Colleagues working in **Livelihood, Protection, and Conflict transformation** in subjects identified in the relevant chapters;
- Colleagues working in Health in subjects identified in the chapter on **Community-based support to people with severe mental disorders**;
- For colleagues working in CCCM, see paragraph **15.4.2.4**.



The MHPSS programme managers will liaise with their counterparts in other units to organize

these trainings, include resource mobilization. Trainings can be conducted by members of the MHPSS teams. For further guidance on contents, contact contactpss@iom.int.

15.4.2.3 Training for implementers and implementing partners



As already described in the chapter on **PMTs**, whenever institutions, civil society or professional groups exist that can perform the functions inherent to the work of PMTs, they should implement the activities and IOM or other agencies should support their work. The support shall include technical supervision and training, based on gaps in their capacity participatorily identified during the mapping, and training needs emerging through the work and the technical supervision. The process will be the same used for the training of the PMTs, and logistics and priorities will be coordinated with the leaders of these groups.

15.4.2.4 Training for the sector under which the programme is implemented

IOM, in several emergencies, leads the CCCM cluster. Naturally, a MHPSS programme implemented by IOM will support the CCCM cluster actors and the sector, in many ways, including referral, exchange of information, liaison between the CCCM cluster and the MHPSS working group and in training. In particular the IOM MHPSS teams will train CCCM actors and camp managers in:

- PFA. A special PFA training package has been elaborated for CCCM actors and can be received from contactpss@iom.int;
- Active listening, supportive communication and non-violent communication and mediation. A relevant training module is included in the core CCCM training, and can be received writing at contactpss@iom.int or globalcccm@iom.int;

- MHPSS essential knowledge for CCCM actors, based on the booklet linked [here](#).



IOM or other agencies may operate under other sectors. Training packages and resources can be found organized per sector in the IASC associated entity MHPSS RG and on mhps.net, the online platform for MHPSS practitioners that can be joined subscribing free of charge clicking [here](#).



15.4.2.5 Training for the technical supervisors and the MHPSS programme managers

Technical supervisors and MHPSS programme managers need also to be trained, at inception and throughout implementation. As for inception trainings, IOM, in collaboration with the Scuola Sant'Anna di Studi Accademici e Perfezionamento in Pisa, Italy, has organized each year, in the last nine years a Summer School in Psychosocial Interventions in Migration, Emergency and Displacement. The School, of the duration of 12 days for 100 hours of teaching, includes a final exam and grants 5 academic credits. It is meant to serve primarily the IOM MHPSS programme managers and technical supervisors, but offers 20 seats to managers and supervisors of other organizations as well. The subjects of the training reflect the ones of this manual, with a more critical, research oriented and academic approach, although remaining quite practical. The School has graduated 210 students from 45 different organizations.

The Psychosocial Training Institute in Cairo organizes training courses more oriented towards urban displacement and NGO work, that can also be used by organizations to give solid inductions to their teams.

Other courses on the offer can be found on the dedicated section of mhps.net.



15.4.3 Trainings as deliverables of programmes



Initial assessment and **mapping** should be analysed to identify as well capacity gaps in country or subcountry MHPSS systems, and trainings can be envisaged as programmatic actions, with an aim to cover these gaps and be able to provide a more quality response. In addition, a community-based approach implies the mobilization of existing formal and informal sociocultural activities' groups, artistic, interest and sport groups and individual artists, sportsmen, religious and traditional leaders and activists to respond to specific MHPSS problems, or to promote social cohesion, with explicit psychosocial objectives. In this case the programme should support trainings for the identified resources that could support them in giving a new focus to their activities in a safe and quality fashion.

In this second case, the approach will be a bottom-up one. Artistic, sociocultural and other resources will be identified. When a critical number of committed professionals, activists or artists is bought in, specific trainings can be organized for them in:



- Facilitation of support groups or peer support **groups**.
- Or more specific psychosocial skills related with their own function-skills, such as:
 - Social theatre trainings for performance artists;
 - Elements of art-therapy for visual artists;
 - Trainings in coaching skills, both technical and psychosocial for animators of sport groups;
 - And so on.

The trainings will be organized:

- For people that are interested and have proved to have a sincere interest in helping others and switching the focus of their activity;

- When a critical number of people is identified. This will help not only to be cost effective, but to focus on activities that are likely to be more popular or more culturally meaningful in a specific context;
- When trainers and supervisors are available.

They will follow the usual organization in three steps, and will include supervision.

For further information, see the chapters on **Sociocultural activities, Creative and art-based activities, Sport and play**.



15.4.3.1 Counselling skills and psychological interventions training

The assessment and mapping may indicate that there is a lack of qualified provision of counselling or psychological therapy or psychological interventions. To respond to such a need, there could be two options, each presenting trade-off.

One possibility is to train people in brief psychological interventions, like **PM+**, so that a sizeable number of responders can be deployed and mobilized in a relatively short-time to provide an evidence-based service.



The other is to engage a number of individuals with the right attitude and ethics in a mid-term capacity building in the foundation of counselling and psychological care. This will bring to professionals that are more versatile and comprehensive in their provision of care, but their training will be completed in a much longer period of time.

IOM favours investing in foundation courses that build broader skillsets, rather than focussing on relatively shorter trainings focussing on brief interventions or a precise model only, in situations where foundation courses do not exist. The counsellors in training will still be able to provide services in a gradual fashion and thanks to on-the-job trainings and technical supervision, while building a more solid and flexible base of

competences, likely to be more sustainable on the long term. For more info see the paragraphs on trainings and adaptation of the chapter on **Counselling**.



15.5. CASE STUDIES

15.4.3.2 Academic professional courses

One main feature of IOM CB MHPSS programmes has been the organization of executive Masters, Diploma or Certificate courses on psychosocial approaches to population mobility in low-resource or crisis-affected countries and communities. These courses have taken place from the Balkans to the Middle East, to South America, being adapted to the specific needs emerged during the assessment and mapping and the cultural, social and political conditions of the context. They are designed in collaboration with national Universities, respecting the requirements for accreditation. They are organized every second weekend, as they target professionals already providing critical services in the field for governments, agencies, civil society groups. The courses are free of charge, and students are selected through a competitive process that evaluates, inter alia, the impact the applicants can have on shaping the provision of MHPSS. Pedagogically, they are organized in lectures, participatory and interactive workshops, simulations and supervised fieldwork. The courses, no matter their main MHPSS subjects, always promote a systemic approach that will help the students to comprehend and manage the complex interactions between the geopolitical, historical, inter- and intra-personal, humanitarian, communitarian and cultural/sub-cultural systems. The courses are functioning as a space for dialogue between international experts identified by the IOM's Mental Health, Psychosocial Response and Intercultural Communication Section, national academic experts brought on board by the national university and field practitioners. They respond to an identified urgent capacity need, build on preparedness and development, and allow participants to keep on providing services in the field and to be supervised in their fieldwork.

15.5.1 Case study for process training. The experiences of the Psychosocial Training Institute in Cairo (PSTIC) in urban settings.



Models of MHPSS intervention are most effective when culturally and contextually designed in response to the needs and problems of a population. PSTIC operates mainly in Cairo, in Egypt. Egypt is home to 240,000 refugees and asylum seekers from 58 countries. Most live in Cairo, the capital city, intermixed in urban neighbourhoods alongside 22 million Egyptians. Most refugees must support themselves. The quality of life common to the poorest Egyptian is amplified for refugees. Neighbourhoods and public health and education facilities are impoverished and overcrowded. The cost of living is higher than the daily wage. Refugees dream of resettlement to a 1st world country; yet few leave. Most live for years in poverty, feeling unsafe with few future opportunities. PSTIC has crafted an urban model in which a network of well-trained refugees offer community and home based MHPSS care 24 hours a day, 7 days a week.

The PSTIC team is a multilingual-multicultural-multidisciplinary network of workers from several countries; 90 per cent are refugees. PSTIC targets the most vulnerable, especially those who do not seek facility-based care. No one is refused services and all efforts are made to assist – refer to other organizations – or, when nothing is available, just encourage those in need. Supportive services are offered at all layers of the Interagency (IASC) Standing Committee Guidelines for MHPSS in Emergency Settings intervention pyramid. This include a 24 hours a day, 7 days a week helpline answered by a team available to give information and respond to any emergency. A roving multilingual team, which shares information daily in community sites. Support to secure safe housing, advocacy

when seeking health care especially during emergencies and advocacy for those detained. In addition, professionally trained refugee Psychosocial Workers (PSW) work alongside their communities to provide case management, individual, family and group psychosocial support and counselling, problem solving and mediation; accompaniment and referral to other services. Finally, Egyptian psychiatrists work alongside the refugee team 24 hours a day, 7 days a week to ensure the combined psychiatric and psychosocial support needed for acute and chronic mental health care.

Few PSW join PSTIC with prior MHPSS training. PSW are carefully selected from their communities based on personality traits and their prior commitment to assisting others. Before beginning to work, they complete 5 weeks of daily training whose content starts with ethics and includes essential psychological, social and health knowledge, practical development of helping skills, and work skills like time management. After this, training and skill enhancement continues weekly. PSW also have individual and group supervision. Each worker is part of a small multinational team lead by a senior refugee worker and a psychiatrist. The team meets weekly to review challenging cases and issues in an open safe learning environment. A few essentials: Commitment to the care of refugee workers includes ensuring they are paid; a work environment that allows for open sharing about the complicated dual allegiance for community workers to their communities and the organization; and continual activities that encourage team building and self-care.



To know more, look at a webinar slideshow, clicking [here](#).

15.5.2 Case study of training as programme activity. The executive Masters in Psychosocial Support and Dialogue in Lebanon.

In 2013, the organization devised a programme to respond to the psychosocial needs of Syrians residing in the Syrian Arab Republic and decided to focus the intervention on the capacity-building of local psychosocial practitioners responding to the crisis. Among different initiatives IOM designed, a one-year Executive Masters programme in 'Psychosocial Support and Dialogue' for Syrians was developed at the Lebanese University after several consultations with Lebanese colleagues and groups of Syrian practitioners. The programme was set up for two generations of students. In 2017, a similar, but shorter, course was organized in Turkey at the Social Sciences University of Ankara (ASBU) for Syrian and Turkish professionals working with Syrian refugees in the country.

For the background and the structure of the course read the introduction of this [publication](#).



For the description of the modules and a sense of the background and professional affiliations of the participants see this [video](#).



For the description of the main themes of the fieldwork of the two editions of the programme in Lebanon read [here](#).



To read the best 4 fieldworks of students of the course in Ankara, read the dedicated section of the number of the review Intervention hypelinked [here](#).



15.6. CHALLENGES AND CONSIDERATIONS

For technical supervision, if the roles of the supervisor and the manager overlap, issues of power and accountability can prevent a fully free supervisory process. It can help in facilitating matters to establish a clear set

of boundaries at the very beginning of the supervision process, and to tailor contents of the supervisory sessions on the possible related shortcomings. However, as a best practice, the two positions should be kept distinct.

The different roles of manager and technical supervisor, and their respective boundaries, need to be clearly defined and communicated to avoid confusion and overlapping.

For both technical supervision and training, programmes may not be funded or not funded enough due to donors' rules. Indeed, these are not considered as life saving emergency response activities and therefore excluded from funding, no matter the size of the program. This creates a situation where an agency is asked to respond on a large scale, but will never be able to grant quality and minimum standards of intervention. This problem can be solved enlarging the pool of donors, and stressing the emergency-development nexus, while reducing the costs of training and supervision mapping national and regional trainers.

Another challenge in training is posed by the short duration of emergency programmes and often the inability of the project manager to foresee incoming funds. This can bring to a fragmentation, that if not probably accounted for in planning can lead to frustrations. It is therefore recommended to plan trainings based on their maximum duration in relation to the life of the programme, and adapt training objectives accordingly.

FURTHER READING

Bragin, M.

2012 So that our dreams will not escape us: Learning to think together in time of war. *Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals*, 32(2):115–135.



Haans, T., J. Lansen and H. Brummelhuis

2007 Clinical Supervision and Culture: A Challenge in the Treatment of Persons Traumatized by Persecution and Violence. In: *Voices of Trauma* (B. Droždek and J.P. Wilson, eds.). Springer, Boston.



Sangath and London School of Hygiene and Tropical Medicine (LSHTM)

2013 *The Premium Counselling Relationship Manual*. LSHTM, London.



For other references, see the full bibliography [here](#).




16. MONITORING AND EVALUATION



➔ 16.1. WHAT MHPSS PROGRAMME MANAGERS SHOULD KNOW

Monitoring and evaluation, currently conceptualized as monitoring, evaluation, accountability and learning (MEAL) (Sphere Project, 2015), are integral to any community-based MHPSS programme in emergencies. A community-based and participatory MEAL process brings programme managers, staff, community leaders and programme participants and clients together to ensure effective programme performance. It strengthens the ability of MHPSS programme managers to reflect thoughtfully on their work, to be sure that it is completed as intended, and to be clear as to whether and how it met expectations to improve MHPSS in affected communities. This process should allow for changes in activities and programmes, and support community learning about effective interventions for MHPSS, during the emergency and afterwards. Such a process creates additional opportunities for community ownership and accountability to accompany institutional learning at the design and implementation levels.

 The aim of this chapter is to introduce the concept of **community-based** and **participatory** monitoring and evaluation in MHPSS programming, and clarify its essential role in reviewing needs, resources, socially and culturally adequate strategies of implementation, and objectives in the rapidly changing environment of humanitarian emergencies, taking into account that communities are not **homogeneous**.


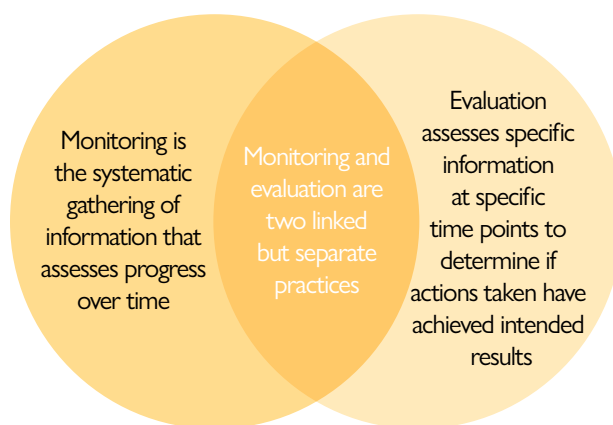
 Monitoring and evaluation are distinct but interrelated processes. In *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007)*, they were identified as an essential part of MHPSS programming in emergencies. Action Sheets 2.1 and 2.2 should be read along with chapter on **Assessment and mapping** of this Manual as an introduction to this chapter.

Figure 15: Monitoring and evaluation



Source: IASC (2017).

Monitoring and evaluation is applied to the following project components:

- Project inputs: Funds, materials, equipment, staff and other resources “put in” to carry on project’s activities.
- Project outputs: The activities achieved or “put out” in the process of implementing a project (such as training session for staff or improved access to services or facilities) that show that operational plans are on track.
- Project outcomes: What “comes about” during the course of a project as a result of the achieved outputs.
- Project impact: A lasting change in individuals, families and communities that results as a consequence of the project.

16.1.1 What monitoring is

Monitoring compares intentions with results. During a humanitarian emergency, even the best assessment and programme design cannot perfectly predict emergency-related changes in circumstance, the difficulties of implementation in specific places, or any other complications in programme

actualization. Community-based and participatory monitoring provides the mechanism for learning, contextualization and adapting programmes throughout the implementation (Sphere, 2018).

Community-based and participatory monitoring addresses the following questions:

- Is the programme being implemented as planned after the participatory assessment?
 - If not, what are the obstacles?
 - How should they be addressed? Need the programme be further contextualized?
- Are all of the intended affected populations being reached?
 - Who is being excluded? Why?
 - How can the programme bring in additional marginalized populations?
- Have the circumstances of any given population changed significantly?
 - What adaptations are needed to operate in these new circumstances?
- Are the needs resources and methodology of intervention identified at assessment still relevant to the psychosocial well-being of the affected individuals and communities?
 - Do the proposed activities still seem likely to improve their psychosocial well-being and social relations?
- What are the unintended negative consequences to date?
 - How do they affect the populations' well-being?
 - How will the programme address these?
 - Is there a functioning and transparent grievance mechanism?
- Is inter-agency coordination proceeding as planned?
 - If not, what adjustments are necessary?
- Are staff members performing according to standards, and are self-care programmes and measures available?
 - If not, what adjustments are needed?
 - Recognize and support the positive efforts of staff, participants, and community members.

With these questions answered, monitoring information can guide programme, project or intervention revisions, verify targeting criteria, and confirm that the intervention is reaching the people who need it. In addition to more structured and consolidated tools, supportive monitoring activities throughout the life of the programme can include:

- Discussions with project management and staff;
- Focus group discussions with programme participants;
- Discussions with community representatives (Warner, 2017).

16.1.2 What evaluation is

Evaluation is a systematic and objective assessment of the design, implementation and results of an ongoing or completed intervention, project, programme or policy (Sphere, 2017). Evaluation refers to the process of examining a programme at specific points in time, minimally at the beginning, then at the middle (if possible), and after completion to see if it achieved the desired results as determined in the assessment. Engaging community members and programme participants in the evaluation process ensures their inclusion in learning. In MHPSS programmes, IOM, from a technical perspective, evaluates outcomes and, when possible, impact:

- Outcome evaluations assess the effectiveness of a programme in producing change. They ask what happened to programme participants and how much of a difference the programme made for them. They are conducted at midterm and again at the end of a project of intervention.
- Impact evaluations attempt to measure if the project promoted lasting positive changes in the participants' mental health, psychosocial well-being, attitudes, behaviours and social relationships.

Box 64
Questions that IOM evaluations of MHPSS programmes try to answer

- How was the programme delivered? Which processes contributed to positive and negative effects?
- Which internal and external factors intervened to affect (positively and negatively) the impact of the project?
- Was the integration of specialized services provided by the project effective in stabilizing, treating and preventing mental, neurological and substance use disorders?
- Did the project improve activate resilience, promote inclusion, facilitate positive human connections, and restore agency, self and community efficacy, and hopefulness to individuals, families and groups at each targeted level of the pyramid?
- Did the project enhance the protection of persons in institutions or segregated at home, in tents or in camps?
- What are the most relevant good practices, innovations and lessons learned in implementation, monitoring and evaluation of the project?
- What structural and ongoing changes have been made to the lives of the individuals, families and communities who participated in the project?

16.1.3 Understanding indicators

Indicators are the measurable information used to help, ask and answer the questions identified in the monitoring and evaluation plan. The choice of indicators informs the rest of the monitoring and evaluation plan, including methods, data analysis and reporting. Indicators can be quantitative or qualitative. Participatory indicators are those that are developed together with stakeholders, especially community members and participants, that help all of those concerned to be precise about whether the programmes are succeeding to improve mental health and psychosocial well-being in the community. Strong indicators are referred to as SMART – specific, measurable, attainable, relevant and time-bound.

- Input indicators: These measure the contributions necessary to enable the programme to be implemented (such as funding, staff, key partners and infrastructure).
- Output indicators: Many programmes use output indicators as their process indicators; that is, the production of strong outputs is the sign that the programme’s activities have been implemented. Others collect measures of the activities and separate output measures of the products/deliverables produced by those activities.
- Outcome indicators: Measure whether the programme is achieving the expected effects/changes in the short, intermediate, and long term.
- Impact indicators: Because outcome indicators measure the changes that occur over time, indicators should be measured at least at baseline (before the programme/project begins) and at the end of the project. Long-term outcomes are often difficult to measure and attribute to a single programme.

Box 65
How do monitoring and evaluation combine with accountability and learning to complete a MEAL?

Accountability to affected populations (AAP) is an integral part of the humanitarian programme cycle, which includes monitoring and evaluation, accountability and learning in its areas of concern.

AAP requires communities to be engaged in programme assessment, design, monitoring and evaluation. AAP requires that, as programmes are amended and adapted based on community feedback, there is a mechanism in place to report back to the community the changes being made and how to make use of newly adapted services. As participatory monitoring is an ongoing process, there are many opportunities to return to community members with the results of any adaptations. In low-resource settings, this information can be disseminated in focus groups, community meetings and activity groups, such as those mentioned earlier in this Manual. In higher resource and urban settings, these methods of dissemination are also useful, but they will require the addition of social media and radio communications in order to be effective.

The IASC toolkit on AAP provides detailed advice on how to implement this process and can be found [here](#).

Participatory monitoring and evaluation invite reflection and learning as managers, staff, community leaders and programme participants work together to evaluate programme effectiveness. Learning conferences that include evaluation reports allow participants – who have participated in the entire process, from assessment and implementation to monitoring and evaluation – to consider next steps. What about the evaluation was surprising? Anticipated? What experiences were pleasant but yielded few results? Such learning conferences and, to the extent that resources allow, their publication on interactive social media sites and through community organizations, ensure that there is a longer-term effect that communities can use to improve well-being going forward.

Some important questions to ask for reflective practice:

- What actions were taken during monitoring and evaluation to ensure that opportunities were created for reflection and learning?
- To what degree did participant perspectives influence these activities?
- How were issues identified in the process documented, acted upon and reflected in the evaluation?

To link these practices to AAP requirements, click [here](#).


16.1.3.1 Goals and indicators supplied by the common framework

The IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings has created the *IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings* (IASC, 2017). This document presents a consensus on the goals, objectives, indicators and actions for the monitoring and evaluation of MHPSS programmes in emergencies. The full document can be found [here](#). Its key elements as they relate to CB MHPSS are summarized here. The document enumerates a five-step process for conducting monitoring and evaluation on MHPSS programmes:

1. Assessments of MHPSS proceed as usual. The beginning of an MHPSS programme design is initiated to meet assessed needs (see chapter 3).
2. The organization considers its own programme outcomes and outputs as they relate to the programme design. Each organization considers how its project will contribute to the goal in the common framework.
3. During the design phase, practitioners/implementers are encouraged to review the common framework to see how it aligns with their own proposed intervention(s).
4. The programme takes (at least) one goal impact indicator and at least one outcome indicator from the common framework. The programme also includes output indicators unique to the programme design.
5. The organization explores possible means of verification to measure impact and outcome indicators. These may be measures previously used by them or other organizations.

The common goal identified for MHPSS programmes is “to reduce suffering and improve mental health and psychosocial well-being”. The framework describes two types of outcomes:

- Community-focused outcomes;
- Person-focused outcomes.

These reflect MHPSS programmatic activities at the community, group, family and individual levels.

The framework identifies five main common outcomes for any MHPSS project in emergency, and provides a set of 49 indicators to measure impact and achievements. The Guide also encourages, along with the overall goal, including at least one outcome and related set of indicators to monitor and evaluate each MHPSS project. For easy reference, Table 12 highlights three key indicators for each outcome, chosen among the ones that most relate community-based MHPSS practices and IOM approach; however, it is highly recommended to refer to the full publication for the full complement of indicators and details on implementation.

Table 12: Key indicators for community-focused and person-focused outcomes

Outcomes			
Community-focused	Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable.	People are safe and protected, and human rights violations are addressed.	Family, community and social structures promote the well-being of all of their members.
Person-focused	Communities and families support people with mental health and psychosocial problems.	People with mental health and psychosocial problems use appropriate focused care.	

Source: Based on IASC (2017).

Table 13 provides a sample of key outcomes and indicators, again chosen among the ones that better serve CB MHPSS programmes and IOM approach.

Table 13: Key outcomes and indicators

Outcomes	
1. Emergency responses do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable.	<ul style="list-style-type: none"> • O1.1: Percentage of affected people who report that emergency responses (a) fit with local values, (b) are appropriate and (c) are provided respectfully. • O1.3: Percentage of target communities where local people have been enabled to design, organize and implement emergency responses themselves. • O1.4: Percentage of staff trained and following guidance (for example, the IASC Guidelines) on how to avoid harm.
2. People are safe, protected, and human rights violations are addressed.	<ul style="list-style-type: none"> • O2.1: Number of reported human rights violations. • O2.2: Percentage of target communities with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women, people with severe mental disorders). • O2.6: Percentage of target group members (such as the general population or at-risk groups) who feel safe.
3. Family, community and social structures promote the well-being and development of all their members.	<ul style="list-style-type: none"> • O3.2: Extent of parenting and child development knowledge and skills among caregivers. • O3.5: Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups). • O3.6: Percentage of target communities where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development.
4. Communities and families support people with mental health and psychosocial problems.	<ul style="list-style-type: none"> • O4.1: Number of people with mental health and psychosocial problems who report receiving adequate support from family members. • O4.2: Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information, and resources needed to access care). • O4.4: Perceptions, knowledge, attitudes (including stigma) and behaviours of community members, families and/or service providers towards people with mental health and psychosocial problems.
5. People with mental health and psychosocial problems use appropriate focused care.	<ul style="list-style-type: none"> • O5.4: Number of women, men, girls and boys who receive focused psychosocial and psychological care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or other psychological interventions). • O5.6: Number of people per at-risk group (for example, unaccompanied and separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (case management, psychological counselling, psychotherapy or clinical management of mental disorders). • O5.8: Level of satisfaction of people with mental health and psychosocial problems and/or their families regarding the care they received.

Source: Based on IASC (2017).



It should be noted that a group of IASC partners and Johns Hopkins University are currently identifying recommended means of verification for each of the indicators. The resulting publication will be added to the online version of this Manual, once ready. A UNICEF manual on methods of monitoring and evaluation particularly tailored to children can be found [here](#).

16.1.3.2 Developing and using participatory indicators.

Many IOM MHPSS programmes, as described in this Manual, while providing a referral system for people with psychological problems, focus on the re-establishment of community protective systems, such as social cohesion and the activation of agency among groups within the population, using terms defined by the participants themselves. These activities contribute to the same overall goals as all other MHPSS programmes, but require specific indicators to represent results to be evaluated, in addition to the ones reported in the IASC Guide. In a community-based approach, it is fundamental to involve affected populations in the identification and development of the indicators used in monitoring and evaluation

16.1.4 The SEE_PET

The SEE_PET is a rapid participatory method that can be used to develop indicators of psychosocial well-being in specific cultural context with concerned social groups. It can be used to develop indicators of MHPSS programme effectiveness, against which staff and participants can evaluate success and discard ineffective practices. Derived from the methodology of a three-country study of conflict-affected women's perceptions of psychosocial well-being (Bragin et al., 2014), it has been adapted for use with children and male adults, as well as IDP settings. The SEE_PET is used to engage community members in defining and operationalizing the components of psychosocial well-being in their own language and thinking, turning those operational definitions into SMART, contextual indicators. The method facilitates participants, community members and programme staff in the use of these indicators to monitor and evaluate the psychosocial components of emergency MHPSS programmes. It provides participants with a moment to reflect on both needs and resources in the midst of crisis, enabling them to articulate and work toward the life that they envision for themselves and their children, now and in the future. This method has subsequently been used by IOM in emergencies in different low-resource contexts, such as in South Sudan and Nigeria.

- For specific step-by-step instructions on how to use the SEE_PET, click [here](#).
- To create and chart specific indicators for adults, click [here](#).
- To create and chart specific indicators for children and adolescents, click [here](#).
- For an illustrative IOM case study, click [here](#).
- For the context and follow-up of the study, click [here](#).

SEE_PET can be community-led but it is typically a process facilitated by trained experts.



Box 66
Developing participatory indicators supporting referral for treatment of mental, neurological and substance use disorders

In some settings, IOM will be called upon to identify people with mental, neurological and substance use disorders, who require specific referral and follow-up care. In some low-resource settings, community members may not have ever had a proper system of locally available mental health care. In those instances, recent studies show that community members are aware of symptoms they associate with mental illness, neurological disorders and response to substance abuse. Such communities often have ways of identifying and differentiating people whose behaviours represent the results of grief and exposure to violence from those with ongoing issues requiring psychiatric care (Ventevogel et al., 2013).

Organizing focus group discussions supplemented by meetings with key informants – such as health-care providers, traditional healers, community leaders and psychiatric personnel who may be available – can produce positive identifications of people requiring specialized referral.

In this case, rather than asking questions regarding psychosocial well-being, focus group discussion questions might ask about persons with behavioural and emotional problems and the optimal way to care for them (Ventevogel et al., 2013). For case examples and a careful description of how to develop and analyse the results of such focus groups, see the referenced article [here](#).




16.2. WHAT MHPSS PROGRAMME MANAGERS SHOULD DO

Nine steps to start the monitoring and evaluation process:

1. Sites and locations: Focus on three different sites (such as camp, transit centres and host community), or three different locations in the same area (such as camp sections, nearby villages and neighbourhoods).
2. Mapping: Carry on at least three different participatory exercises, such as transect and well-being walks, social networks diagrams (see [INTRAC website](#)) for resources and free online related publications ([here](#)), and [community scoring cards](#); and see MHPSS.net for an array of downloadable and practical tools and instructions on how to use [them](#)).
3. Affected population: Purposive sample of approximately 30 informants for each site/location, including men and women, GBV survivors, persons with disabilities, elderly and people from marginalized groups. If children are to be included in the programme, there should be separate groups for children and adolescents.
4. Stakeholders and gatekeepers: Identification of four key informants for each site/location – teachers, health-care workers, local and religious leaders, and camp managers – to be interviewed.
5. Indicators: Identification of at least two SMART, qualitative and quantitative indicators for each activity, output and outcome.
6. Tools: Selection of at least three tools – such as activity monitoring forms, participants satisfaction questionnaires and focus group discussions – for each indicator.
7. Timing: According to the operational plans but as regular as possible, including weekly activity monitoring data, monthly participants' satisfaction questionnaires and quarterly focus groups.



8. Staff: Identification of dedicated staff with appropriate language and cultural competence to be trained in data collection and data management, including field team leaders, data entry assistants, IT managers and project officers.
9. Data management: Identification of available platforms to store information (such as spreadsheets, online databases and Word documents) and reporting forms to graphically share data (such as monthly and quarterly).

16.3. CHALLENGES AND CONSIDERATIONS

Challenges include the following:

- Special care must be taken to ensure that all community subgroups are represented in the monitoring and evaluation process. This requires a specific effort to prevent obstacles to participation such as language, education, cultural norms, disability, social and gender discrimination, power struggles, political interests and open conflicts.
- Cultural acceptance of methodologies and tools of community-based monitoring and evaluation might not be taken seriously by stakeholders and affected populations themselves in emergency contexts. It is important to make them part of a larger effort to engage communities.
- Subjective changes and self-perceptions of well-being are also determined by external concurrent factors, such as conflict dynamics, displacement stages, cultural interpretations of illness, social conditions and political narratives that might rapidly change in a typical emergency scenario. This all needs to be considered when analysing the results of monitoring and evaluation.
- Community-based activities – such as public gatherings, awareness campaigns, religious celebrations, sport tournaments, skill training and livelihood promotion – require a set of specific indicators and tools to measure the actual impact on psychosocial well-being of affected populations. These are signalled, when relevant, in the relevant chapters.
- Positive and lasting impact in MHPSS might require more time than the usual short operational frame of an emergency intervention. Therefore, indicators and evaluation tools should be accurate enough to measure trends and attitudes instead of consolidated achievements and lasting changes.
- Budgets often fail to allocate sufficient resources for dedicated and qualified human resources to attend to MEAL. When resources lack, they should be included in the job descriptions and related competencies of core staff. These activities will therefore not represent added burdens, but rather a part of regular duties.

Depending on the size and characteristics of the emergency, a full participatory identification of indicators may be difficult to achieve in the very initial phase of the response. Communities and the programme can achieve this capacity later in the process. In those cases, a SEE_PET or other processes can also be initiated at a later stage, since they can still impact programme outcomes and learning.

FURTHER READING

Ager, A., L. Stark, T. Sparling and W. Ager

2011 *Rapid Appraisal in Humanitarian Emergencies Using Participatory Ranking Methodology (PRM)*. Program on Forced Migration and Health, Columbia University Mailman School of Public Health, New York.



Augustinavicius, J.L., M.C. Greene, D.P. Lakin and W.A. Tol

2018 Monitoring and evaluation of mental health and psychosocial support programmes in humanitarian settings: a scoping review of terminology and focus. *Conflict and health*, 12(1):9.



Bragin, M., K. Onta, J. Taaka, D. Ntacobakinvuna, K. Adolphs, J. Bolen, N. Tammelleo and T. Eibs

2013 *To be well at heart: Perceptions of psychosocial well-being among conflict affected women in Nepal, Burundi, and Uganda*. CARE Österreich, Vienna.



Eggeman, M. and C. Panter-Brick

2011 Fieldwork and Research Process and Community Engagement: Experiences from the Gambia and Afghanistan. In: *Centralizing Fieldwork: Critical Perspectives from Primatology, Biological and Social Anthropology*. Studies of the Biosocial Society, (4). Berghahn, New York.



International Federation of Red Cross and Red Crescent Societies (IFRC)

2017 *Monitoring and evaluation framework for mental health and psychosocial support in emergency settings: Guidance and Overview*. IFRC, Geneva.



International Organization for Migration (IOM)

2018b *OIG Strategy for the Management of its Evaluation and Monitoring Functions, 2018–2020*. Office of the Inspector General, IOM, Geneva.



Rogers, P.

2014 *Theory of Change: Methodological Briefs – Impact Evaluation No. 2*. UNICEF Office of Research, Florence.



For other references, see the full bibliography [here](#).



ANNEX 1

INTER-AGENCY COORDINATION



1. INTRODUCTION

Coordination is an important component of a successful MHPSS programme implementation. It is included as an annex in this Manual not because it is deemed less important than other programmatic aspects, but for the following reasons:

- Coordination and partnership with different actors, community members, civil society organizations, stakeholders, affected populations and clients, leaders, religious leaders and academia on the overall planning and implementation of an MHPSS programme, and with other humanitarian organizations to optimize assessment efforts and define common monitoring and evaluation frameworks, are already mainstreamed—described throughout the Manual. This annex covers issues related to inter-agency coordination, which are essential knowledge for managers, but are not necessarily a part of a community-based approach.
- The differential role that IOM plays or can play in inter-agency coordination of MHPSS efforts is essential knowledge for IOM MHPSS managers, but not necessarily relevant for readers from other organizations.

The chapter will discuss how IOM PMs should coordinate inter-agency MHPSS activities and how to facilitate community engagement, to the possible extent, within country level MHPSS working groups (MHPSS WGs).

Inter-agency coordination is an essential component of the emergency response at any stage of its cycle – including preparedness and recovery – to ensure:

- Accurate information-sharing and reliable channels of communication;
- Identification of common strategies and priority of interventions;
- Even allocation of available resources according to needs, locations and partners' operational capacity;
- Adherence to humanitarian principles and minimum standards;
- Adherence to identified minimum technical and **ethical standards**;
- Promotion of joint training sessions and advocacy actions.

IOM's Principles for Humanitarian Action (2015b) clearly commit the organization to IASC's procedures and guidelines, along with other United Nations coordinating bodies. **IOM's Migration Crisis Operational Framework (2012a)** recognizes the importance of external coordination with concerned States, IASC and United Nations agencies, particularly with UNHCR.

A joint IOM–UNHCR letter addresses the coordination between the two **agencies**.



2. COORDINATION OF MHPSS IN EMERGENCIES

Globally, a Reference Group on Mental Health and Psychosocial Support in Emergency Settings is an IASC-associated inter-agency entity. It was established in 2007, immediately after the launch of *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings*, (IASC, 2007), with the aim to:

- (a) Facilitate integration of the core principles of the Guidelines into all sectors or clusters of emergency response;
- (b) Foster collaboration among agencies and diverse stakeholders (such as governments and communities) for MHPSS in emergencies;
- (c) Support inter-agency coordination and activities for MHPSS at the global, regional and national levels;
- (d) Develop relevant tools linked to the Guidelines and actively disseminate these with relevant actors in the field;
- (e) Encourage individual agencies to institutionalize the Guidelines;
- (f) Promote and support ongoing capacity development to enable effective use of the Guidelines and related tools;
- (g) Share experiences of implementation of the Guidelines among MHPSS actors;
- (h) Interface with the United Nations Cluster System, refugee and migration coordination systems to include MHPSS in policies, tools, capacity-building and planning processes;
- (i) Facilitate language translations, printing and dissemination of the Guidelines.

Box 1

Actors and bodies of humanitarian coordination

IASC serves as the primary mechanism for inter-agency coordination, and acts in an action-oriented manner on policy issues related to humanitarian assistance, and for formulating a coherent and timely United Nations response to major and complex emergencies. **IOM** is among the 19 permanent members (Principals) of IASC.

The United Nations Office for the Coordination of Humanitarian Affairs (OCHA), at the global, regional and country levels, convenes humanitarian partners for the coordinated, strategic and accountable delivery of humanitarian **action**. OCHA is mandated to support humanitarian efforts in complex crisis and internal displacement. UNHCR remains the lead agency with the mandate to support refugee response and refugee coordination, with IOM leading on migration.

The Humanitarian Coordinator (HC) and the Humanitarian Country Team (HCT), made up of the operational United Nations agencies involved in the emergency response, represent the main coordinating body in countries affected by complex humanitarian crises related to internal displacement (note not refugees and migrants).

Eleven Global Clusters coordinate the different sectors of any emergency:

- Camp Coordination and Camp Management (CCCM);
- Early Recovery;
- Education;
- Emergency Telecommunications;
- Food Security;
- Health;
- Logistics;
- Nutrition;
- Protection that includes Child Protection, Mine Action, Housing Land and Property and Gender-Based Violence Areas of Responsibility (AoR);
- Shelter;
- Water, Sanitation and Hygiene (WASH).

For each cluster, IASC designated a lead agency (including WHO for Health, UNHCR for Protection, and IOM for CCCM in displacement due to natural disasters) to be supported by co-lead organizations, usually an international NGO (such as Save the Children and UNICEF as lead agencies of the Global Education Cluster). The Global Clusters have a permanent nature and yearly plans, aiming at setting and disseminating standards, practices and knowledge. When a humanitarian intervention starts, the same clusters are established at country level, based on needs, number of actors and the specific request from the host Government declaring which clusters should be activated. Sometimes clusters merge (for example the Health and Nutrition Cluster in NE Nigeria response) and sometimes the clusters are labelled slightly differently based upon the host Governments request. MHPSS is cross-cutting potentially all clusters, and is a particularly relevant theme in CCCM, Education, Health, Nutrition, Protection (and its AoRs), Shelter and WASH.

The Humanitarian System-Wide Scale-Up seeks to reinforce focused collective and time-bound emergency procedures. Scale-Up activation is time-bound and limited to six months, and can only be extended once, for an additional three months, in exceptional **circumstances**.





The group has produced a wealth of additional operationally focused documents, tools and guidance that have been quoted and referred to throughout the Manual. The entire list of publications can be found [here](#). Particularly relevant for this Manual is *Community-Based Approaches to MHPSS Programmes: A Guidance Note* (**IASC, 2019a**).

Particularly relevant for IOM staff is the booklet *IASC, Mental Health and Psychosocial Support in Emergency Settings: What should Camp Coordinators and Camp Manager Actors Know?* (IASC, 2014c), because it is addressed to actors of the cluster that IOM co-leads globally and at the country **level**.

The MHPSS Reference Group has advocated for the establishment of MHPSS Working Groups at the national and subnational levels, as the best way to coordinate the various actors engaged in the different sectors of the response, particularly in order to avoid fragmentation among humanitarian actors traditionally associated with the Health (clinical mental health) and Protection (community-based psychosocial support) Clusters. The MHPSS Working Group should collaborate with the relevant clusters and be proactive in mobilizing resources through the Consolidate Appeals Process, drafting policies and promoting joint advocacy actions. What is at the stake is not only the coordination of the operational capacities of different service providers, but the coherence of the integrated program approach of MHPSS services (the four layers of the pyramid) throughout the whole humanitarian response.

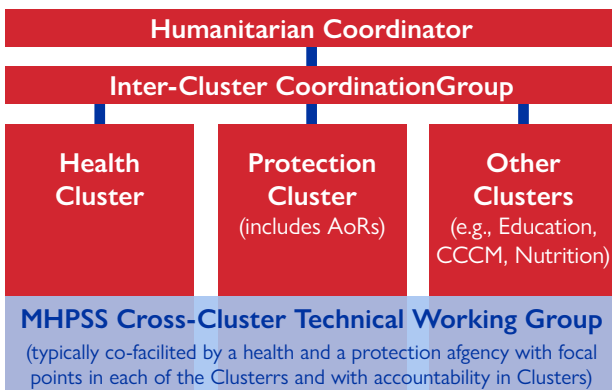
Preferably, the MHPSS Working Groups should be established at the national and subnational levels at the early onset of the crisis. MHPSS WG should never be attached to any single cluster, but be kept inter-cluster (meaning a floating body that supports all relevant clusters – CCCM, health, education, nutrition and protection). Each participating organization can then be tasked to link to the cluster to which their organization is more related to in terms of programming.

Box 2

IOM and the IASC RG on MHPSS

IOM has been a member of the group since its inception, and has institutionalized the use of the Guidelines in internal guidance notes; in its internal trainings for MHPSS, Protection, Health and Emergency actors; external trainings for MHPSS actors; and in recruitment processes for MHPSS staff.

Figure 16: Generic humanitarian response mental health and psychosocial support (MHPSS) coordination structure for large emergencies with numerous MHPSS actors - to be adapted locally -



IOM is among the organizations that usually take the leadership in establishing and co-chairing the country-level MHPSS Working Groups. It has chaired or co-chaired the groups in different countries and emergencies worldwide, including in Myanmar, Haiti, Nigeria, South Sudan, Libya, Iraq and many others.

When the size and scope of the project allows, IOM appoints a full-time MHPSS inter-cluster coordinator (South Sudan, Nigeria, Haiti), which is the preferred option. The coordinator is managerially attached to the IOM MHPSS manager, but can technically refer to the global Co-Chairs of the IASC MHPSS Reference Group for guidance.

If resources or the scope of the programme do not allow for a dedicated position, part of the MHPSS programme manager's and/or MHPSS officer's working time will be dedicated towards supporting the MHPSS Working Groups, either co-chairing, or as active members. Typically, in this case, at the minimum, IOM MHPSS staff will act as a link between the MHPSS Working Group and the CCCM Cluster.

If a cross-sectoral MHPSS Working Group cannot be established, it would still be important that MHPSS's focal points sit in the relevant clusters and sub-cluster working groups to ensure that the following minimum coordinated actions still occur:

- Share information on the context of operations and documents, such as MHPSS needs assessments, indicators, data collection tools, advocacy reports and plans of actions.
- Create and constantly update a mailing list of concerned organizations to quickly disseminate information, materials and schedules (meetings, workshops and events).
- Conduct joint MHPSS needs assessments and surveys.
- Provide regular updates on each organization's programme, highlighting constraints and opportunities for collaboration.
- Compile and regularly update MHPSS 4Ws mapping of service providers (Who is Where, When and doing What).
- Search for synergies and integration of services with local organizations, including State and private mental health providers, schools, clubs, cultural centres, civil society organizations, women's association and faith-based organizations.
- Promote local organizations' participation in cluster and inter-cluster working groups' and sub-working groups' meetings.
- Set-up an inter-agency referral system.
- Address minimum standards, harmful practices and codes of ethics through joint monitoring exercises and reports.
- Mainstream MHPSS Guidelines in relevant sectors of the emergency response.
- Provide training sessions to humanitarian staff on MHPSS basic response (such as PFA) and on the MHPSS Guidelines.

- Promote joint advocacy campaigns on MHPSS in the affected groups and communities of concern (such as posters, leaflets, brochures and radio programmes in the relevant languages).
- Promote awareness on MHPSS' needs and opportunities at OCHA, and the Humanitarian Coordinator and Humanitarian Country Team level (such as funding requirements).
- Participate in the preparation of the annual Humanitarian Needs Overview (HNO) and related Humanitarian Response Plan (HRP). Note that some HRPs may run for 2 years.
- Identify approximately 5 MHPSS related indicators (**see Common Monitoring and Evaluation Framework as a guide**) that agencies can report against. These inter-agency MHPSS indicators can also feed into the relevant cluster chapters of the HNO and HRPs.
- Support the regular update of humanitarian information systems (such as the Displacement Tracking Matrix) and cluster database (for example, ActivityInfo) as far as MHPSS data are concerned.
- Draft terms of reference for consultancies on specific topics (research, training, advocacy, policies) jointly promoted by the MHPSS inter-cluster Working Group and other relevant clusters/AoRs (such as Health, Child Protection, Mine Action and GBV).
- Support government and private mental health institutions with technical guidance and ad hoc capacity-building initiatives (workshops, seminars, conferences, training sessions, internships and scholarships).
- Support relevant government bodies at the national and local levels to draft emergency strategies, operational plans and MHPSS policies.



In addition, when IOM chairs the country-level CCCM clusters, the MHPSS managers should touch base with the CCCM team to support the following actions:

- Train CCCM actors in PFA and basic MHPSS.
- Teach the psychosocial modules of the core CCCM training.
- Disseminate the booklet IASC, Mental Health and Psychosocial Support in Emergency Settings: What should Camp Coordinators and Camp Manager Actors Know? (IASC, 2014c).
- Participate in the cluster meeting to identify MHPSS needed to refer to the MHPSS Working Group, and report requests for support and troubleshooting from MHPSS actors operating in camps.

Box 3

List of members of the IASC RG on MHPSS

- | | |
|---|---------------------------------|
| ACT Alliance | International Medical Corps |
| Action Aid International | International Rescue Committee |
| Action Contra La Faim | IOM/ UN Migration Agency |
| Africa Psychosocial Support Institute | IsraAID |
| Americares | Jesuit Refugee Service |
| American Red Cross | Medair |
| Antares Foundation | Medicin du Monde (France) |
| Care Austria | Medicine du Mondo (Spain) |
| CBM International | Mercy Corps |
| Centre for the Victims of Torture | MERCY Malaysia |
| Child Fund | MHPSS.net |
| Church of Sweden | OCHA |
| COOPI | Oxfam GB |
| DIGNITY | Plan International |
| GIZ - Gesellschaft für Internationale
Zusammenarbeit | Red-R |
| Global Practice Group | Refugee Education Trust |
| Global Psychosocial Training Institute-Cairo | Save the Children International |
| Health Right International | Terre des Hommes |
| Health Works | TPO Nepal |
| Heartland Alliance International | TPO Uganda |
| Hebrew Immigrant Aid Society (HIAS) | UNFPA |
| Humanity & Inclusion | UNHCR |
| ICVA | Unicef |
| IFRC and ICRC (Special status - Standing Invitees
to the IASC) | UNRWA |
| INEE | War Child Holland |
| InterAction | War Trauma Foundation |
| International Catholic Migration Commission | WHO |
| | World Vision International |






ANNEX 2 ETHICAL CONSIDERATIONS



Applying ethical principles to Community-Based MHPSS is necessary to avoid risky practices and grant communities' safety. Generally, ethical guidelines in MHPSS respond to two principles:

- Non-maleficence or “do no harm”.
- Quality and effectiveness of intervention.

Ethical standards for humanitarian programmes are defined and enshrined in a series of guidelines, which apply to MHPSS programmes as well, including:

- 
 • **International Federation of Red Cross (IFRC), Code of Conduct in Principles of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programmes, 2007.**
- 
 • **Core Humanitarian Standard on Quality and Accountability in The Sphere Handbook, CHS, 2018.**
- 
 • **The 6 core principles of the IASC Guidelines on MHPSS in Emergency Settings, Core Principles, IASC (2007), Geneva, 2007**, p. 9. In particular, when promoting a CB approach to MHPSS it is paramount that:
 - o The needs, best interests and resources of the emergency affected population must be of primary consideration when planning and implementing interventions, not only the agenda of the provider or donor.
 - o Care must be taken that all those engaged in any aspect of CB MHPSS are aware of the ethical prohibition against sexual exploitation and abuse, sexual activity with programme participants or any other potentially exploitative “dual” relationships. See the UN website on Preventing Sexual Exploitation and Abuse (PSEA) [here](#).
 - o Confidentiality must be maintained. This includes providing services in such a way that vulnerable groups can receive services without being specifically identified by their vulnerabilities (**IASC, 2019a**). If a person of concern discloses confidential information during a community-based
- 
- 

activity, they need to have the same level of trust as when MHPSS specialized services and be referred to further MHPSS resources when needed.

In addition

- **Be careful to avoid exacerbating marginalization/discrimination/stigmatization**

There are many possible ways in which exclusion can take place within a community. At times, paying close attention to one group of concern, can lead to the needs of another group of concern being overlooked or neglected, sometimes making people feel discriminated against. Marginalization can also be caused by drawing attention to survivors in certain circumstances, especially when their experiences are likely to attract social stigma. It is therefore important to be aware of community dynamics and power structures, and to aim for an approach that is inclusive while also being responsive to the needs of different subgroups. A gender analysis can also be a powerful tool to identify power dynamics in a community. Programme methodologies may have to change to reach different subgroups, even if the outcome is the same. Examples include conducting awareness-raising sessions at household level and at a community centre, to ensure that women, persons with disabilities or others with movement limitations outside of the home also have access to information. One should also be mindful of inadvertently reinforcing power imbalances or subverting existing power balances in a way that creates tensions and further oppression. Therefore, when providing humanitarian relief and facilitating community participation, it is critical to understand the local power structures and patterns of community conflict, to work with different subgroups and to avoid privileging particular groups.

- **Do Not Harm**

When terrible things happen in a community, particularly following mass violence or during armed conflict, the existence and espousal of different narratives can intensify feelings of rage and hatred. Participatory needs assessments and tools can invite the above-mentioned feelings. In turn, these narratives can marginalize those with conflicting views or those who have family members on the “other side”; and may be used to organize retaliatory violence. It is important to be mindful of group composition (e.g. differences in gender, political affiliation) and the types of questions asked. The content of discussions needs consideration as does the most suitable time to carry out a focus group discussion, separate discussions among specific groups (for example women only) or one on one (key informant) interviews.

- **Respect traditions and promoting change**

Cultural traditions and identities are in a constant evolution. Some traditions entrench unequal power relations, are a source of rights violations, or incite social violence. As important as it is to support existing traditional support systems, community based MHPSS should also include actions that can shed light on harmful and exclusionary practices, thereby allowing positive traditional aspects to develop and negative ones to be left aside (Bragin, 2014). In the case of specific vulnerabilities, a MHPSS worker should exercise extra caution in identifying the most fruitful community-based mechanisms to activate.

- **Obtain consent**

In the case management system, informed consent should always be explained and signed by the client. In the case of minors, a parent or guardian must receive information and sign on their behalf. It is important that people of concern understand the limits of the programme from the start; knowing what the organization can do and cannot do for them. This will help to avoid unrealistic expectations, distress and distrust in future

programmes. People of concern must also be informed of the practicalities of what will happen during the time they receive services in an adequate way, in order to avoid misunderstandings.

- **Recognize competence**

Staff must recognize the limits of their professional competence and not attempt to provide services beyond their expertise. When a staff member does not have the required expertise to support a person of concern, a referral should be made to other team members with the adequate knowledge or to local MHPSS resources.

- **Avoid conflict of interest**

MHPSS staff must keep the best interest of people of concern in mind. When donor visits are organized, staff must consider the impact of the visits and receive consent from people of concern. This kind of exposure can be exploitative, people of concern might feel they are obliged to give consent, and it might be a trigger for distress. Staff must think of power dynamics they might be recreating. Steps to eliminate conflict of interest situations must be in place to follow when a situation arise.

- **Avoid grossly unethical behaviour**

Behaviours such as fraud, exploitation, abuse, criminal behaviour, etc., further amplify unbalanced power dynamics. A code of conduct must be signed by all staff. Both staff and people of concern should receive information on unethical behaviour and safe reporting mechanisms.

This annex has been partially copied from the document *Community-Based Approaches to MHPSS Programmes: A Guidance Note* and the video *Restoring Livelihoods with Psychosocial Support* by Dr. Adeyinka Akinsulure-Smith. For additional information on ethical considerations within IOM MHPSS programmes you can contact the IOM MHPSS and Intercultural Communication Global Section: contactpss@iom.int.



MANUAL ON COMMUNITY-BASED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCIES AND DISPLACEMENT

© 2019 International Organization for Migration (IOM)

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise without the prior written permission of the publisher.

BIBLIOGRAPHY



Abramowitz, S.A.

- 2010 Trauma and humanitarian translation in Liberia: The tale of open mole. *Culture, Medicine, and Psychiatry*, 34(2):353–379.

Abramowitz, S. and A. Kleinman

- 2008 Humanitarian intervention and cultural translation: a review of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. *Intervention*, 6(3):219–227.

Academia

- 2019 Available from <https://www.academia.edu/> (accessed 20 May 2019).

ACAPS

- 2015 Rapid Humanitarian Assessment in Urban Settings. Available from <https://www.acaps.org/rapid-humanitarian-assessment-urban-settings> (accessed 21 May 2019).

Action contre la Faim (ACF)

- 2011 *Food Security and Livelihood Monitoring and Evaluation – A practical guide for field workers*. Available from https://www.actioncontrelafaim.org/wp-content/uploads/2018/01/acf_fsl_me_programme_guidelines_en_dec_2011-1.pdf (accessed 15 May 2019)

Adams, P.

- 1998 *Gesundheit! Bringing Good Health to You, the Medical System and Society through Physician Service, Complementary Therapies, Humor*. Rochester: Healing Art Press.

African Centre for the Constructive Resolution of Disputes

- 2019 Available from <https://www.accord.org.za/> (accessed 20 May 2019)

Ager, A., J. Annan and C. Panter-Brick

- 2013 *Resilience: From conceptualization to effective intervention*. Available from www.cpcnetwork.org/resource/resilience-from-conceptualization-to-effective-intervention/ (accessed 4 May 2019).

Ager, A., N. Boothby and M. Wessells

- 2007 The use of consensus methodology in determining key research and practice: development questions in the field of intervention with children associated with fighting forces, *Intervention*, 5 (2):124–129.

Ager, J., E. Fiddian-Qasmiyeh and A. Ager

- 2015 Local Faith Communities and the Promotion of Resilience in Contexts of Humanitarian Crisis. *Journal of Refugee Studies*, 28(2):202–221.

Ager, A. L. Stark, B. Akesson, and N. Boothby

- 2010 Defining Best Practice in Care and Protection of Children in Crisis-Affected Settings: A Delphi Study. *Child Development*, July/August 2010, 81(4) 1271–1286.



Ager, A., L. Stark, T. Sparling and W. Ager

- 2011 *Rapid Appraisal in Humanitarian Emergencies Using Participatory Ranking Methodology (PRM)*. Program on Forced Migration and Health, Columbia University Mailman School of Public Health, New York.

Alexander, J., N. Boothby and M. Wessells

- 2010 Education and protection of children and youth affected by armed conflict: an essential link. In: *Protecting Education from Attack – A State-of-the-Art Review* (UNESCO, ed.).

Alexandria University Theories and Applications the International Edition (TAIE)

- 2011 *Sport as an Instrument for People Development and Peace Promotion*. TAIE. Faculty of Physical Education, Abu Qir, Alexandria University, Alexandria.

Alliance for Child Protection in Humanitarian Action

- 2018a *Case Management Supervision and Coaching Package*. Available from <https://resourcecentre.savethechildren.net/library/case-management-supervision-and-coaching-package> (accessed 15 May 2019).
- 2018b *Child Neglect in Humanitarian Settings*. The Alliance for Child Protection in Humanitarian Settings, Geneva.

Alliance for Peacebuilding – Harnessing collective action for peace

- 2019 Available from <https://allianceforpeacebuilding.org/> (accessed 20 May 2019).

American Psychological Association

- 2019 Available from <https://www.apa.org/pubs/databases/psycinfo/index> (accessed 20 May 2019).

American Society of Group Psychotherapy and Psychodrama (ASGPP)

- 2019 Available from <https://asgpp.org/index.php> (accessed 15 May 2019)

Anand, P., G. Hunter and R. Smith

- 2005 Capabilities and well-being: evidence based on the Sen–Nussbaum approach to welfare. *Social Indicators Research*, 74(1):9–55. Available from <https://pdfs.semanticscholar.org/3c7a/11e3d5918274d80a902b065b1fb1b8c25b6f.pdf> (accessed 4 May 2019).

Antares Foundation

- 2005 *Managing stress in humanitarian workers: Guidelines for good practice*. Available from <https://cms.emergency.unhcr.org/documents/11982/45255/Antares+Foundation%2C+Managing+Stress+of+Humanitarian+Workers+-+Best+practice+guide%2C+2005/41f70ba9-c429-4d89-8263-2567d956298a> (accessed 15 May 2019).

Anderson, H., and H.A. Goolishian

- 1988 Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 27(4):371–393.
- 1992 The client is the expert: A not-knowing approach to therapy. In: *Inquiries in social*



construction. *Therapy as social construction* (S. McNamee and K.J. Gergen, eds.). Sage Publications, Thousand Oaks, CA, United States, pp. 25–39.

Anderson, M.B.

1999 *Do No Harm: How Aid Can Support Peace – or War*. Lynne Rienner, Boulder, CO, United States.

Antares Foundation

2005 *Managing Stress in Humanitarian Workers: Guidelines for Good Practice*.

Arai, T.

2009 *Creativity and Conflict Resolution: Alternative Pathways to Peace*. Routledge, London.

2012a Development Sensitivity for Reconciliation: Lessons Learned from Rwanda. *Conflict Trends* 4. Available from https://works.bepress.com/tatsushi_arai/31/ (accessed 6 May 2019).

2012b Rebuilding Pakistan in the Aftermath of the Floods: Disaster Relief as Conflict Prevention. *Journal of Peacebuilding and Development*, 7(1). Available from www.tandfonline.com/doi/full/10.1080/15423166.2012.719331 (accessed 4 May 2019).

2017a Conflict-Sensitive Repatriation: Lessons from Displaced Communities in Northeastern Nigeria. *Conflict Trends* 1. Available from www.accord.org.za/conflict-trends/conflict-sensitive-repatriation (accessed 4 May 2019).

2017b *Promoting Interreligious Harmony in Myanmar: A Guide to Training and Dialogue*. Peaceful Myanmar Initiatives, Yangon, Myanmar.

Armaghanyan, S.

2018 *Theatre as Psychosocial Approach in Humanitarian Settings*. (Unpublished masters' thesis).

Augustinavicius, J.L., M.C. Greene, D.P. Lakin and W.A. Tol

2018 Monitoring and evaluation of mental health and psychosocial support programmes in humanitarian settings: a scoping review of terminology and focus. *Conflict and health*, 12(1):9.

Baca, M., K. Fayyad, A. Marini and I. Weissbecker

2012 The development of a comprehensive mapping service for mental health and psychosocial support in Jordan. *Intervention*, 10(2):177–187. Available from www.interventionjournal.com/content/development-comprehensive-mapping-service-mental-health-and-psychosocial-support-jordan (accessed 4 May 2019).

Bacigalupe, G.

2011 Is there a role for social technologies in collaborative healthcare? *Families, Systems and Health*, 29(1):1.

Baetz, M., R. Bowen, G. Jones and T. Koru-Sengul

2006 How spiritual values and worship attendance relate to psychiatric disorders in the Canadian population. *Canadian Journal of Psychiatry*, 51(10):654–661.



Balfour, M. (ed.)

2013 *Refugee Performance, Practical Encounters*. Intellect, Bristol, United Kingdom.

Banerjee, A., E. Duflo, N. Goldberg, D. Karlan, R. Osei, W. Parienté, J. Shapiro, B. Thuysbaert and C. Udry

2015 A multifaceted program causes lasting progress for the very poor: Evidence from six countries. *Science*, 348(6236).

Banting, R., C. Butler and C. Swift

2017 The adaptation of a Solution-Focused Brief Therapy domestic violence perpetrator programme: A case study with a client with a learning disability. *Journal of Family Therapy*, 40(4):489–502.

Barba, E.

2001 “Theatre, Cohabitation of the Different.” *Armadilla*. EDT, Milano.

Baron, N.

2002 Community-based psychosocial and mental health services for southern Sudanese refugees in long-term exile in Uganda. In: *The Plenum series on stress and coping. Trauma, war, and violence: Public mental health in socio-cultural context* (J. de Jong, ed.). Kluwer Academic/Plenum Publishers, New York, pp. 157–203.

Barry-Murphy, E. and M. Stephenson

2014 Engaging IDPs in Sri Lanka: A Buddhist approach. *Forced Migration Review*, 48:59–60.

Barsky, A.E.

2014 *Conflict Resolution for the Helping Professions*. Oxford University Press, New York.

Basaglia, F.

2000 *Scritti 1968—1980. Dall'apertura del manicomio alla nuova legge sull'assistenza psichiatrica*. Torino: Einaudi.

Bateson, G.

1979 *Mind and Nature. A Necessary Unity*. E.P. Dutton, New York.

Bava, S.

2017 Creativity in couple and family therapy. In: *Encyclopedia of couple and family therapy* (J.L. Lebow, A.L. Chambers and D. Breundlin, eds.), Springer, New York.

Beer, J.E. and C.C. Packard, with E. Stief

2012 *The Mediator's Handbook*. New Society Publishers, Gabriola Island, B.C., Canada.

Bernardi, C.

1996 *Corpus Hominis, riti di violenza, teatri di pace*. Milano: Euresis Edizioni.

2000 “Sull'antropologia del teatro.” In *Ifuoriscena, esperienze e riflessioni sulla drammaturgia nel*



sociale, edited by Claudio Bernardi, Benvenuto Cuminetti, and Sisto Dall Palma, 25—59. Milano: Euresis Edizioni.

2000 “Fare fuori il teatro.” *Comunicazioni sociali* XXIII.

2009 For a dramaturgy of communities. In: *Drama-therapy and social theatre. Necessary dialogues* (Jennings, S. ed.). Routledge, London.

2009 For a dramaturgy of communities. In: *Drama-therapy and social theatre. Necessary dialogues* (Jennings, S. ed.). Routledge, London.

Bernardi, C. and B. Cuminetti

1998 *L'ora di Teatro: Orientamenti europei ed esperienze italiane nelle istituzioni educative*. Milano: Euresis Edizioni.

Bernardi, C., B. Cuminetti and S.D. Palma

2000 *Ifuori.scena, esperienze e riflessioni sulla drammaturgia nel sociale*. Milano: Euresis Edizioni.

Bernardi, C., M. Dragone and G. Schinina

2002 *War Theatres and Actions for Peace: Community-Based Dramaturgy and the Conflict Scenes*. Milano: Euresis Edizioni.

Bertoni, A.

2000 “La drammaterapia.” In *Ifuoriscena, esperienze e riflessioni sulla drammaturgia nel sociale* (C. Bernardi et al. ed.), pp. 185—195. Milano: Euresis Edizioni.

Betancourt, T.S., M.S.E. Meyers-Ohki, M.A.P. Charrow and W.A. Tol

2013 Interventions for children affected by war: an ecological perspective on psychosocial support and mental health care. *Harvard review of psychiatry*, 21(2):70.

Beyond Intractability

2019 Available from <https://www.beyondintractability.org/> (accessed 20 May 2019)

Bhana, A., I. Petersen, K.L. Baillie, A.J. Flisher and Mhapp Research Programme Consortium

2010 Implementing the World Health Report 2001 recommendations for integrating mental health into primary health care: a situation analysis of three African countries: Ghana, South Africa and Uganda. *International Review of Psychiatry*, 22(6):599–610.

Bjerneld, M.

2009 Images, Motives and Challenges for Western Health Workers in Humanitarian Aid. *Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine* (453).

Black, K. and P. Stevenson

2011 *The inclusion spectrum*. Available from http://www.sportdevelopment.org.uk/index.php?option=com_content&view=article&id=748%3Athe-inclusion-spectrum&catid=98%3Adisability-sport-a-physical-activity&Itemid=1 (accessed 15 May 2019)



Blattman, C., N. Fiala and S. Martinez

- 2014 Generating Skilled Self-Employment in Developing Countries: Experimental Evidence from Uganda. *Quarterly Journal of Economics*, 129(2):697–752.

Blattman, C., J. Jamison and M. Sheridan

- 2015 Reducing Crime and Violence: Experimental Evidence on Adult Non-Cognitive Investments in Liberia. *Working Paper No. 21204*, National Bureau of Economic Research, Cambridge, Massachusetts, United States.

Boal, A.

- 1974 *Teatro del oprimido y otras poeticas politicas*. De la Flor, Buenos Aires.
1974 *Theatre of The Oppressed*. Routledge, London.
1990 *L'Arc en ciel du désir. Méthode Boal de Théâtre et de Thérapie*. Ramsay, Paris.
1992 *Games for Actors and non-actors*. Routledge, London.
1995 *The Rainbow of Desire: The Boal Method of Theatre and Therapy*. Routledge, London.
2002 *Games for Actors and non-Actors*. Second edition. Routledge, London.
2008 *Theatre of the Oppressed*. Second edition. Routledge, London.

Bond, G.R.

- 1992 Vocational rehabilitation. In: *Handbook of Psychiatric Rehabilitation* (R.P. Lieberman, ed.). Macmillan, New York, pp. 244–75.

Bonelli, R. and H.G. Koenig

- 2013 Mental disorders, religion and spirituality 1990 to 2010: a systematic evidence-based review. *Journal of Religion and Health*, 52(2):657–673.

Bonino, S.

- 1987 *I riti del quotidiano: Studio psicologico sulla ritualizzazione personale*. Boringhieri, Torino.

Boothby, N., A. Strang and M. Wessells

- 2006 *A world turned upside down: Social ecological approaches to Children and War*. Kumarian Bloomfield, CT, United States.

Boss, P.

- 2004 Ambiguous loss. In: *Living beyond loss* (M. McGoldrick and F. Walsh, eds.). Norton, New York, pp. 237–246.
2018 Families of the missing: Psychosocial effects and therapeutic approaches. *International Review of the Red Cross*, 99(905):519–534.

Boyd, F., T. Morris and B. Bry

- 1997 Parent and family support groups with African American families: The process of family and community empowerment. *Cultural diversity and mental health*. 3(2):63–92.



Bragin, M.

- 2005a Pedrito: Exploring the roots of aggression through the traditional treatment of a former child soldier in Angola. *Journal of Infant Child and Adolescent Psychotherapy*, 4(1):1–21.
- 2005b Pedrito: The blood of the ancestors. *Journal of Infant Child and Adolescent Psychotherapy*, 4(1):1–20.
- 2005c The Community Participatory Evaluation Tool for Psychosocial Programs: A guide to implementation. *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 3(1):3–24.
- 2005d *The tiger is our guest: Helping children to grow up in time of war and afterwards*. CARE Österreich, Vienna. Available from www.care.at/care-resources/psychosocial/ (accessed 4 May 2019).
- 2012 So that our dreams will not escape us: Learning to think together in time of war. *Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals*, 32(2):115–135.
- 2014 Clinical social work with survivors of disaster and terrorism: A social ecological approach. In: *Essentials of clinical social work*. Second edition (J. Brandell, ed.). Sage Publications, Thousand Oaks, CA, United States, pp. 366–401.
- 2017 *The SEE_PET – A Participatory Method for Developing and Measuring the Effectiveness of Psychosocial Programs in Emergency Contexts – Version 2 – generic*. CARE Österreich, Vienna. Available from <http://silo.hunter.cuny.edu/g1B0LnFr> (accessed 4 May 2019).

Bragin, M., K. Onta, J. Taaka, D. Ntacobakinvuna, K. Adolphs, J. Bolen, N. Tammelleo and T. Eibs

- 2013 *To be well at heart: Perceptions of psychosocial well-being among conflict affected women in Nepal, Burundi, and Uganda*. CARE Österreich, Vienna.

Bragin, M., J. Taaka, K. Adolphs, H. Gray and T. Eibs

- 2014 Measuring the un-measurable: Operationalizing psychosocial well-being in post-conflict Uganda. *Clinical Social Work Journal*.

Brandell, J.R. (ed.)

- 2014 *Essentials of clinical social work*. Sage Publications, Thousand Oaks, CA, United States.

British Psychodrama Association (BPA)

- 2019 Available from <http://www.psychodrama.org.uk/index.php> (accessed 15 May 2019)

Bronfenbrenner, U.

- 1979 *The ecology of human development*. Harvard University Press, Cambridge, MA, United States.
- 1992 *Ecological systems theory*. Jessica Kingsley Publishers, London.

Brook, P.

- 1987 *The shifting point - Forty Years of Theatrical Exploration, 1946-87*. Harper and Row, London.
- 1994 *The shifting point - Theatre, Film, Opera 1946-1987*. Theatre Communication Group, New York.



Brown, F.L., A.M. de Graaff, J. Annan and T.S. Betancourt

- 2017 Annual Research Review: Breaking cycles of violence – a systematic review and common practice elements analysis of psychosocial interventions for children and youth affected by armed conflict. *Journal of child psychology and psychiatry*, 58(4):507–524.

Bush, K. and C. Duggan

- 2013 Evaluation in conflict zones: Methodological and ethical challenges. *Journal of Peacebuilding and Development*, 8(2):5–25.

Business Dictionary

- 2019 *Tradeoff*. Available from <http://www.businessdictionary.com/definition/tradeoff.html> (accessed 15 May 2019).

Butterworth, P., L. Leach, L. Strazdins, S. Olesen, B. Rodgers and D. Broom

- 2011 The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results from a Longitudinal National Household Panel Survey. *Occupational and Environmental Medicine*, 68(11):806–812.

Capire Consulting Group

- 2015 *The Engagement Triangle*. Capire Consulting Group, Victoria, Australia.
2016 *Inclusive Community Engagement Toolkit*. Capire Consulting Group, Victoria, Australia.

CARE Österreich

- n.d. *Psychosocial resources including a guide for indicator development*. Available from www.care.at/care-resources/psychosocial (accessed 4 May 2019).

CARE Nederland

- 2013 *The Community Score Card Toolkit*. Available from <https://www.carenederland.org/carexpertise/publication/the-community-score-card-toolkit/> (accessed 16 May 2019).

Caribbean Country Management Unit.

- 2006 *Social resilience and state fragility in Haiti. A country social analysis*. World Bank, Washington DC.

CDA collaborative

- 2018 Do No Harm and Gender: A Guidance Note. Available from <http://cdacollaborative.org/publication/no-harm-gender-guidance-note/> (accessed 4 May 2019).
2019 Available from <https://www.cdacollaborative.org/> (accessed 20 May 2019).

Chambers, R. and G. Conway

- 1992 *Sustainable Rural Livelihoods: Practical concepts for the 21st Century*. Institute of Development Studies, Brighton, United Kingdom.

Charlés, L.L. and G. Samarasinghe (eds.)

- 2016 *Family Therapy in Global Humanitarian Contexts: Voices and Issues from the Field*. Springer, New York.



Chibanda, D., R. Verhey, E. Munetsi, F.M. Cowan and C. Lund

- 2016 Using a theory driven approach to develop and evaluate a complex mental health intervention: the friendship bench project in Zimbabwe. *International Journal of Mental Health Systems*, 10(1):16.

Chibanda, D., H.A. Weiss, R. Verhey, V. Simms, R. Munjoma, S. Rusakaniko and M. Abas

- 2016 Effect of a primary care-based psychological intervention on symptoms of common mental disorders in Zimbabwe: a randomized clinical trial. *JAMA*, 316(24):2618–2626.

Cimellaro, G.P., A. Caverzan, G. Tsionis and G. Solomos

- 2017 Proceedings of the 1st International Workshop on Resilience. Available from <https://ec.europa.eu/jrc/en/publication/proceedings-1st-international-workshop-resilience> (accessed 4 May 2019).

Clancy, M. A. and B. Hamber

- 2008 Trauma, Peacebuilding and Development: An overview of key positions and critical questions. Paper presented at the Trauma, Development and Peacebuilding Conference, New Delhi, India, 9–11 September 2008. Available from www.incore.ulst.ac.uk/pdfs/IDRCclancyhamber.pdf (accessed 4 May 2019).

Clemens Ley, C. and M. Rato Barrio

- 2010 Movement, Games and Sport in Psychosocial Intervention: A Critical Discussion of its Potential and Limitations within Cooperation for Development. *Intervention*, 8(2):106–120.

Cohen, O., D. Leykin, M. Lahad, A. Goldberg and L. Aharonson-Daniel

- 2013 The conjoint community resiliency assessment measure as a baseline for profiling and predicting community resilience for emergencies. *Technological Forecasting and Social Change*, 80(9):1732–1741.

Conciliation Resources – Working together for peace

- 2019 Available from <https://www.c-r.org/> (accessed 20 May 2019).

Conflict Sensitivity Consortium

- 2012 *How to Guide to Conflict Sensitivity*. Available from http://conflictsensitivity.org/wp-content/uploads/2015/04/6602_HowToGuide_CSF_WEB_3.pdf (accessed 20 May 2019).
- 2019 Available from <http://conflictsensitivity.org/> (accessed 15 May 2019).

Crigler, L., J. Gergen and H. Perry

- 2013 *Supervision of Community Health Workers*. Available from https://www.mchip.net/sites/default/files/mchipfiles/09_CHW_Supervision.pdf (accessed 15 May 2019).

Dash, J.M.

- 2001 *Culture and customs of Haiti*. Greenwood Press, Westport, CT.



De Dieu Basabose, J.

- 2014 *Community based sociotherapy in Rwanda: healing a post-violent conflict society*. Available from <https://www.peaceinsight.org/blog/2014/09/community-based-sociotherapy-rwanda/> (accessed 20 May 2019).

De Haene, L.

- 2013 Children and Youth Affected by Armed Conflict: Where Do We Go from Here? Conference Proceedings, Kampala, 25–27 September 2013. Available from https://resourcecentre.savethechildren.net/sites/default/files/documents/conference_proceedings_1.pdf (accessed 4 May 2019).

De Haene, L., P. Rober, P. Adriaenssens and K. Verschueren

- 2012 Voices of dialogue and directivity in family therapy with refugees: Evolving ideas about dialogical refugee care. *Family Process*, 51(3):391–404.

De Marinis, M.

- 1987 *Il Nuovo Teatro, 1947—1970*. Milano: Bompiani.

Demetrio, D.

- 1997 *Il Jjioco della vita. Kit Autobiografico. Trenta proposte per raccontarsi*. Guerini ed associati, Milano.

DeMott, M.A.M.

- 2014 Chapter Six: Breaking the Silence: Expressive Arts as Testimony. In: *Nordic Work with Traumatised Refugees: Do We Really Care?* (G. Overland, E. Guribye and B. Lie, eds), p. 192.
- 2017 Expressive Arts: A Group Intervention for Unaccompanied Minor Asylum Seekers and Young Adults. In: *Reconstructing Meaning After Trauma* (E. Altmaier, ed), pp. 153–166.

Denborough, D.

- 2008 *Collective narrative practice: Responding to individuals, groups, and communities who have experienced trauma*. Dulwich Centre Publications, Adelaide, Australia.
- 2012 The Team of Life with young men of refugee backgrounds. *International Journal of Narrative Therapy and Community Work*, (2):44–53.
- 2014 *Retelling the stories of our lives: Everyday narrative therapy to draw inspiration and transform experience*. Norton, New York.
- 2018 *Do You Want to Hear a Story? Adventures in Collective Narrative Practice*. Dulwich Centre Publications, Adelaide, Australia.

Dennis, R.

- 2004 *Public performance, personal story: a study of playback theatre*. Griffith University, Brisbane, Australia.



Directorate-General Humanitarian Aid and Civil Protection.

- 2016 *Humanitarian Protection - Improving protection outcomes to reduce risks for people in humanitarian crises*. Available from https://ec.europa.eu/echo/sites/echo-site/files/policy_guidelines_humanitarian_protection_en.pdf (accessed 15 May 2019).

Dokter, D.

- 1998 *Arts Therapists, Refugees and Migrants: Reaching Across Borders*. London: Jessica Kingsley Publishers.

Doocy, S., H. Tappis and E. Lyles

- 2016 Are cash-based interventions a feasible approach for expanding humanitarian assistance in Syria? *Journal of International Humanitarian Action*, 1:13.

Dragone, M.

- 2000 "Esperienze di teatro sociale in Italia." In *I fuoriscena, esperienze e riflessioni sulla drammaturgia nel sociale*, (C. Bernardi, ed.), 61 — 123. Milano: Euresis Edizioni.

Dudovskiy, J.

- 2019 *Purposive sampling*. Available from <https://research-methodology.net/sampling-in-primary-data-collection/purposive-sampling/> (accessed 20 May 2019).

Eggeman, M. and Panter-Brick, C.

- 2011 Fieldwork and Research Process and Community Engagement: Experiences from the Gambia and Afghanistan. In: *Centralizing Fieldwork: Critical Perspectives from Primatology, Biological and Social Anthropology*. Studies of the Biosocial Society, (4). Berghahn, New York.

Eibl-Eibesfeld, I.

- 1989 *Human Ethology*. New York: Aldine de Gruyten.

Ekman, P.

- 1972 *Emotion in the Human Face*. Cambridge: Cambridge University Press.

El-Khani, A., F. Ulph, S. Peters and R. Calam

- 2016 Syria: the challenges of parenting in refugee situations of immediate displacement. *Intervention*, 14(2):99–113.
- 2017 Syria: coping mechanisms utilised by displaced refugee parents caring for their children in pre-resettlement contexts. *Intervention*, 15(1):34–35 .

Erikson, K.

- 1976 *Everything in its Path: Destruction of Buffalo Creek*. Simon and Schuster, New York.
- 1991 Notes on Trauma and Community. *American Imago*, 48(4):455–472.
- 2001 Disaster at Buffalo Creek. In: *Down to Earth Sociology* (J.M. Henslin, ed.).



Falicov, C.J.

1995 Training to think culturally: A multidimensional comparative framework. *Family Process*, 34:373–388.

Fazel, S., V. Khosla, H. Doll and J. Geddes

2008 The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. *PLoS Medicine*, 5(12).

Ferris, E.

2011 Faith and Humanitarianism: It's Complicated. *Journal of Refugee Studies*, 23 (3):606–625.

Finn Church Aid (FCA)

2018 Improving Well-being Through Education – Integrating Community Based Psychosocial Support into Education in Emergencies. FCA, Helsinki.

Fitzgerald, C., A. Elkaied and I. Weissbecker

2012 Mapping of mental health and psychosocial support in post-conflict Libya. *Intervention*, 10(2):188–200. Available from www.interventionjournal.com/content/mapping-mental-health-and-psychosocial-support-post-conflict-libya (accessed 4 May 2019).

Ford, B. and V. Searing

2000 *Community approaches: Mayan survivors in Guatemala*. International Trauma Studies Program, New York University.

Fox, K. A.

2017 *Social Mobilization Lessons Learned: The Ebola Response in Liberia*. John Hopkins Center for Communication Programs, Baltimore.

Fraenkel, P.

2006 Engaging families as experts: Collaborative family program development. *Family Process*, 45(2):237–257.

2009 The therapeutic palette: A guide to choice points in integrative couple therapy. *Clinical Social Work Journal*, 37(3):234–247.

2014 The Bases of Counseling. Course Syllabus.

Fraenkel, P. and W.M. Pinsof

2001 Teaching family therapy-centered integration: Assimilation and beyond. *Journal of Psychotherapy Integration*, 11:59–85.

Franklin, C.

2015 An Update on Strengths-Based, Solution-Focused Brief Therapy. *Health & Social Work*, 40 (2): 73-76.

Franklin, C., A Zhang, A. Froerer and S. Johnson

2017 Solution-Focused Brief Therapy: A Systematic Review and Meta-Summary of Process Research. *Journal of Marital and Family Therapy*, 43(1):16–30.



Galtung, J.

- 1958 *Theories of conflict. Definitions, Dimensions, Negations, Formations*. Available from https://www.transcend.org/files/Galtung_Book_Theories_Of_Conflict_single.pdf (accessed 17 May 2019).
- 2000 *Transcend and Transform: An Introduction to Conflict Work*. Paradigm Publishers Boulder, Colorado, United States.

Geertz, C.

- 1973 *The Interpretation of Cultures*. Basic Books, Inc. New York.
- 2008 Thick description: Toward an interpretive theory of culture. In: *The Cultural Geography Reader* (P.L. Price and T. Oakes, eds.). Routledge, London, pp. 41–51.

Giardinelli, L., G. Kios, B. Abubakar, G. Schininà and C. Hammen

- 2015 *An Assessment of Psychosocial Needs and Resources in Yola IDP camps: North East Nigeria*. IOM, Abuja.

Gilbert, A. and Y. Sliep

- 2009 Reflexivity in the Practice of Social Action: From Self- to Inter-Relational Reflexivity. *South African Journal of Psychology*, 39(4):468–479.

Gingerich, W.J., J.S. Kim and A. MacDonald

- 2012 Solution-Focused Brief Therapy outcome research. In: *Solution-Focused Brief Therapy: A handbook of evidence-based practice* (C. Franklin, T.S. Trepper, W.J. Gingerich and E.E. McCollum, eds.). Oxford University Press, New York, pp. 95–111.

Gingerich, T.R., D.L. Moore, R. Brodrick and C. Beriont

- 2017 *Local Humanitarian Leadership and Religious Literacy: Engaging with Religion, Faith and Faith Actors*. Oxfam GB, Oxford, United Kingdom. Available from https://s3.amazonaws.com/oxfam-us/www/static/media/files/Oxfam_Harvard_Local_humanitarian_leadership_and_religious_literacy.pdf (accessed 4 May 2019).

Gingerich, W.J. and L.T. Peterson

- 2013 Effectiveness of solution-focused brief therapy: a systematic qualitative review of controlled outcome studies. *Database of Abstracts of Reviews of Effects (DARE): Quality-assessed Reviews*, 23(3):266–283.

Gioffi Caverzasio, S.

- 2001 *Strengthening Protection in War: A Search for Professional Standards*. Available from <https://www.icrc.org/en/publication/0783-strengthening-protection-war-search-professional-standards> (accessed 16 May 2019).

Girard, R.

- 1972 *La violence et le sacré*. Grasset, Paris.



Girl Effect

2019 Available from <https://www.girleffect.org/> (accessed 15 May 2019).

Glass, N., N. Perrin, A. Kohli and M. Remy

2014 Livestock/animal assets buffer the impact of conflict-related traumatic events on mental health symptoms for rural women. *Plos One*, 9(11).

2017 Randomised controlled trial of a livestock productive asset transfer programme to improve economic and health outcomes and reduce intimate partner violence in a postconflict setting. *BMJ Global Health*, 2(11).

Global Protection Cluster

2016 *The Centrality of Protection in Humanitarian Action – Questions and Answers*. Available from http://www.globalprotectioncluster.org/_assets/files/news_and_publications/gpc-qa-hc-and-hct-centrality-of-protection-15-12-2016.pdf (accessed 16 May 2019).

Global Protection Cluster and Inter-Agency Standing Committee (IASC)

2015 *Guidelines for Integrating Gender-Based Violence in Humanitarian Action*. Gender-Based Violence Area of Responsibility, Geneva.

Goffman, E.

1959 *The Presentation of Self in Everyday Life*. New York: Doubleday.

Google Scholar

2019 Available from <https://scholar.google.be/> (accessed 20 May 2019).

Goolishian, H.A. and H. Anderson

1992 Strategy and intervention versus nonintervention: A matter of theory? *Journal of Marital and Family therapy*, 18(1):5–15.

Graham-Harrison, E.

2017 *'I was sold seven times': the Yazidi women welcomed back into the faith*. Available from <https://www.theguardian.com/global-development/2017/jul/01/i-was-sold-seven-times-yazidi-women-welcomed-back-into-the-faith> (accessed 15 May 2019).

Gray, A.E.L.

2008 Dancing in our blood. Dance/movement therapy with street children and victims of organized violence in Haiti. In: *Dance, human rights and social justice*, (N. Jackson and T. Shapiro-Phim). Scarecrow Press, Plymouth.

Green-Rennis, L.L., L.J. Hernandez-Cordero, K. Schmitz and M.T. Fullilove

2013 “We have a situation here!”: Using situation analysis for health and social research. In: *Qualitative Methods for Social Work Research* (A.E. Fortune, W.J. Reid and R.L. Miller, eds), pp. 192–212.



Greene, C.M., M.J.D. Jordans, B.A. Kohrt, P. Ventevogel, L.J. Kirmayer, G. Hassan, A. Chiumento, M. van Ommeren and W.A. Tol

- 2017 Addressing culture and context in humanitarian response: Preparing desk reviews to inform mental health and psychosocial support. *Conflict and Health*, 11-21. Available from https://www.researchgate.net/publication/321081217_Addressing_culture_and_context_in_humanitarian_response_Preparing_desk_reviews_to_inform_mental_health_and_psychosocial_support (accessed 15 May 2019).

Growing Interns

- 2019 *Group vs. Individual Supervision*. Available from <http://www.growinginterns.com/group-vs-individual-supervision/> (accessed 15 May 2019).

Haans, T., J. Lansen and H. Brummelhuis

- 2007 Clinical Supervision and Culture: A Challenge in the Treatment of Persons Traumatized by Persecution and Violence. In: *Voices of Trauma* (B. Droždek and J.P. Wilson, eds.). Springer, Boston.

Hammer, M. and J. Adams

- 2014 Context and sustainability: Monitoring and evaluating humanitarian aid. *ONTRAC: Newsletter of the International NGO Training and Resource Center (INTRAC)*, 58. Available from www.intrac.org/wpcms/wp-content/uploads/2016/09/ONTRAC-58.pdf (accessed 4 May 2019).

Hanlon, C., P. Nagendra, T.K. Luitel, M. Vaibhav, S. Shrivasta, G. Medhin, J. Ssebunnya et al.

- 2014 Challenges and opportunities for implementing integrated mental health care: a district level situation analysis from five low-and middle-income countries. *Plos One*, 9(2).

Harknett, S.

- 2013 *Sport and Play for All: A Manual on Including Children and Youth with Disabilities*. Handicap International, Colombo, Sri Lanka. Available from www.sportanddev.org/sites/default/files/downloads/sport_and_play_for_all.pdf (accessed 16 April 2019).

Health Sector Nigeria

- 2018 *World Mental Health Day 2018 – 10th October*. Mental Health and Psychosocial Support (MHPSS) – Sub Working Group, North East Nigeria.

Heers, J.

- 1983 *Fetes de fous et carnivals*. Fayard, Paris.

Herman, J. L.

- 1992 Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress*, 5(3):377–391.

Hijazi, Z., I. Weissbecker and R. Chammay

- 2011 The integration of mental health into primary health care in Lebanon. *Intervention*, 9(3):265–278.



Hinari – Research for Health

2019 Available from <https://www.who.int/hinari/en/> (accessed 20 May 2019).

Hobfoll, S.E., P. Watson, C.C. Bell, R.A. Bryant, M.J. Brymer, M.J. Friedman and S. Maguen

2007 Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry: Interpersonal and Biological Processes*, 70(4):283–315.

Hollander, A., H. Dal, G. Lewis, C. Magnusson, J. Kirkbride and C. Dalman

2016 Refugee migration and risk of schizophrenia and other non-affective psychoses: cohort study of 1.3 million people in Sweden. *BJM*, 352:1030.

Holloway, E.L.

2016 Essential dimensions of systems approach to supervision. In: *Clinical supervision essentials. Supervision essentials for a systems approach to supervision* (E.L. Holloway, ed.), pp. 13–31. American Psychological Association, Washington DC.

Howe, K., R., Krystalli, V. Krishnan, J. Kurtz and R. Macarenas

2018 *The Wages of War: Learning from how Syrians have adapted their livelihoods through seven years of conflict*. Available from https://reliefweb.int/sites/reliefweb.int/files/resources/RD_SyriaReport_dl_0118_FINAL-A4-web.pdf (accessed 15 May 2019)

Huizinga, J.

1949 *Homo Ludens*. Routledge, London.

Human Rights Council

2018 “I lost my dignity”: Sexual and gender-based violence in the Syrian Arab Republic. Conference room paper of the Independent International Commission of Inquiry on the Syrian Arab Republic. A/HRC/37/CRP.3, 8 March.

Humanitarian Policy Group

2011 *Risk in humanitarian action: towards a common approach?* Available from <https://www.odi.org/resources/docs/6764.pdf> (accessed 15 May 2019)

Humanitarian Practice Network

2018 Mental health and psychosocial support in humanitarian crisis. *Humanitarian Exchange*, 72:1–56. Available from <https://reliefweb.int/report/world/special-feature-humanitarian-exchange-magazine-no-72-mental-health-and-psychosocial> (accessed 4 May 2019).

Ideo U

2016 *Design Thinking: A Method for Creative Problem Solving*. Available from www.ideo.com/pages/design-thinking (accessed 4 May 2019).

Institute for Solution-Focused Brief Therapy

n.d. What Does the Research Say About Solution-Focused Brief Therapy? Available from <https://solutionfocused.net/research/> (accessed 5 May 2019).



Inter-Agency Standing Committee (IASC)

- 2004 *FAQ on IHL, IHRL and IRL*. IASC, Geneva.
- 2005 *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*. IASC, Geneva.
- 2007 *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings*. IASC, Geneva.
- 2012a *Accountability to Affected Populations – Tools to assist in implementing the IASC AAP Commitments*. IASC, Geneva. Available from https://interagencystandingcommittee.org/system/files/legacy_files/TOOLS%20to%20assist%20in%20implementing%20the%20IASC%20AAP%20Commitments.pdf (accessed 16 May 2019).
- 2012b *Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes*. IASC, Geneva. Available from www.who.int/mental_health/publications/iasc_4ws/en (accessed 14 April 2019).
- 2013 *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide*. IASC, Geneva.
- 2013 *Statement - The Centrality of Protection in Humanitarian Action*. Available from https://interagencystandingcommittee.org/sites/default/files/the_centrality_of_protection_in_humanitarian_action_english_.pdf (accessed 15 May 2019).
- 2014a *IASC, Mental Health and Psychosocial Support in Emergency Settings: What should Camp Coordinators and Camp Manager Actors Know?* IASC, Geneva.
- 2014b *Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings*. Available from <https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings/documents-public/iasc-recommendations> (accessed 14 April 2019).
- 2014c *What should Camp Coordinators and Camp Manager Actors Know?, 2014*. Available from <https://interagencystandingcommittee.org/node/2839> (accessed 16 May 2019).
- 2015a *AAP – The Operational Framework*. IASC, Geneva. Available from http://earlyrecovery.global/sites/default/files/aap_operational_framework_final_revision_0_0.pdf (accessed 16 May 2019).
- 2015b *Multi-sector Initial Rapid Assessment Guidance*. IASC, Geneva. Available from https://interagencystandingcommittee.org/system/files/mira_2015_final.pdf (accessed 14 April 2019).
- 2015c *Nepal Earthquakes 2015: Desk Review of Existing Information with Relevance to Mental Health and Psychosocial Support*. IASC, Kathmandu.
- 2016 *IASC Policy on Protection in Humanitarian Action*. IASC, Geneva.
- 2017 *IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings, 2017*. IASC, Geneva.
- 2018a *A Faith-Sensitive Approach in Humanitarian Response: Guidance on Mental Health and Psychosocial Programming, 2018*. IASC, Geneva.



- 2018b *Humanitarian System-Wide Scale-Up Activation – Frequently Asked Questions*. IASC, Geneva. Available from https://interagencystandingcommittee.org/system/files/181113_iasc_scale-up_frequently_asked_questions_final.pdf (accessed 16 May 2019)
- 2019a *Community-Based Approaches to MHPSS Programmes: A Guidance Note*. IASC, Geneva.
- 2019b *IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings*. Available from <https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings> (accessed 16 May 2019).
- 2019c *New IASC Structures*. Available from <https://interagencystandingcommittee.org/content/iasc-structure> (accessed 16 May 2019).

International Committee of the Red Cross (ICRC)

- 2007 *Code of Conduct in Principles of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programmes*. ICRC, Geneva.
- 2013 *Accompanying the Families of Missing Persons: A Practical Handbook*. ICRC, Geneva. Available from www.icrc.org/en/publication/4110-accompanying-families-missing-persons-practical-handbook (accessed 14 April 2019).
- 2018 *Professional Standards for Protection Work (3rd ed.)*. ICRC, Geneva.

International Committee of the Red Cross (ICRC) and International Federation of Red Cross and Red Crescent Societies (IFRC)

- 2008 *Guidelines for assessment in emergencies*. ICRC and IFRC, Geneva. Available from www.ifrc.org/Global/Publications/disasters/guidelines/guidelines-for-emergency-en.pdf (accessed 14 April 2019).
- 2014 *Moving Together: Promoting Psychological Well-Being through Sport and Physical Activity*. Available from <http://legacy.pscentre.org/resources/moving-together-promoting-psychosocial-well-sport-physical-activity/> (accessed 14 May 2019).
- 2018a *A Guide to Psychological First Aid for Red Cross Red Crescent Societies PFA*. Available from <http://pscentre.org/?resource=a-guide-to-psychological-first-aid-for-red-cross-red-crescent-societies> (accessed 15 May 2019).
- 2018b *PFA for Red Cross Red Crescent – Module 2: Basic PFA*. Available from <http://pscentre.org/?resource=pfa-for-red-cross-red-crescent-module-2-basic-pfa> (accessed 15 May 2019).
- 2018c *Psychological First Aid for Red Cross Red Crescent: Module 3: Children*. Available from <http://pscentre.org/?resource=psychological-first-aid-for-red-cross-red-crescent-module-3-children> (accessed 15 May 2019).

International Council of Sport Science and Physical Education (ICSSPE)

- 2008 *Sport and Physical Activity in Post-Disaster Intervention – Second Edition*. Available from <https://www.icsspe.org/sites/default/files/Handbook%20Sport%20and%20Physical%20Activity%20in%20Post-Disaster%20Intervention.pdf> (accessed 4 May 2019).

International Federation of Anti-Leprosy Associations

- 2019 *Zero Discrimination – Ending the stigma of leprosy*. Available from <https://indd.adobe.com/>



view/794531c5-0b0f-4b1b-bf24-5bf13bf15854 (accessed 16 May 2019).

International Federation of Leprosy Sufferers

- 2012 *NLEP guidelines on reduction of stigma and discrimination against persons affected by leprosy*. Available from <http://nlep.nic.in/pdf/Guidelines%20-%20reduction%20of%20stigma.pdf> (accessed 5 May 2019).
- 2019 *Stigma guidelines*. Available from <https://ilepfederation.org/what-we-do/zero-discrimination/break-barriers-to-inclusion/stigma/> (accessed 15 May 2019).

International Federation of Red Cross and Red Crescent Societies (IFRC)

- 2001 *Guidelines on family reunifications. Platform for European Red Cross Cooperation on Refugees, Asylum Seekers and Migrants*. IFRC, Geneva.
- 2011 *Protect. Promote. Recognize. Volunteering in emergencies*. IFRC, Geneva. Available from www.ifrc.org/PageFiles/41321/Volunteering%20in%20emergency_EN-LR.pdf (accessed 6 May 2019).
- 2016 *Broken Links: Psychosocial support for people separated from family members – a field guide*. IFRC, Geneva. Available from <http://pscentre.org/?resource=broken-links-psychosocial-support-for-people-separated-from-family-members-a-field-guide> (accessed 15 May 2019).
- 2017 *Monitoring and evaluation framework for mental health and psychosocial support in emergency settings: Guidance and Overview*. IFRC, Geneva.

International Medical Corps (IMC)

- 2016 *Rapid Mental Health and Psychosocial Support Assessment: Needs, Services, and Recommendations for Support to Individuals Affected by the Mosul Emergency*. IMC, Erbil, Iraq.
- 2017 *Ethnographic Assessment of Psychosocial Needs of Children at Vasilika Camp*. IMC, Athens.

International Network for Education in Emergency (INEE)

- 2010 *Minimum Standards for Education: Preparedness, Response, Recovery* (2nd ed.). INEE, Geneva.
- 2016 *Background Paper on Psychosocial Support and Social and Emotional Learning*. INEE, Geneva.
- 2018 *Guidance Note on Psychosocial Support*. INEE, Geneva.

International Organization for Migration (IOM)

- 2001 *Archives of Memory: Supporting Traumatized Communities Through Narration and Remembrance*. Available from <https://publications.iom.int/fr/books/archives-memory-supporting-traumatized-communities-through-narration-and-remembrance> (accessed 15 May 2019).
- 2009a *Assessments on Psychosocial Needs of Iraqis Displaced in Jordan and Lebanon*. Available from <https://publications.iom.int/books/assessment-psychosocial-needs-iraqis-displaced-jordan-and-lebanon> (accessed 15 May 2019).
- 2009b *Caring for Trafficked Persons: Guidance for Health Providers*. IOM, Geneva.



- 2009c *Migration Health Assessments in IOM*. IOM, Geneva. Available from www.iom.int/jahia/webdav/shared/shared/mainsite/activities/health/assessments/Migration-Health-Assessments-IOM.pdf (accessed 4 May 2019).
- 2010a *Assessment of the Psychosocial Needs of Haitians affected by the January 2010 Earthquake*. Available from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/MP_infosheets/Assessment-of-Psychosocial-Needs-Haiti.pdf (accessed 15 May 2019).
- 2010b *Data Protection Manual*. IOM, Geneva.
- 2010c *Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return: IOM Tools*. Available from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/MP_infosheets/Psychosocial-Needs-Assessment-Emergency-Displacement-Early-Recovery-Return-IOM-Tools.pdf (accessed 15 May 2019).
- 2011 *Who am I? Assessment of Psychosocial Needs and Suicide Risk Factors Among Bhutanese Refugees in Nepal and After the Third Country Resettlement*. IOM, Kathmandu, Nepal.
- 2012a *IOM Migration Crisis Operational Framework*. IOM, Geneva.
- 2012b *Mental Health and Psychosocial Support to Migrant, Displaced, and Crisis Affected Populations, including Returnees*. IOM, Geneva. Available from <https://dmsportal/PublishedDocuments/Instructions/IN206.pdf#search=guidance%20note%20on%20migrant%20children> (accessed 15 May 2019).
- 2014 *A rapid assessment of psychosocial needs and resources in South Sudan following the outbreak of the 2013/2014 conflict*. IOM, Geneva. Available from www.iom.int/sites/default/files/our_work/DMM/Migration-Health/MP_infosheets/A-rapid-assessment-of-psychosocial-needs-and-resources-in-South-Sudan-following-the-outbreak-of-the-20132014-conflict_IOM-2014.pdf (accessed 4 May 2019).
- 2014 *Self-help Booklet for Men facing crisis and displacement*. Available from <https://publications.iom.int/books/self-help-booklet-men-facing-crisis-and-displacement-0> (accessed 15 May 2019).
- 2015a *An assessment of Psychosocial Needs and Resources in Yola IDP Camps: North East Nigeria*. Available from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/MP_infosheets/Yola-Assessment-MHPSS-2015.pdf (accessed 15 May 2019).
- 2015b *IOM's Humanitarian Policy – Principles for Humanitarian Action*. IOM, Geneva.
- 2015c *Voices from BOR - Reflecting on a mental health and psychosocial support project at the Bor protection of civilians site in South Sudan*. Available from <https://www.iom.int/sites/default/files/country/docs/south-sudan/SouthSudan-Voices-from-Bor1.pdf> (accessed 15 May 2019).
- 2016 *Mental Health and Psychosocial Support*. IOM South Sudan – Quarterly Update, Q1 and Q2 2016. IOM, Geneva. Available from www.iom.int/sites/default/files/our_work/DMM/Migration-Health/IOM_MHU_MHPSS.pdf (accessed 4 May 2019).
- 2017a *IOM Iraq – Social Cohesion Programme – Annual Report 2017*. Available from <https://www.iomiraq.net/reports/iom-iraq-social-cohesion-programme-annual-report-2017> (accessed 15 May 2019).
- 2017b *Mental health, psychosocial assistance and cultural integration in emergency and displacement:*



IOM perspective. IOM, Geneva. Available from www.iom.int/jahia/webdav/shared/shared/mainsite/activities/health/Mental-Health-Psychosocial-Assistance.pdf (accessed 4 May 2019).

2017c PSS Mobile Teams - Nigeria. Available from <https://www.youtube.com/watch?v=YcaYkdhSP24> (accessed 16 May 2019).

2018a *Development of Participatory Psychosocial Well-being Indicators for IOM-MHPSS Programming in Wau, South Sudan*. Available from <https://southsudan.iom.int/media-and-reports/other-reports/development-participatory-psychosocial-well-being-indicators-iom> (accessed 15 May 2019).

2018b *OIG Strategy for the Management of its Evaluation and Monitoring Functions, 2018–2020*. Office of the Inspector General, IOM, Geneva.

2018c *Psychosocial Support and Dialogue in the Syrian Arab Republic and Lebanon*. IOM, Geneva.

2019a *Assessments in emergencies*. Available from <https://emergencymanual.iom.int/entry/25283/assessments-in-emergencies#1,1554807519882> (accessed 4 May 2019).

2019b *Displacement Tracking Matrix*. Available from <https://www.globaldtm.info/> (accessed 15 May 2019).

2019c *IOM Online Bookstore*. Available from <https://publications.iom.int/> (accessed 20 May 2019).

2019d *Protection mainstreaming in IOM crisis response*. Available from <https://www.iom.int/protection-mainstreaming-iom-crisis-response> (accessed 15 May 2019).

2019e *Who is a migrant?* Available from <https://www.iom.int/who-is-a-migrant> (accessed 21 May 2019).

International Organization for Migration (IOM) Office of the Inspector General

2018 *IOM Evaluation Policy*. IOM, Geneva. Available from www.iom.int/sites/default/files/about-iom/evaluation/iom_evaluation_policy_in_266_external_18.pdf (accessed 4 May 2019).

International Organization for Migration (IOM) and United Nations High Commissioner for Refugees (UNHCR)

2019 *Joint Letter*. Available from https://interagencystandingcommittee.org/system/files/joint_iom-unhcr_letter_-_25_january_2019.pdf (accessed 16 May 2019).

International Organization for Migration (IOM) and US Foreign Disaster Assistance (USAID/OFDA)

2018 *Tackling gender based violence in Iraq*. IOM, Geneva.

International Playback Theatre Network

2019 *What is Playback Theatre?* Available from https://www.iptn.info/?a=group&id=what_is_playback_theatre (accessed 15 May 2019).

International Rescue Committee (IRC)

n.d. *Clinical Care for Survivors of Gender-Based Violence at the International Rescue Committee*. IRC, New York.



International Training and Resource Center (INTRAC)

n.d. *Resources Archive*. Available from www.intrac.org/resources/page/1?terms= (accessed 4 May 2019).

Intervention – Journal of Mental Health and Psychosocial Support in Conflict Affected Areas

2019 Available from <http://www.interventionjournal.org/> (accessed 20 May 2019).

Iqbal, Y. and R. Bilali

2017 Community Radio as a Vehicle for Social Change in Conflict-Affected Settings. In: *Emancipatory and Participatory Methodologies in Peace, Critical, and Community Psychology* (M. Seedat, S. Suffla and D.J. Christie, eds.). Springer, Cham, Switzerland, pp. 33–44.

Jacobs, M. and G. Goodman

1989 Psychology and self-help groups: Predictions on a partnership. *American psychologist*, 44(3):536–545.

Jalal, C.S., E. Frongillo and A. Warren

2015 Food Insecurity Mediates the Effect of a Poverty Alleviation Programme on Psychosocial Health Among the Ultra-Poor in Bangladesh. *The Journal of Nutrition*, 145:1934–1941.

Jean Pierre, J.S.

2006 *Impacts Psychosociaux des Proverbes Creoles sur les habitants des bidonvilles en Haiti*. Educa Vision, Port Au Prince, Haiti.

Jennings, S.

1994 *The Handbook of Dramatherapy*. Routledge, London.

1997 *Drama Therapy: Theory and Practice 3*. Routledge, London.

1999 *Dramatherapy: Theory and Practice III*. London: Routledge.

2003 *Creative Play and Drama with Adults at Risk*. Routledge, London.

2004 *Creative Storytelling with children at risk*. Speechmark Publishing Ltd, Oxon, United Kingdom.

2008 *Creative Puppetry with Children and Adults at Risk*. Routledge, London.

2009a *Creative Storytelling with Children at Risk*. Routledge, London.

2009b *Dramatherapy and Social Theatre – Necessary Dialogues*. Routledge, London.

2017a *Creative Play with Children at Risk*. Routledge, London.

2017b *Creative Puppetry with Children at Risk*. Routledge, London.

2018 *Creative Puppetry with Children and Adults*. Routledge, London.

2019 *Embodiment – Projection Role*. Available from <http://www.suejennings.com/epr.html> (accessed 21 May 2019).



Jennings, S., A. Cattanach, S. Mitchell, A. Chesner and B. Meldrum

1994 *The Handbook of Dramatherapy*. Routledge, London.

Jones, L., J.B. Asare, M. El Masri, A. Mohanraj, H. Sherief and M. Van Ommeren

2009 Severe mental disorders in complex emergencies. *The Lancet*, 374(9690):654–661.

Jordans, M.J., B.A. Kohrt, N.P. Luitel, C. Lund and I.H. Komproe

2017 Proactive community case-finding to facilitate treatment seeking for mental disorders, Nepal. *Bulletin of the World Health Organization*, 95(7):531.

Jordans, M.J., H. Pigott and W.A. Tol

2016 Interventions for children affected by armed conflict: a systematic review of mental health and psychosocial support in low-and middle-income countries. *Current psychiatry reports*, 18(1):9.

Keeping Children Safe

2012 *Safeguarding children in emergencies: A pocket guide*. Available from https://resourcecentre.savethechildren.net/node/6128/pdf/kcs_emergency_pocket_guide3.pdf (accessed 15 May 2019)

Kidwai, S., L.V. Moore and A. FitzGibbon

2014 The role of religion in the formation of cross-community relationships. *Forced Migration*, 48:10–13.

Killian, K.D.

2016 Time, Trauma, and Ambiguous Loss: Working with Families with Missing Members in Post-Conflict Cyprus. In: *Family Therapy in Global Humanitarian Contexts* (L.L. Charlés and G. Samarasinghe, eds.), pp. 77–89.

Kim, J.S.

2008 Examining the Effectiveness of Solution-Focused Brief Therapy: A Meta-Analysis. *Research on Social Work Practice*, 18(2).

Kirmayer, L.J., M. Sehdev and C. Isaac

2009 Community resilience: Models, metaphors and measures. *International Journal of Indigenous Health*, 5(1):62.

Klerman, G.L., M.M. Weissman, B.J. Rounsaville and E.S. Chevron

1984 *Interpersonal Psychotherapy of Depression*. Basic Books, New York.

Klien, S.

2016 Shinto Ritual Practice in Miyagi Prefecture after the Great East Japan Earthquake. *Asian Ethnology*, 75(2):359–376.



Kohrt, B.A., M.J. Jordan, S. Rai, P. Shrestha, N.P. Luitel, M.P. Ramaiya, D.R. Singla and V. Patel

- 2015 Therapist competence in global mental health: Development of the Enhancing Assessment of Common Therapeutic factors (ENACT) rating scale. *Behaviour Research and Therapy*, 69:11–21.

Kraft, K.

- 2015 Faith and impartiality in humanitarian response: Lessons from Lebanese evangelical churches providing food aid. *International Review of the Red Cross*, 97(897):395–421.

Kühhas, B., J. Taaka, K. Adolphs and M. Bragin

- 2018 *Development of Participatory Psychosocial Well-being Indicators for IOM-MHPSS Programming in Wau, South Sudan*. IOM, Geneva. Available from <https://southsudan.iom.int/media-and-reports/other-reports/development-participatory-psychosocial-well-being-indicators-iom> (accessed 4 May 2019).

Kutash, K. et al.

- 2014 Quality Indicators for Multidisciplinary Team Functioning in Community-Based Children's Mental Health Services. *Administration and Policy in Mental Health and Mental Health Services Research*, 41(1):55–68.

Kumar, S. and A. Willman

- 2016 Healing invisible wounds and rebuilding livelihoods: Emerging lessons for combining livelihood and psychosocial support in fragile and conflict-affected settings. *Journal of public health policy*, 37 (Suppl1): 32-50.
- 2017 Restoring Livelihoods with Psychosocial Support. *Journal of Public Health Policy*, 37(1):32–50.

Landau, J.

- 2004 El modelo LINC: una estrategia colaborativa para la resiliencia comunitaria. *Sistemas Familiares*, 20(3):87–102.
- 2007 Enhancing resilience: Families and communities as agents for change. *Family Process*, 46(3):351–365.
- 2010 Communities that care for families: The LINC model for enhancing individual, family, and community resilience. *American Journal of Orthopsychiatry*, 80(4):516–524.
- 2012 Family and community resilience relative to the experience of mass trauma: Connectedness to family- and culture-of-origin as the core components of healing. In: *Handbook of Family Resilience* (D. Becvar, ed.). Springer Publishing Company, New York, pp. 459–480.
- 2018 Transitional Family Therapy. In: *Encyclopedia of Couple and Family Therapy* (J. Lebow, A. Chambers and D. Breunlin, eds.). Springer, Cham, Switzerland.

Landau, J., M. Mittal and E. Wieling

- 2008 Linking human systems: Strengthening individuals, families, and communities in the wake of mass trauma. *Journal of Marital and Family Therapy*, 34(2):193–209.



Landau, J. and J. Saul

- 2004 Facilitating family and community resilience in response to major disaster. In: *Living beyond loss* (F. Walsh and M. McGoldrick, eds.), Norton, New York, pp. 285–309.

Landau, J. and A.M. Weaver

- 2006 The LINC model of family and community resilience: new approaches to disaster response. *Journal of family and consumer sciences*, 30(2):11–14.

Landau-Stanton, J.

- 1986 *Competence, Impermanence, and Transitional Mapping. Systems Consultation: A New Perspective for Family Therapy*. Guilford, New York.

Le Roux, E. and B. Bartelink

- 2017 *No more 'Harmful Traditional Practices': Working effectively with faith leaders*. Available from <https://jliflc.com/wp/wp-content/uploads/2017/11/HTP-report-final-draft.pdf> (accessed 4 May 2019).

LeBaron, M. and V. Pillay

- 2006 *Conflict Across Cultures: A Unique Experience of Bridging Differences*. Intercultural Press, Boston, MA, United States.

Lederach, J.P.

- 2003 *The Little Book of Conflict Transformation*. Good Books, Intercourse, PA, United States.
2005 *The Moral Imagination: The Art and Soul of Building Peace*. Oxford University Press, Oxford, United Kingdom.

Levine, R.S., J.E. Foster, R.E. Fullilove, M.T. Fullilove, N.C. Briggs, P.C. Hull and C.H. Hennekens

- 2016 *Black-white inequalities in mortality and life expectancy, 1933–1999: implications for healthy people 2010*. Public health reports.

Leykin, D., M. Lahad, O. Cohen, A. Goldberg and L. Aharonson-Daniel

- 2013 Conjoint community resiliency assessment measure-28/10 items (CCRAM28 and CCRAM10): A self-report tool for assessing community resilience. *American Journal of Community Psychology*, 52(3-4):313–323.

Lindgren, K.N. and R.D. Coursey

- 1995 Spirituality and serious mental illness: A two-part study. *Psychosocial Rehabilitation Journal*, 18(3):93–111.

Link, B.G. and J.C. Phelan

- 2001 Conceptualizing Stigma. *Annual Review of Sociology*, 27:363–85.

London Health Commission

- 2002 *Culture & Health – Making the Link*. London Health Commission, London.



Losi, N.

- 2002a Psychosocial and Trauma Response in Kosovo. In: *No Place Like Home* (Papadopoulos, R. ed.). Karnac Books, London.
- 2002b Some Assumptions on Psychological Trauma Interventions in Post-Conflict Communities. In *Therapeutic Care for Refugees: No Place Like Home* (R. K. Papadopoulos, ed.), pp. 110-35. Karnac Books, London.

Lund, C., M. De Silva, S. Plagerson, S. Cooper, D. Chisolm, J. Das, M. Knapp, and V. Patel

- 2011 Poverty and Mental Disorders: Breaking the Cycle in Low-Income and Middle-Income Countries. *The Lancet*, 378 (9801): 1502-1514.

Making the Difference – Professional Counselling Services

- 2019 *Professional Skype Supervision*. Available from <http://www.makingthedifference.com.au/site/index.php/professional-skype-supervision> (accessed 15 May 2019).

Mani, A., S. Mullainathan, E. Sharif and J. Zhao

2013. Poverty Impedes Cognitive Function. *Science*, 341:76–80.

Masten, A.S., A.H. Gewirtz and J.K. Sapienza

- 2013 *Resilience in Development: The Importance of Early Childhood*. Available from www.child-encyclopedia.com/resilience/according-experts/resilience-development-importance-early-childhood (accessed 4 May 2019).

Mazurana, D., A. Marshak, T. Atim, R. Gordon and B. McEvoy

- 2016 Disability and Recovery from War in Northern Uganda. *Third World Thematic: A Third World Quarterly*, 1(3):353–369.

McDaniel, S. and J. Landau-Stanton

- 1991 Family-of-origin work and family therapy skills training: Both–And. *Family Process*, 30(4):459–471.

McDowell, T. and P. Kabura

- 2016 Humanitarianism, Colonization, and/or Collaboration? Working Together in Uganda and the United States. In: *Family Therapy in Global Humanitarian Contexts* (L.L. Charlés and G. Samarasinghe, eds.), pp. 27–37.

McGill University, Division of Social and Transcultural Psychiatry

- 2010 *Mental health in Haiti: A literature review*. World Health Organization, Geneva.

Mental Health First Aid USA

- 2013 Available from www.mentalhealthfirstaid.org/ (accessed 4 May 2019).

Mercy Corps

- 2018 *CONCUR Impact Evaluation*. Available from www.mercycorps.org/research-resources/impact-evaluation-reducing-conflict-and-increasing-local-economic-activities (accessed 4 May 2019).



Merriam-Webster

2018a *Counseling*. Available from www.merriam-webster.com/dictionary/counseling (accessed 4 May 2019).

2018b *Ecosystem*. Available from www.merriam-webster.com/dictionary/ecosystem (accessed 4 May 2019).

Metzl, J.M. and H. Hansen

2014 Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science and Medicine*, 103:126–133.

Meyer DeMott, M.A., M. Jakobsen, T. Wentzel-Larsen and T. Heir

2017 A controlled early group intervention study for unaccompanied minors: Can Expressive Arts alleviate symptoms of trauma and enhance life satisfaction? *Scandinavian Journal of Psychology*, 58(6):510–518.

MHPSS.net

2017 *Interim Mental Health & Psychosocial Support Emergency-Toolkit*. Available from <https://app.mhpss.net/images/20170401-emergency-toolkit-version-for-online-placement.pdf> (accessed 16 May 2019).

2019 *The Mental Health & Psychosocial Support Network*. Available from <https://www.mhpss.net/> (accessed 20 May 2019).

Miller, K.E. and A. Rasmussen

2010 War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Social science and medicine*, 70(1):7–16.

2017 The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. *Epidemiology and Psychiatric Sciences*, 26(2):129–138.

Mittlin, D. and J. Thompson

1994 Addressing the gaps or dispelling the myth: participatory approaches in low-income urban communities. In: *Participatory Tools and Methods in Urban Areas* (D. Mittlin and J. Thompson, eds.), RRA Notes 21, International Institute for Environment and Development (IIED), London, pp. 3–12.

Molyneux, J.

2001 Interprofessional team working: what makes team works well? *Journal of Interprofessional Care*, 15(1):29–35.

Moore, C.W.

2014 *The Mediation Process: Practical Strategies for Resolving Conflict*. Jossey-Bass, San Francisco, CA, United States.

Moreno, J.L. (ed.)

1947 *Psychodrama 1*. Beacon House, New York.



1987 *The Essential Moreno*. Springer, Washington D.C.

Mullainathan, S. and E. Shafir

2013 *Scarcity: Why having too little means so much*. Times Books, Henry Holt and Company, New York.

Murray, H., S. El-Leithy and J. Billings

2017 Intensive cognitive therapy for post-traumatic stress disorder in routine clinical practice: A matched comparison audit. *British Journal of Clinical Psychology*, 56(4):474–478.

Murray, L.K., S. Dorsey, P. Bolton, M.J. Jordans, A. Rahman, J. Bass and H. Verdeli.

2011 Building capacity in mental health interventions in low resource countries: an apprenticeship model for training local providers. *International Journal of Mental Health Systems*, 5(1):30.

Murray, L.K., W. Tol, M. Jordans, G.S. Zangana, A.M. Amin, P. Bolton and G. Thornicroft

2014 Dissemination and implementation of evidence-based mental health interventions in post-conflict, low-resource settings. *Intervention*, 12(1), 94.

Nader, K., N. Dubrow and H. Stamm (eds.)

1998 *Honouring differences: Cultural issues in the treatment of trauma and loss*. Brunner/Mazel, Philadelphia, PA, United States, pp. 99–121.

National Center for Biotechnology Information

2019 *PubMed – US National Library of Medicine – National Institute of Health*. Available from <https://www.ncbi.nlm.nih.gov/pubmed> (accessed 20 May 2019)

Ncube, N.

2006 The Tree of Life Project: Using narrative ideas in work with vulnerable children in Southern Africa. *International Journal of Narrative Therapy and Community Work*, (1):3–16.

Nicolas, G., B. Schwartz and E. Pierre

2009 Weathering the storms like bamboo: The strengths of Haitians in coping with natural disasters. In: *International handbook of emotional healing: Rituals and practices for resilience after mass trauma* (A. Kalayjian, D. Eugene and G. Reyes, eds.). Greenwood Publishing Group, Inc., Westport, CT, United States, pp. 96–106.

Nordbrandt, M.S., J. Carlsson, L.G. Lindberg, H. Sandahl and E.L. Mortensen

2015 Treatment of traumatised refugees with basic body awareness therapy versus mixed physical activity as add-on treatment: Study protocol of a randomised controlled trial. *Trials*, 16(1):477.



Norris, F., S. Stevens, B. Pfefferbaum, K. Wyche and R. Pfefferbaum

2008 Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *American Journal of Community Psychology*, 41(1–2):127–150.

O’Connell, R., B. Poudyal, E. Streel, F. Bahgat, W. Tol and P. Ventevogel

2012 Who is Where, When, doing What: mapping services for mental health and psychosocial support in emergencies. *Intervention*, 10(2):171–176. Available from www.interventionjournal.com/content/who-where-when-doing-what-mapping-services-mental-health-and-psychosocial-support (accessed 4 May 2019).

Office of the United Nations High Commissioner for Refugees (UNHCR)

2006 *Participatory Assessment in Operations*. UNHCR, Geneva. Available from www.unhcr.org/publications/legal/450e963f2/unhcr-tool-participatory-assessmentoperations.html (accessed 5 May 2019).

2008a *A Community-Based Approach in UNHCR operations*. UNHCR, Geneva. Available from www.unhcr.org/publications/legal/47ed0e212/community-based-approach-unhcr-operations.html (accessed 5 May 2019).

2008b 4 – Knowledge, skills, attitudes and multifunctional teams. In: *A Community-based Approach in UNHCR Operations* (UNHCR, 2008a). UNHCR, Geneva. Available from www.unhcr.org/47f0a71e5.html (accessed 5 May 2019).

2008c 3 – Implementing a community-based approach. In: *A Community-based Approach in UNHCR Operations* (UNHCR, 2008a). UNHCR, Geneva. Available from www.unhcr.org/47f0a6db2.pdf (accessed 5 May 2019).

2011 *Age, Gender and Diversity Policy: Working with People for Equality and Protection*. UNHCR, Geneva.

2013 *Operational Guidance: Mental Health and Psychosocial Support Programming for Refugee Operations*. UNHCR, Geneva. Available from www.unhcr.org/en-us/protection/health/525f94479/operational-guidance-mental-health-psychosocial-support-programming-refugee.html (accessed 5 May 2019).

2014a *Child Protection Issue Brief: Mental Health and Psychosocial Well-being of Children*. UNHCR, Geneva.

2014b *Understanding Community-Based Protection*. UNHCR, Geneva.

2017 *Community-Based Protection and Mental Health and Psychosocial Support*. Available from www.refworld.org/docid/593ab6add.html (accessed 5 May 2019).

2018a *Emergency Handbook. Mental Health and Psychosocial Support*. UNHCR, Geneva.

2018b *The Global Compact on Refugees*. Available from <https://www.unhcr.org/5b3295167.pdf> (accessed 15 May 2019).

2019 *Emergency Handbook – Identifying persons with specific needs (PWSN)*. Available from <https://emergency.unhcr.org/entry/125333/identifying-persons-with-specific-needs-pwsn> (accessed 15 May 2019).

2019 *Emergency Manual – Protection from Sexual Exploitation and Abuse: IOM Awareness-Raising*



and Reporting Procedures. Available from <https://emergencymanual.iom.int/entry/34105/protection-from-sexual-exploitation-and-abuse-iom-awarenessraising-and-reporting-procedures> (accessed 15 May 2019).

Office of the United Nations High Commissioner for Refugees (UNHCR), International Olympic Committee (IOC) and Terre des hommes (Tdh)

- 2018 *Sport for Protection Toolkit: Programming with Young People in Forced Displacement Settings*. Available from <https://stillmed.olympic.org/media/Document%20Library/OlympicOrg/IOC/What-We-Do/Promote-Olympism/Olympic-Refuge-Foundation/Sport-for-Protection-Toolkit-LowRes.pdf> (accessed 15 May 2019).

Oxfam

- 2010 *Emergency Market Mapping and Analysis Toolkit*. Available from <https://policy-practice.oxfam.org.uk/publications/emergency-market-mapping-and-analysis-toolkit-115385> (accessed 4 May 2019).
- 2015 *Household Economy Approach – Integrating a Gender Approach into the Prevention and Management of Food Insecurity*. Available from <https://www.oxfam.org/en/tags/household-economy-approach> (accessed 21 May 2019).
- 2016 *Innovative Electronic Cash Transfer Programme for Emergencies: An Oxfam-Visa Case Study in the Philippines*. Available from <https://policy-practice.oxfam.org.uk/publications/innovative-electronic-cash-transfer-programme-for-emergencies-an-oxfamvisa-case-619969> (accessed 4 May 2019).

Oxford English Dictionary (OED)

- 2019 Available from www.oed.com/ (accessed 4 May 2019).

Padgett, D.

- 2002 Social work research on disasters in the aftermath of the September 11 tragedy: Reflections from New York City. *Social Work Research*, 23:42–53.

Paine, A., Y. Suarez-Balcazar, S. Fawcett, L. Jameson and M. Embree

- 1990 *Self-help leader's handbook: Leading effective meetings*. Research and Training Center on Independent Living, Lawrence, KS, United States.

Panter-Brick, C. and J.F. Leckman

- 2013 Editorial commentary: resilience in child development—interconnected pathways to wellbeing. *Journal of Child Psychology and Psychiatry*, 54(4):333–336.

Papadopoulos, R.K.

- 2002 Refugees, home and trauma. In: *Therapeutic Care for Refugees. No Place Like Home* (R.K. Papadopoulos, ed.). Karnac, London.
- 2007 Refugees, trauma and adversity-activated development. *European Journal of Psychotherapy and Counselling*, 9(3):301–312.
- 2008 Systemic challenges in a refugee camp. *Context, the Journal of the Association of Family Therapy*, August:16–19.



- 2011 The Umwelt and Networks of Archetypal Images: A Jungian approach to therapeutic encounters in humanitarian contexts. *Psychotherapy and Politics International*, 9(3):212–231.
- 2017 *Community as a system* (PowerPoint presentation). Steering Committee for the elaboration of a community based MHPSS manual. IOM, Brussels.

Papadopoulos, R.K. and N. Gionakis

- 2018 The neglected complexities of refugee fathers. *Psychotherapy and Politics International*, 16(1).

Pasolini, P.P.

- 1968 “Manifesto per un nuovo teatro.” *Nuovi argomenti*, III (1) : 12—22.

Patel, V.

- 2012 Global mental health: from science to action. *Harvard Review of Psychiatry*, 20(1):6–12.
- 2014 Rethinking mental health care: bridging the credibility gap. *Intervention*, 12:15–20.

Patel V. and C. Hanlon

- 2018 *Where There is no Psychiatrist*. Royal College of Psychiatrists, London.

Patel, V. and S. Saxena

- 2014 Transforming lives, enhancing communities – innovations in global mental health. *New England Journal of Medicine*, 370 (6):498–501.

Patel, V., S. Saxena, C. Lund, G. Thornicroft, F. Baingana, P. Bolton and H. Herrman

- 2018 The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392(10157):1553–1598.

Pavis, P.

- 1988 *Le Théâtre au croisement des cultures*. José Corti, Paris.

Peace Insight

- 2019 Available from <https://www.peaceinsight.org/> (accessed 20 May 2019).

Perdomo, C., D. Healy, D. Ceja, K. Dunne and K. Whitaker

- 2016 Kaleidoscopic Shifts: The Development of New Understandings as Therapists “Go and Find out”. In: *Family Therapy in Global Humanitarian Contexts* (L.L. Charlés and G. Samarasinghe, eds.), pp. 125–138.

Pimenta, M.

- 2017 Photos: *Yazidi women undergo a rebirth ceremony after ISIS enslavement*. Available from <https://www.pri.org/stories/2017-09-12/photos-yazidi-women-undergo-rebirth-ceremony-after-isis-enslavement> (accessed 16 May 2019).



Pinheiro, M.D.A.

2017 *Governing Disasters: Beyond Risk Culture*. Palgrave Macmillan, London.

Pitruzzella, S.

2004 *Manuale di teatro creativo*. Franco Angeli, Milano.

2006 *Manual of Creative Theatre. Games to Use in Therapeutic, Educational, and Social Theatre Settings*. Franco Angeli, Milan.

Priebe, S., D. Giacco and R. El-Nagib

2016 *Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region*. Health Evidence Network Synthesis Report, No. 47. Copenhagen: WHO, Regional Office for Europe.

Puac-Polanco, V.D., V.A. Lopez-Soto, R. Kohn, D. Xie, T.S. Richmond and C.C. Branas

2015 Previous violent events and mental health outcomes in Guatemala. *American Journal of Public Health*, 105(4):764–771.

Pupavac, V.

2001 *Therapeutic governance: Psycho-social intervention and trauma risk management*. *Disasters*, 25 (4): 358-372.

2004 *Therapeutic Governance: The Politics of Psychosocial Intervention and Trauma Risk Management*. Available from https://www.researchgate.net/publication/253316004_Therapeutic_Governance_the_Politics_of_Psychosocial_Intervention_and_Trauma_Risk_Management (accessed 21 May 2019).

PYKKA and United Nations Children’s Fund (UNICEF)

2010 *Changing Life Through the Power of Sports*. PYKKA and UNICEF, New Delhi.

Quosh, C., L. Eloul and R. Ajlani

2013 Mental health of refugees and displaced persons in Syria and surrounding countries: a systematic review. *Intervention*, 11(3):276–294.

Ramaswamy, R., R. Shidhaye and S. Nanda

2018 Making complex interventions work in low resource settings: developing and applying a design focused implementation approach to deliver mental health through primary care in India. *International Journal of Mental Health Systems*, 12(1):5.

Regional Psychosocial Support Initiative (REPPSI)

2010 *Mainstreaming Psychosocial Care and Support - Facilitating Community Support Structures*. REPPSI, Johannesburg, South Africa.

Reichelt, S. and N. Sveaass

1994 Therapy with refugee families: What is a “good” conversation? *Family Process*, 33(3):247–262.



Reliefweb

2019 Available from <https://reliefweb.int/> (accessed 20 May 2019).

Richters, A.

2010 Suffering and Healing in the Aftermath of War and Genocide in Rwanda: Mediations through community-based Sociotherapy. In: *Mediations of Violence in Africa – Fashioning new futures from contested pasts* (L. Kapteijns and A. Richters, eds.). Brill, Leiden.

Richters, A., C. Dekker and W.F. Scholte

2008 Community based sociotherapy in Byumba, Rwanda. *Intervention*, 6 (2): 100-116.

Robins, S.

2013 *Families of the missing: A test for contemporary approaches to transitional justice*. Routledge, London.

Rodin, D. and M. van Ommeren

2009 Commentary: Explaining enormous variations in rates of disorder in trauma-focused psychiatric epidemiology after major emergencies. *International Journal of Epidemiology*, 38 (4):1045–1048.

Rogers, P.

2014 *Theory of Change: Methodological Briefs – Impact Evaluation No. 2*. UNICEF Office of Research, Florence.

Rossignoli, C.M., A. Giani, F. Di Iacovo, R. Moruzzo and P. Scarpellini

2017 Enhancing participatory evaluation in a humanitarian aid project. *Evaluation*, 23(2):134–151.

Rostagno, M.

1980 “Animazione.” In *Enciclopedia del teatro del Novecento* (A. Attisani, ed.), pp 185—203. Feltrinelli, Milano.

Ruzek, J.I. et al.

2016 Mobile mental health interventions following war and disaster. *mHealth*, 2(37).

Ruzek, J.I. and C.M. Yeager

2017 Internet and mobile technologies: addressing the mental health of trauma survivors in less resourced communities. *Global Mental Health*, 4(16).

Sangath and London School of Hygiene and Tropical Medicine (LSHTM)

2013 *The Premium Counselling Relationship Manual*. LSHTM, London.

Saul, J.

2013 *Collective trauma, collective healing: Promoting community resilience in the aftermath of disaster*. Routledge, New York and London.



- 2014 *Collective trauma, collective healing: Promoting community resilience in the aftermath of disaster*. Routledge, New York and London.
- 2017 *Collective healing from collective trauma: Promoting community resilience in the aftermath of disaster* (PowerPoint presentation). Steering Committee for the elaboration of a community-based MHPSS manual. IOM, Brussels.
- 2018 *The poetics of therapeutic space. Presentation at International Trauma Studies Program*. August. New York City.

Saul, J. and W. Simon

- 2016 Building resilience in families, communities, and organizations: A training program in global mental health and psychosocial support. *Family Process*, 55(4):689–699.

Save the Children

- 2019 *Save the Children Psychological First Aid Training*. Available from <https://resourcecentre.savethechildren.net/document-collections/save-children-psychological-first-aid-training> (accessed 15 May 2019)

Schafer, A., M. Harper-Shehadeh, K. Carswell, E. van't Hof, J. Hall, A. Malik, T. Au, M. van Ommeren

- 2018 Scalable psychological interventions for people affected by adversity. *Humanitarian Exchange*, 72:19–21.

Schechner, R.

- 1985 *Between Theatre and Anthropology*. University of Pennsylvania Press, Philadelphia.
- 1993 *The Future of Ritual: Writings on Culture and Performance*. Routledge, London.
- 1998 “Believed in Theatre.” *Performance 2* (2):76 – 91.

Scheinberg, M. and P. Fraenkel

- 2001 *The relational trauma of incest: A family-based approach to treatment*. Guilford Press, New York.

Schininà, G.

- 1998 *Augusto Boal: Storia critica del teatro dell'oppresso*. Edizioni la Meridiana, Bari.
- 2000 “Gli arrabbiatissimi adolescenti di Senokos.” *Catarsi, teatri delle diversità* 5, 13-14:53-54.
- 2001 “Casi lontano, così vicino. Interventi di animazione psicosociale e creativa in situazioni d'emergenza e di conflitto nell'area dei Balcani.” *Comunicazioni Sociali*, 23 (3):234-55.
- 2002a “Arts and the Theatre: A Circle of Barter and Encounters-A Training Module on Community Needs.” IOM Psychosocial Notebook 3 (3):67-104.
- 2002b “Cursed Communities, Rituals of Separation and Communication as Vengeance. A Redefinition of Artistic Interventions in War and War-Torn Situations. The Kosovo Case.” In *War Theatres and Actions for Peace: Community-Based Dramaturgy and the Conflict Scenes*, (C. Bernardi et al, eds.) pp. 77—91. Euresis Edizioni, Milano.
- 2004a Cursed Communities, Rituals of Separation and Communication as Vengeance. A



Redefinition of Artistic Interventions in War and War-Torn Societies. In: *War Theatres and Actions for Peace* (C. Bernardi, M. Dragone and G. Schininà, eds.). Euresis, Milan.

2004b 'Far Away, So close'. Psychosocial and Theatre Activities with Serbian Refugees. *The Drama Review*, 48 (3):32-49.

2004c Here we are. Social Theatre and Some Open Question on its Development. *The Drama Review*, 48(3):17–31.

2009 Like ham in a temperance hotel – Healing, participation and education in social theatre. In: *Dramatherapy and Social Theatre – Necessary Dialogues* (Jennings, S. ed). Routledge, London.

Schininà, G., M. Aboul Hosn, A. Ataya, G. Dieuveut and M. Salem

2010 Psychosocial Response to the Haiti Earthquake: The Experiences of International Organization for Migration. *Intervention*, 8(2):158–164.

Schininà, G., E. Babcock, R. Nadelman, J.S. Walsh, A. Willhoite and A. Willman

2016 The integration of livelihood support and mental health and psychosocial wellbeing for populations who have been subject to severe stressors. *Intervention*, 2016, 14 (3):211–222.

Schininà, G., E. Bartoloni and R. Nuri

2008 *Assessment on Psychosocial Needs of Iraqis Displaced in Jordan and Lebanon*. IOM, Beirut.

Schininà, G., N. Nunes, P. Birot, L. Giardinelli and G. Kios

2016 Mainstreaming Mental Health and Psychosocial Support in Camp Coordination and Camp Management. The Experience of the International Organization for Migration in the North East of Nigeria and South Sudan. *Intervention*, 14(3), 232–244.

Schininà, G. and M. Tankink

2018 Introduction to *Special Section* on: Psychosocial support, conflict transformation and creative approaches in response to the needs of Syrian refugees in Turkey. *Intervention*, 16(2):161–163.

Schininà, G., J. Voltaire, A. Ataya and M. Salem

2011 “Dye Mon, Gen Mon” (“Beyond the Mountains, More Mountains”). Social Theatre, Community Mobilisation and Participation after Disasters: The International Organization for Migration Experience in Haiti, after January 2010’s Earthquake. *Research in Drama Education: The Journal of Applied Theatre and Performance*, 16(1):47–54.

Schininà, G. and T.E Zanghellini

2018 Internal and International Migration and its Impact on the Mental Health of Migrants. In: *Mental Health and Illness in Migration. Mental Health and Illness Worldwide* (D. Moussaoui, D. Bhugra and A. Ventriglio, eds.). Springer, Singapore, pp. 1-19.

Schirch, L.

2013 *Conflict Assessment and Peacebuilding Planning: Toward a Participatory Approach to Human*



Security. Kumarian Press, Boulder, CO, United States.

Scholte, W.F. and A.K. Ager

2014 Social capital and mental health: connections and complexities in contexts of post-conflict recovery. *Intervention*, 12(2):210–218.

Scholte, W.F., F. Verduin, A.M. Kamperman, T. Rutayisire, A.H. Zwiderman and K. Stronks

2011 The effect on mental health of a large-scale psychosocial intervention for survivors of mass violence: a quasi-experimental study in Rwanda. *Plos One*, 6(8).

Schrock-Shenk, C.

2002 *Mediation and facilitation training manual: Foundations and skills for constructive conflict transformation*. Mennonite Conciliation Service, Akron, PA, United States.

Schultz, J.H. and L. Weisæth

2015 The power of rituals in dealing with traumatic stress symptoms: cleansing rituals for former child soldiers in Northern Uganda. *Mental Health, Religion and Culture*, 18(10):822–837.

Schwarz, R.

1994 *The Skilled Facilitator: Practical Wisdom for Developing Effective Groups*. Jossey-Bass, San Francisco, CA, United States.

SEEP Network

2017 *Minimum Economic Recovery Standards*. Available from https://seepnetwork.org/files/galleries/1750_MERS_3rd_Edition_PDF.pdf (accessed 5 May 2019).

2019 The SEEP Network: Leading Collaboration and Learning. Available from <https://seepnetwork.org> (accessed 5 May 2019).

Segre, A.

1999/2000 *La comunicazione sociale negli interventi di solidarieta internazionale. Il caso del consorzio italiano di solidarieta*. (tesi di laurea). Universita' di Padova, Padova.

Sell, H.L. and R. Nagpal

1992 *Assessment of subjective well-being: The subjective well-being inventory (SUBI)*. WHO Regional Office for South-East Asia, New Delhi. Available from <https://apps.who.int/iris/handle/10665/204813> (accessed 5 May 2019).

Sharma, B. and M. Van Ommeren

1998 Preventing torture and rehabilitating survivors in Nepal. *Transcultural Psychiatry*, 35(1):85–97.

Side by Side Research Consortium

2017 *Developing peer support in the community: a toolkit*. Available from: <https://www.mind.org.uk/media/17944275/peer-support-toolkit-final.pdf> (accessed 15 May 2019).



Sijbrandij, M., R.A. Bryant, A. Schafer, K.S. Dawson, D. Anjuri, L. Ndogoni and M. Ommeren

- 2016 Problem Management Plus (PM+) in the treatment of common mental disorders in women affected by gender-based violence and urban adversity in Kenya. Study protocol for a randomized controlled trial. *International Journal of Mental Health Systems*, 10(1):44.

Sijbrandij, M., S. Farooq, R.A. Bryant, K. Dawson, S.U. Hamdani, A. Chiumento and M. Ommeren

- 2015 Problem Management Plus (PM+) for common mental disorders in a humanitarian setting in Pakistan; study protocol for a randomised controlled trial (RCT). *BMC Psychiatry*, 15(1):232.

Skateistan

- 2019 Available from <https://skateistan.org/> (accessed 15 May 2019)

Slade, M., M. Amering, M. Farkas, B. Hamilton, M. O'Hagan et al.

- 2014 Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13 (1):12–20.

Sliep, Y.

- 2005 A narrative theatre approach to working with communities affected by trauma, conflict and war. *International Journal of Narrative Therapy and Community Work* 2005(2):47.
- 2009 *Healing Communities by Strengthening Social Capital: A Narrative Theatre Approach: Training Facilitators and Community Workers*. War Trauma Foundation, Diemen, Netherlands.
- 2011 Collective healing a social action approach – Supplement to support sustainable use for narrative theatre. *War Trauma Foundation*, Diemen, Netherlands.

Sluzki, C.E.

- 1992 Disruption and reconstruction of networks following migration/relocation. *Family Systems Medicine*, 10(4):359.

Smith, I.

- 2005 Solution-focused brief therapy with people with learning disabilities: a case study. *British Journal of Learning Disabilities* 33(3):102-105.

Snider, L

- 2018 *Psychological First Aid: Five Year Retrospective (2011-2016)*. Church of Sweden, Uppsala. Available from [https://www.svenskakyrkan.se/filer/Psychological%20First%20Aid_Five%20year%20retrospective%20\(pdf,%2094%20sidor\).pdf](https://www.svenskakyrkan.se/filer/Psychological%20First%20Aid_Five%20year%20retrospective%20(pdf,%2094%20sidor).pdf) (accessed 15 May 2019)

Souheil, R.

- 2017 *Using Creative Mediation in the Psychosocial Intervention*. IOM, Nigeria.

Sphere Association

- 2018 *The Sphere Handbook*. The Sphere Association, Geneva.



Sphere Project

- 2015 *Sphere for Monitoring and Evaluation*. The Sphere Project, Geneva. Available from www.spherestandards.org/wp-content/uploads/sphere-for-monitoring-and-evaluation.pdf (accessed 5 May 2019).

sportanddev.org

- N.D. Sport as a Psychosocial Intervention. Available from <https://www.sportanddev.org/en/learn-more/disaster-response/sport-psychosocial-intervention-0> (accessed 20 May 2019).

Sport Inclusion Network

- 2012 *Inclusion of Migrants in and through Sports: A Guide to Good Practice*. Sport Inclusion Network, Vienna.

Squire, J. and K. Hope

- 2014 Journeys of a secular organization in south Lebanon. *Forced Migration Review*, 48:24–25.

Sriram, C.L., O. Martin-Ortega and J. Herman

- 2014 *War, Conflict and Human Rights: Theory and Practice*. Second edition. Routledge, London.

Stiglitz, J.E., A. Sen and J.P. Fitoussi

- 2009 *Report by the Commission on the Measurement of Economic Performance and Social Progress to the French President*. Available from <https://ec.europa.eu/eurostat/documents/118025/118123/Fitoussi+Commission+report> (accessed 5 May 2019).

Strang, A. and A. Ager

- 2010 Refugee integration: Emerging trends and remaining agendas. *Journal of Refugee Studies*, 23 (4):589–607.

Sullivan, J. and R.S. Lloyd

- 2006 The Forum Theatre of *Augusto Boal: A Dramatic Model for Dialogue and Community-Based Environmental Science*. *The International Journal of Justice and Sustainability*, 11(6):627–646.

Summerfield, D.

- 2001 The Invention of Post Traumatic Stress Disorder and the Social Usefulness of a Psychiatry Category. *British Medical Journal*, 322 (13): 121 – 6.

Távora, G., M. Brinton Lykes and A. Crosby

- 2018 Standing in Between: The Healing Praxis of Mayan Women Intermediaries in Post-Genocide Guatemala. *Women and Therapy*, 41(1–2):30–51.

Terre des Hommes

- 2007 *Laugh, Run and Move to develop together*. Available from <https://www.tdh.ch/en/media-library/documents/laugh-run-and-move-develop-together> (accessed 15 May 2019).

Terre des Hommes

- 2012 *Traditional games for child protection*. Available from <https://www.tdh.ch/en/media-library/>



documents/traditional-games-child-protection (accessed 15 May 2019).

Terre des Hommes

2012 *Working with children and their environment*. Available from https://www.tdh.ch/sites/default/files/document-de-reference-travailler-avec-des-enfants-et-leur-environnement_en.pdf (accessed 15 May 2019).

The Friendship Bench - Zimbabwe

2019 Available from <https://www.friendshipbenchzimbabwe.org/> (accessed 15 May 2019).

The New York Times

2010 *Haiti earthquake of 2010*. Available from <http://topics.nytimes.com/top/news/international/countriesandterritories/haiti/index.html?8qa&scp1-spot&sq&stnyt> (accessed 21 October 2010).

Tol, W.A., C. Barbui, A. Galappatti, D. Silove, T.S. Betancourt, R. Souza and M. Van Ommeren

2011 Mental health and psychosocial support in humanitarian settings: linking practice and research. *The Lancet*, 378(9802):1581–1591.

Trepper, T.S. and C. Franklin

2012 The future of research in Solution-Focused Brief Therapy. In: *Solution-Focused Brief Therapy: A handbook of evidence-based practice* (C. Franklin, T.S. Trepper, W.J. Gingerich and E.E. McCollum, eds.). Oxford University Press, New York, pp. 405-412.

Tungpunkom, P.

2012 Life skills programmes for chronic mental illnesses. *Cochrane Database Systematic Review* (1).

Turner, V.

1982 *From Ritual to Theatre: The Human Seriousness of Play*. Performing Arts Journal Publications, New York.

1990 “Are There Universals of Performance in Myth, Ritual and Drama?” In *By Means of Performance: Intercultural Studies of Theatre and Ritual* (R. Schechner and W. Appel, eds.) pp. 8—22. Cambridge University Press, Cambridge.

Unger, J.B., L.J. Cabassa, G.B. Molina, S. Contreras and M. Baron

2013 Evaluation of a fotonovela to increase depression knowledge and reduce stigma among Hispanic adults. *Journal of Immigrant and Minority Health*, 15(2):398–406.

United Nations

2015 *Transforming our World: The 2030 Agenda for Sustainable Development*. Available from <https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf> (accessed 15 May 2019)

2019 *Preventing Sexual Exploitation and Abuse*. Available from <https://www.un.org/preventing->



sexual-exploitation-and-abuse/ (accessed 20 May 2019)

United Nations Children's Fund (UNICEF)

- 2007 *I can do*. UNICEF, New York.
- 2009 *A practical guide for developing child-friendly spaces*. UNICEF, New York.
- 2011 *Inter-agency guide to the evaluation of psychosocial programming in Humanitarian Crises*. UNICEF, New York. Available from <https://www.unicef.org/protection/files/Inter-AgencyGuidePSS.pdf> (accessed 15 May 2019).
- 2012 *Partnering with Religious Communities for Children*. Available from https://www.unicef.org/about/partnerships/files/Partnering_with_Religious_Communities_for_Children_%28UNICEF%29.pdf (accessed 21 May 2019).
- 2017 *Partnering with Religious Communities for Children*. UNICEF, New York.
- 2018 *Operational Guidelines: Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families*. UNICEF, New York. Available from <https://app.mhpss.net/resource/unicef-operational-guidelines-on-community-based-mental-health-and-psychosocial-support-in-humanitarian-settings-three-tiered-support-for-children-and-families> (accessed 5 May 2019).

United Nations Development Programme (UNDP)

- 2014a *UNDP Guidelines on Engaging with Faith-based Organizations and Religious Leaders*. UNDP, New York. Available from www.undp.org/content/dam/undp/documents/partners/2014_UNDP_Guidelines-on-Engaging-with-FBOs-and-Religious-Leaders_EN.pdf (accessed 5 May 2019).
- 2014b *Post-Disaster Needs Assessment*. UNDP, New York. Available from www.undp.org/content/undp/en/home/librarypage/crisis-prevention-and-recovery/pdna.html (accessed 5 May 2019).

United Nations Educational, Scientific and Cultural Organisation (UNESCO) and International Centre for Technical and Vocational Education and Training (UNEVOC)

- 2019 *TVETipedia Glossary – Informal learning*. Available from <https://unevoc.unesco.org/go.php?q=TVETipedia+Glossary+A-Z&term=Informal+learning> (accessed 15 May 2019)

United Nations General Assembly (UNGA)

- 2018 *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Available from https://www.un.org/en/ga/search/view_doc.asp?symbol=A/73/216 (accessed 15 May 2019).
- 2019 *Resolution adopted by the General Assembly on 19 December 2018 – Global Compact for Safe, Orderly and Regular Migration*. Available from https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/195 (accessed 15 May 2019).

United Nations Office for the Coordination of Humanitarian Affairs (OCHA)

- 2012 *OCHA Message: Humanitarian Principles*. Available from https://www.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf (accessed 15 May 2019)



- 2015 *Community Engagement*. OCHA, New York.
- 2017 *Community engagement at the centre of disaster response*. Available from www.unocha.org/story/community-engagement-centre-disaster-response (accessed 4 May 2019).
- 2019a *Humanitarian response*. Available from <https://www.humanitarianresponse.info/en> (accessed 20 May 2019).
- 2019b *Who we are*. Available from <https://www.unocha.org/about-us/who-we-are> (accessed 16 May 2019).

United Nations Office of the High Commissioner for Human Rights (OHCHR)

- 2011 *International Legal Protection of Human Rights in Armed Conflict*. OHCHR, Geneva.

United Nations Peacemaker (UNFPA)

- 2019 *Mediation Resources Overview*. Available from <https://peacemaker.un.org/resources> (accessed 20 May 2019).

United Nations Population Fund (UNFPA)

- 2014 *Assessment in Emergencies*. Available from www.unfpa.org/resources/assessment-emergencies (accessed 5 May 2019).

University of Oxford Refugee Studies Centre

- 2013 *Local faith communities and the promotion of resilience in humanitarian situations: A scoping study* (E. Fiddian-Qasmiyeh and A. Ager, eds.). Working Paper No. 90.

Valdivieso, P. and K.P. Andersson

- 2017 *Local politics of environmental disaster risk management: institutional analysis and lessons from Chile*. *The Journal of Environment and Development*, 26(1):51–81.

Valters, C.

- 2015 *Theories of change: Time for a radical approach to learning in development*. Available from www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9835.pdf (accessed 5 May 2019).

Van der Noordt, M., H. Ijzelenberg, M. Droomers and K. Proper

- 2014 *Health effects of employment: A systematic review of prospective studies*. *Occupational and Environmental Medicine*, 71(10):730–736.

Varatharajan, N.

- 2018 *Symptomatic Stories: The problem of Representation in Human-Centered Design*. (Unpublished master's thesis).

Ventevogel, P.

- 2014 *Integration of mental health into primary healthcare in low-income countries: avoiding medicalization*. *International Review of Psychiatry*, 26(6):669–679.



Ventevogel, P. and H. Faiz

- 2018a Capturing mental disorder or emotional distress? How mental health surveys in Afghanistan ignore the role of gender, culture and context. *Intervention*, 16(3):207–214.
- 2018b Mental disorder or emotional distress? How psychiatric surveys in Afghanistan ignore the role of gender, culture and context. *Intervention*, 16(3):207–214.

Ventevogel, P., M. Jordans, R. Reis and J. de Jong

- 2013 Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Conflict and Health* 2013(7):3. Available from www.conflictandhealth.com/content/7/1/3 (accessed 5 May 2019).

Ventevogel, P. and G. Schinà

- 2009 MHPSS Assessment, Coursework of the Summer School in Psychosocial Interventions in Migration, Emergency and Displacement. IOM/Scuola Sant'Anna, Pisa, Italy.

Verduin, F., G.E. Smid, T.R. Wind and W.F. Scholte

- 2014 In search of links between social capital, mental health and sociotherapy: A longitudinal study in Rwanda. *Social Science and Medicine*, 121:1–9.

Walsh, F.

- 2007 Traumatic loss and major disasters: Strengthening family and community resilience. *Family Process*, 46(2):207–227.

War Child Holland

- 2009 Guidelines Community mobilization, draft.

Warner, A.T.

- 2017 *What is monitoring in humanitarian action? Describing practice and identifying challenges*. ALNAP Scoping Paper. ALNAP/ODI, London. Available from www.alnap.org/system/files/content/resource/files/main/monitoring-of-humanitarian-action-scoping-paper-%5Bweb%5D.pdf (accessed 5 May 2019).

War Trauma Foundation

- 2014 *Evaluation Report – Psychosocial Programme IOM Libya*. War Trauma Foundation, Diemen, Netherlands.

Watters, C.

- 2017 Three challenges to a life course approach in global mental health: Epistemic violence, temporality and forced migration. In: *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* (R.G. White, S. Jain, D.M.R. Orr and U. Read, eds.). Palgrave Macmillan, London, pp. 237–256.

Weine, S., Y. Danieli, D. Silove, M.V. Ommeren, J.A. Fairbank and J. Saul

- 2002 Guidelines for international training in mental health and psychosocial interventions for trauma exposed populations in clinical and community settings. *Psychiatry: Interpersonal*



and *Biological Processes*, 65(2):156–164.

Weine, S., S. Ukshini, J. Griffith, F. Agani, E. Pulleyblank Coffey, J. Ulaj, C. Becker, L. Ajeti, M. Elliott, V. Alidemaj-Sereqi, J. Landau, M. Asllani, M. Mango, I. Pavkovic, A. Bunjaku, J. Rolland, G. Cala, J. Sargent, J. Sauland and K. Weingarten

2005 A Family Approach to Severe Mental Illness in Post-War Kosovo. *Psychiatry*, 68:17–27, 10.1521/psyc.68.1.17.64187.

Weissbecker, I., F. Hanna, M. El Shazly, J. Gao and P. Ventevogel

2019 Integrative Mental Health and Psychosocial Support Interventions for Refugees in Humanitarian Crisis Settings. In: *Uncertain safety. Understanding and assisting the 21st century refugees* (T. Wenzel and B. Drozdek, eds.). Springer, New York, pp. 117–153.

Weissbecker, I., P. Ventevogel, F. Hanna and S. Pathare

2019 Mental Health and Psychosocial Support in Humanitarian Settings: Considerations for protecting and promoting human rights. In: *Cambridge Handbook of Psychology and Human Rights* (N.S. Rubin, R.L. Flores, eds.). Cambridge University Press, Cambridge.

Wessells, M.G.

2009 Do no harm: toward contextually appropriate psychosocial support in international emergencies. *The American Psychologist*, 64(8):842–54.

Wessells, M.G. and C. Monteiro

2004 Healing the wounds following protracted conflict in Angola: A community-based approach to assisting war-affected children. In: *Handbook of culture, therapy, and healing* (U.P. Gielen, J.M. Fish and J.G. Draguns, eds.). Lawrence Erlbaum Associates Publishers, Mahwah, NJ, United States, pp. 321–341.

Whiteley, J.S.

1986 Sociotherapy and Psychotherapy in the Treatment of Personality Disorder. *Journal of the Royal Society of Medicine*, 79 (12): 721 – 725.

Wilkinson, O. and J. Ager

2017 *Scoping Study on Local Faith Communities in Urban Displacement: Evidence on Localisation and Urbanisation*. JLI Hub on Refugees and Forced Migration, UCL Migration Research Unit, London. Available from www.geog.ucl.ac.uk/research/research-centres/migration-research-unit/pdfs/Scoping%20Report%20typeset.pdf (accessed 5 May 2019).

Wilmot, W.W. and J.L. Hocker

2018 *Interpersonal Conflict*. McGraw Hill, Boston.

Women's Refugee Commission

2014 *A double-edged Sword: Livelihoods in Emergencies – Guidance and Tools for Improved Programming*. Available from <https://www.womensrefugeecommission.org/resources/document/1046-a-double-edged-sword-livelihoods-in-emergencies> (accessed 21 May 2019).



World Bank

- 2002 *Sleeping on our Own Mats: An Introductory Guide to Community-Based monitoring and evaluation*. Available from https://commdev.org/userfiles/files/1688_file_communitybased.pdf (accessed 15 May 2019).
- 2019 *World Bank short course: Restoring Livelihoods with Psychosocial Support*. Available from <https://olc.worldbank.org/content/restoring-livelihoods-psychosocial-support-4> (accessed 15 May 2019).

World Bank and United States Institute of Peace

- 2019 *Introduction to Psychosocially Responsive Development and Humanitarian Programs*. Available from <https://www.usipglobalcampus.org/training-overview/psychosocial/> (accessed 15 May 2019).

World Council of Churches and Norwegian Church Aid

- 2016 *The Protection Needs of Minorities from Syria and Iraq*. Available from www.oikoumene.org/en/resources/documents/commissions/international-affairs/the-protection-needs-of-minorities-from-syria-and-iraq (accessed 5 May 2019).

World Health Organization (WHO)

- 1996 WHO Initiative of Support to People Disabled by Mental Illness. Psychosocial rehabilitation – A consensus statement. WHO, Geneva.
- 2002 *Community participation in local health and sustainable development: Approaches and techniques*. WHO, Geneva.
- 2004 *Promoting Mental Health: Concepts, Emerging Evidence, Practice*. WHO, Geneva.
- 2011 *Psychological first aid: Guide for field workers*. WHO, Geneva.
- 2012 *WHO QualityRights Tool Kit - Assessing and improving quality and human rights in mental health and social care facilities*. Available from https://www.who.int/mental_health/publications/QualityRights_toolkit/en/ (accessed 15 May 2019).
- 2013 *Mental Health – Action Plan 2013 - 2020*. WHO, Geneva. Available from https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf?sequence=1 (accessed 15 May 2019).
- 2013 *Psychological first aid: facilitator's manual for orienting field workers*. WHO, Geneva.
- 2014 *Social Determinants of Mental Health*. WHO, Geneva.
- 2015a *A manual for psychological management of perinatal depression*. WHO, Geneva. Available from https://www.who.int/mental_health/maternal-child/thinking_healthy/en/ (accessed 16 May 2019).
- 2015b *Caregiver skills training for the management of developmental disorders* (updated 2015). WHO, Geneva.
- 2015c *Recovery-oriented strategies enhancing vocational and economic inclusion (such as supported employment)*. WHO, Geneva.
- 2015d *Recovery-oriented psychosocial strategies enhancing independent living and social skills (such as*



life skills and social skills training). WHO, Geneva.

- 2016 *Worried about the future? Preventing depression during your teens and twenties*. Available from <https://www.who.int/campaigns/world-health-day/2017/handouts-depression/adolescents-05.pdf?ua=1> (accessed 17 May 2019).
- 2017a *Creating peer support groups in mental health and related areas – WHO QualityRights training to act, unite and empower for mental health (pilot version)*. WHO, Geneva. Available from apps.who.int/iris/bitstream/handle/10665/254813/WHO-MSD-MHP-17.13-eng.pdf?sequence=1 (accessed 5 May 2019).
- 2017b *Providing individualized peer support in mental health and related areas – WHO QualityRights training to act, unite and empower for mental health (pilot version)*. WHO, Geneva.
- 2017c *Setting up and operating a civil society organization in mental health and related areas – WHO QualityRights training to act, unite and empower for mental health (pilot version)*. WHO, Geneva.
- 2017d *Advocacy actions to promote human rights in mental health and related areas – WHO QualityRights training to act, unite and empower for mental health (pilot version)*. WHO, Geneva.
- 2018a *Management of physical health conditions in adults with severe mental disorders*. WHO, Geneva.
- 2018b *Mental Disorders*. WHO, Geneva.
- 2018c *Mental health promotion and mental health care in refugees and migrants*. WHO, Geneva. Available from www.euro.who.int/__data/assets/pdf_file/0004/386563/mental-health-eng.pdf?ua=1 (accessed 5 May 2019).
- 2018d *Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity. (Generic field-trial version 1.1)*. WHO, Geneva.
- 2018e *mhGAP Operations Manual*. WHO, Geneva. Available from www.who.int/mental_health/mhgap/operations_manual/en/ (accessed 5 May 2019).
- 2019a *Depression*. Available from https://www.who.int/mental_health/management/depression/en/ (accessed 15 May 2019).
- 2019b *The Interagency Emergency Health Kit 2017 - Medicines and medical devices for 10 000 people for approximately three months*. Available from <https://apps.who.int/iris/bitstream/handle/10665/279428/9789241515221-eng.pdf?ua=1> (accessed 15 May 2019).

World Health Organization (WHO) and Columbia University

- 2016 *Group Interpersonal Therapy (IPT) for Depression (WHO generic field-trial version 1.0)*. Available from <https://apps.who.int/iris/bitstream/handle/10665/250219/WHO-MSD-MER-16.4-eng.pdf;jsessionid=317665E243C22358ACAB1BDD579F8F25?sequence=1> (accessed 15 May 2019).

World Health Organization (WHO) and International Medical Corps (IMC)

- 2014 *Who is Doing What, Where and When (4Ws) in Mental Health and Psychosocial Support in Jordan – Interventions Mapping Exercise October 2014*. WHO and IMC,



Geneva. Available from <https://resourcecentre.savethechildren.net/sites/default/files/documents/jordan204ws20mapping20final20report-202014.pdf> (accessed 5 May 2019).

World Health Organization (WHO) and Office of the United Nations High Commissioner for Refugees (UNHCR)

- 2004 *Clinical Management of Rape Survivors – Developing protocols for use with refugees and internally displaced persons*. WHO and UNHCR, Geneva.
- 2012 *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings*. WHO and UNHCR, Geneva. Available from www.refworld.org/docid/55b889c34.html (accessed 5 May 2019).
- 2015 *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies*. WHO and UNHCR, Geneva.

World Health Organization (WHO) and Pan American Health Organization

- 2010 *Culture and Mental Health in Haiti: A Literature Review*. WHO and PAHO, Geneva.

World Vision International

- 2013 *Channels of Hope: Igniting a Movement to Transform Communities*. Available from www.wvi.org/health/publication/channels-hope (accessed 5 May 2019).

Wurzer, J. and M. Bragin

- 2009 *Integrating the psychosocial dimension in women's empowerment programming. A guide for CARE country offices*. CARE Österreich, Vienna.

Yeboah-Antwi, K., G. Snetro-Plewman, K.Z. Waltensperger, D.H. Hamer, C. Kambikambi, W. MacLeod, S. Filumba, B. Sichamba and D. Marsh

- 2013 *Measuring Teamwork and Taskwork of Community-Based Teams Delivering Life-Saving Health Intervention in Rural Zambia: The Qualitative Study*. *BMC Medical Research Methodology*, 13:84.

Zehr, H., L.S. Amstutz, A. MacRae and K. Pranis

- 2015 *The Big Book of Restorative Justice*. Good Books, New York.

Zelizer, C.

- 2013 *Integrated Peacebuilding: Innovative Approaches to Transforming Conflict*. Westview Press, Boulder, CO, United States.



Outline of psychosocial consequences and implications following the Haiti Heartquake of 2010

	Suffering Depression, anxiety Ordinary human suffering Default consequences	Resilience	Adversity's Activated Development
Individual	<ul style="list-style-type: none"> a) non clinical depression c) anxieties d) powerlessness e) fears for the future socioeconomic life f) fear of another disaster g) guilt towards the dead h) guilt towards the community i) guilt driven by the belief that the disaster was a punishment from God or Lwas l) sense of anger and frustration due to the poor services received and the disinformation about settlement plans 	<ul style="list-style-type: none"> a) religion b) refer to the collectivity of the experience c) getting organized to help the others d) reviving social life e) creative activities, including ritual dances and songs 	<ul style="list-style-type: none"> a) renewed sense of being part of a collectivity b) personal organizational and solidarity skills c) stronger coping mechanism than expected
Family	<ul style="list-style-type: none"> a) loss of loved ones b) separation and abandonment c) challenges to traditional family roles d) Hyper-protection of children e) Increase in stress and violence f) Loss of belongings and memories 	<ul style="list-style-type: none"> a) revival of family support and lakou systems b) trans-generational support c) solidarity d) sharing of emotional experience within the family e) neighbourhood support 	<ul style="list-style-type: none"> a) increased trust b) increased sensitivity and listening c) increased respect d) increased physical nurturing
Group (identified as religious congregations, neighborhood and colleagues)	<ul style="list-style-type: none"> a) withdrawal b) confusion c) disorganization d) loss of members of the group e) disorientations 	<ul style="list-style-type: none"> a) sharing experiences b) religious rituals c) intellectualization/ rationalization of the experience d) activation to help the others 	<ul style="list-style-type: none"> a) a more participatory approach to group leadership and decision making b) new spontaneous affiliation c) groups becoming more inclusive d) community based security systems organized
Society	<ul style="list-style-type: none"> a) loss of lives, leaders, experts b) destruction and loss of cultural heritage c) enhancement of the "aid culture" d) pollution and poor environmental health e) fears and paranoia related with the presence of foreigners, especially in relation to cultural colonialism and political control f) redefinition of geographical and urbanistic boundaries g) exacerbation of existing socio-cultural divides and fears of future social tensions 	<ul style="list-style-type: none"> a) hope b) religious beliefs and explanatory models c) aid d) referral to cultural and artistic life e) banalizing the experience 	<ul style="list-style-type: none"> a) stronger national sense b) more critical political sense c) acknowledgement of the necessity to reconstruct better than before, on multiple levels d) reciprocity e) solidarity f) increased sense of community responsibility g) increase in volunteerism

Source: IOM, 2010a.



EVALUATION REPORT
PSYCHOSOCIAL PROGRAMME IOM LIBYA

ACKNOWLEDGEMENTS

We would like to thank the IOM for entrusting us with this evaluation, in particular to Guglielmo Schininá, Head of the Mental Health Psychosocial Response and Intercultural Communication Section of IOM in Geneva and Marcio Gagliato, Programme Manager of the IOM Psychosocial Programme in Libya.

With thanks too to the IOM Libya staff in the Tripoli and Misrata offices: Othman Belbeisi, Chief of Mission, the project staff, in particular Khaled Hamidi for facilitating the Tripoli based elements of the evaluation.

Special thanks to the PSS Centre staff who gave their time to be interviewed in a very busy period, and to the children and parents for sharing their stories and opinions.

The photos used in this report were taken by Orso Muneghina and Marieke Schouten and are included with the permission of IOM.

The evaluation team takes responsibility for all opinions expressed in this report.

Marieke Schouten, Orso Muneghina

War Trauma Foundation, The Netherlands, 3rd of March 2014

WARTRAUMA
FOUNDATION



CONTENTS

Acknowledgements	I
List of Acronyms	III
EXECUTIVE SUMMARY	IV
1. BACKGROUND	7
2. THE IOM PSS PROJECT	10
3. RATIONALE AND METHODOLOGY OF THE EVALUATION	12
4. GENERAL FINDINGS	14
5. SPECIFIC FINDINGS	23
6. LESSONS LEARNED, RECOMMENDATIONS	31
Recommendations for improving adherence to IASC standards	31
Recommendations for improving partnerships and coordination	32
Recommendations for improving outcomes for beneficiaries	32
Recommendation for capacity building in human resources	32
Lessons learned for future replicability in similar contexts by IOM	33
Annexes	34

LIST OF ACRONYMS

CCS	Country Cooperation Strategy
CSO	Civil Society Organisation
GBV	Gender-Based Violence
GPCHE	General People's Committee for Health and Environment
HSR	Health Sector Reform
IASC	Inter Agency Standing Committee (UN coordination mechanism on defined themes)
IMC	International Medical Corps
INTRAC	International NGO Training and Research Centre
IDP	Internally Displaced Person
MH	Mental Health
MHPSS	Mental Health and Psychosocial Support
MoE	Ministry of Education
MoSA	Ministry of Social Affairs
NCDC	National Centre for Disease Control
NATO	North Atlantic Treaty Organisation
PSP	Psychosocial Programme
PSS	Psychosocial Support
RCC	Recreational and Counselling Centre
SCT	Master of Social and Community Theatre (University of Turin)
UNDSS	United Nations Department of Safety and Security

EXECUTIVE SUMMARY

The Mental Health, Psychosocial Response and Intercultural Communication Section of IOM in Geneva and the IOM Mission in Libya developed the 'Psychosocial Assistance for Crisis-Affected Children and Youth and their Families in Libya' programme (hereafter PSP) soon after the revolution in Libya in 2011.

Previously, IOM successfully created a safe and protective environment for crisis-affected people in conflict areas through community-based centers in Lebanon, Kenya, Colombia, Serbia, Kosovo and Haiti, among many others. The 12-month project officially started in January 2012. In line with the project's objectives, IOM Libya initiated an evaluation process in August 2013.

The purpose of this evaluation is to document the development and present operations of the PSP, analysing its key strengths and weaknesses, with a view to identify areas for improvement and to advise on future direction.

The evaluation team was asked to focus in particular on the two PSP centers in Tripoli and Misrata, with the aim to assess the extent to which the centers have contributed to community empowerment and in creating capacities amongst the centre's staff and the communities they worked with.

With a view to the future sustainability of the initiative, the IOM also asked the evaluators to identify positive aspects that could be sustained over the long term so as to facilitate the centers' future hand-over to local actors.

Against the backdrop of a traditionally conservative society, emerging from 42 years of an oppressive regime, the psychosocial programme being offered by IOM to the Libyan population is in the opinion of many of the respondents one of the few examples of an effective and relevant intervention in this moment of great transition. It is particularly significant in having an impact directly on the population affected by the revolution and the current state of turmoil.

In a country where the security situation is in constant flux, where cultural restrictions make it difficult for people to talk about emotions, and for them to participate in activities intended to provide with psychosocial support, the sheer existence of a space in which these activities can take place is seen as vital and unique.

It is remarkable that in a relative short space of time the program has gained credibility, evident in the range of participation and appreciation of its activities by local communities, authorities and other external actors.

To date, the two centers in Tripoli and Misrata effectively provide a safe and protective environment for children's and women's activities, together with work with families, and outreach activities with IDPs. Despite initial challenges in creating strong and cohesive teams, the centre staff have overcome considerable cultural barriers amongst themselves, as well as from their beneficiaries, in overcoming prejudices against the concept of psychosocial support.

Alongside significant positive outcomes, there are areas for improvement. Although the centers have gained the support from local authorities, which is indeed a prerequisite for functioning, some key local resources have yet not been accessed to their fullest extent.

As the reach of the centre expands, new skills will also probably be needed. Staff already recognised a need to refer more serious cases, but currently have no specialised services to consult with.

Based on findings from staff working directly with beneficiaries and external actors, it is apparent that the centers have reached out to their local communities. This could be an excellent starting point for the next phase, in focussing on groups still not reached to date (such as former combatants, migrants, young men). Strategies for targeting groups should also include the involvement of the intended beneficiaries.

On the whole, the IOM PSP has gained sufficient leverage and credibility such that its experience could be used as an example for other community initiatives in post conflict countries that are in a transitional phase, illustrating how links to different levels of services and appropriately trained staff are needed to build a comprehensive health sector. A key informant said, *“Their professional growth and attitude is remarkable. They are the people who know how to mainstream MHPSS in services, they show sincerity in how they work and good leadership.”*

Whilst operating in extremely challenging circumstances, the IOM PSS is achieving remarkable changes for communities and in particular children. Significant progress in meeting existing standards in providing MHPSS has been made

in a short period of time, and clear areas for improvement in reaching particular groups of yet unreached beneficiaries and further enhancing the skills of staff have been identified. The vital role of sustained mentoring and supervision has been emphasized through the changes achieved for the communities surrounding the centers. Lessons have been learned that will benefit not only the IOM team in Libya, but also other similar IOM initiatives internationally.

The consequent recommendations that could serve as suggestions and guidance for IOM in ensuring that psychosocial support continues to thrive and improve, and that IOM emergency programming more broadly may benefit from learning gained in Libya can be found at the end of this report.



EVALUATION FINDINGS



Main Square, Tripoli, near Old Suk

1.BACKGROUND

1.1 Historical overview

For many Libyans, Muammar Qaddafi's reign represents their defining historical memory. It is what Vamik Volkan calls a 'chosen trauma,' or "the shared mental representation of the historical traumatic event that becomes a significant marker for the large-group identity (V.D. Volkan 'Blood Lines:From Ethnic Pride to Ethnic Terrorism', 1997). However, in order to understand the complexity in which the IOM Psychosocial Programme operates, we need to look beyond the events that took place during the so-called 'revolution' in 2011 and the Qaddafi era.

When Libya gained independence from Italian colonial rule (1911-1943), it became a constitutional monarchy and was ruled by the head of the Senussi Sufi order. After independence and prior to the oil boom, the country was poor and the judiciary relatively safe from corruption. When Qaddafi came to power in 1969 after overthrowing King Idris, he set up the 'Jamahiriya.' This means 'a state of the masses,' a state where power was concentrated around Qaddafi himself. One of the principles of the Jamahiriya is that 'representation is fraud' (see the 'Green Book', in which Qaddafi describes his alternative to both communism and capitalism) and that no formal political representation is allowed. In theory, people's committees held power

in a system of direct democracy, without political parties. In practice, Qaddafi's power was absolute, exercised through 'revolutionary committees' formed by regime loyalists. Against this political backdrop, there was very little growth in effective formal institutions or civil society organisations. The regime heavily relied on tribal solidarities to secure its power base. Strategic power positions were held by members of the Qaddafi family and the regular armed forces were deliberately kept weak.

In 2011, Qaddafi's government used excessive force against the popular uprising, which was inspired by the anti-authoritarian protests that took place throughout the Arab world. The UN Security Council passed a resolution authorising NATO air strikes to protect civilians in Libya. After months of near stalemate, the rebels stormed into Tripoli in August 2011 and several weeks later Qaddafi was killed. A transitional government took charge with the challenge of imposing order, disbanding the former rebel forces, rebuilding the economy, creating functioning institutions and managing the pledged transition to democracy and the rule of law. The first free elections were held in 2012 and Ali Zeidan was appointed Prime Minister by the congress.

Libya is again facing a crucial point in its history. In February 2014 elections are scheduled for the 60-member committee that will draw up Libya's new Constitution.

A major challenge for the authorities is the proliferation of armed groups, some originating in the anti-Qaddafi rebellion and others formed more recently. They have defied repeated attempts to be disarmed, causing concerns about the prospects for stabilisation (BBC, 2013). Although the overthrow of Qaddafi's reign took place at the same time as regime changes in other Arab countries, there are significant differences due to the unique history of Libya. 'The protest movement's early demand that Qaddafi leave was inextricably linked with the collapse of the

entire order that he had established. In Tunisia and Egypt, by contrast, the distinction between the state and the regime was crucial in enabling the armies to act as mediators in the conflict between people and presidency. This was impossible in Libya. 'There is no doubt that the Jamahiriya is moribund and that only a very different form of state – one that allows political and civic freedoms – will satisfy the desire of Libyans for representative and law-bound government. Yet, it was never going to be an easy matter to find a way out of the historic cul-de-sac of Qaddafi's creation' (International Crisis Group, 2011).

1.2 Tribes and cultural differences

Most sources refer to 140 main Arab Berber tribes in Libya. Between 30-50 are thought to play an important political and social role. Libyans strongly identify with their tribal networks, which provided access to social, political and economic opportunities during the Qaddafi regime. Indeed, some tribes in Libya are closely associated with the Qaddafi regime due to the privileged status that they were perceived to have been given, including the Qadhafha, Magraha, Warfalla, Worshefena and Tarhouna tribes. Some of these tribes also played a significant role in the regime's security forces, which gives rise to discrimination and violence against these groups today.

Tribal allegiances are however weakening, with the majority of the population now living in urban areas and becoming more mixed. Some towns, including Ajdabjiya and Benghazi, have witnessed strong post-revolution political action to reduce the power of tribal network in local politics. There was also a push to ensure that Libyans did not vote along tribal lines during the elections for a National Congress, through a law banning parties formed along tribal lines. However, tribes and tribal relations are still believed to be:

- a driver of conflict. This is due to the collective grievances between tribal groups stemming from the revolution, the way in which opportunities were allocated during the Qaddafi period, and longer historical relationships; and
- a resource for managing conflict. This is especially the case in the less developed and less mixed parts of the country (Civil Society Dialogue Network, 2012; Integrated Regional Information Networks 2012).

The regime's collapse has thus left a power vacuum that has been filled by, among others, revolutionaries, political parties, NGOs, and media groups with competing agendas and no history of cooperating with one another.

Currently there is a growth spurt in civil society organisations. It is estimated that each month, 20-30 new NGOs are registered (personal communication with representative of the Ministry of Social Affairs and Civil Society). Concurrently, there are numerous initiatives from both international and Libyan organizations to train professionals including those working in health and psychosocial support. Some respondents in the evaluation, who are working in different ministries (i.e. Ministry of Health, Ministry of Social Affairs and Civil Society) expressed their appreciation for the efforts and investments made by (inter)national organizations to train local NGOs in such areas as health and also emphasised the need for action research to better inform policy making and the need for follow-up on trainings for quality assurance.

Perhaps one of the deepest divisions emerging in post-Qaddafi Libya is between revolutionary towns and tribes described as 'thumar' (revolutionaries, e.g. Misrata, Zentan, Benghazi, Souk al-Jumaa, Zawya, Zwara) and 'azlam' (regime cronies, e.g. parts of Werfella, Bani Walid, Qathathfah, Mashaysha, Western Rayayneh). This split was exacerbated

by Qaddafi's manipulation of the tribe as a Libyan social institution, which he used both to sustain his 42-year reign and to try to defeat the 2011 revolution. These past allegiances have also produced what is one of the most serious IDP-related problems in Libya today, that of the Tawergha people.

According to residents of neighboring Misrata, Tawergha fighters affiliated with the Qaddafi brigades were responsible for a systematic campaign of rape and murder during their two-month siege of Misrata. After the fall of Qaddafi, Misrata militias forced all 42,000 residents of Tawergha from the town, leaving it to date completely deserted. The majority of Tawerghans now live in three camps, but others have sought refuge in other Libyan cities or have fled the country.

1.3 Future prospects

The current situation in Libya is extremely fluid, compounded by localised outbreaks of violence, an influx of refugees from the civil war in Syria placing further strain on surviving services, and a government that is under great pressure to build new state institutions and legislation. The majority of the respondents who are directly involved with activities within the IOM Libya psychosocial centres expressed their concern about the level of violence they perceive and see and the easy access people have to guns. To avoid the continued state of chaos resulting from Qaddafi's downfall, a process of comprehensive national reconciliation must be undertaken. National reconciliation can, in this context, be defined as the process of addressing the grievances of parties to a conflict with the aim of redefining their relationships and forging a new social contract. It is against this background that the current programme implemented by the IOM appears to be relevant. In its efforts to support the Libyan people address their unresolved traumas of the past and generate a new vision of hope for its future, as it aims at changing the social fabric of the country.



Drawing by PSS Tripoli staff symbolising the partnership between the Centre and the surrounding community

2. THE IOM PSYCHOSOCIAL SUPPORT PROJECT (PSP)

2.1 IOM In Libya

The IOM started its mission in Libya in 2006. Several programmes are operational including:

- Assisted voluntary return and integration
- Counter-trafficking
- Immigration and border management
- Migration and health
- Migration management
- Labour migration
- Emergency operation.

2.2 IOM PSP

Following a solicitation from the Italian Ministry of Foreign Affairs, the Mental Health, Psychosocial Response and Intercultural Communication Section of IOM in Geneva and the IOM Mission in Libya developed the 'Psychosocial Assistance for Crisis-Affected Children and Youth and their Families in Libya' programme soon after the revolution in Libya in 2011. Previously, IOM successfully created a safe and protective environment for crisis-affected people in conflict areas through community-based centres in Lebanon, Kenya, Colombia, Serbia, Kosovo and Haiti, among many others.

The overall objective of the PSP in Libya was to 'support and strengthen capacities and initiatives of the national authorities in Libya, including the Libyan Ministry of Health, Libyan Ministry of Education, Libyan Ministry of Youth and Sport and other relevant local authorities, Inter Agency Standing Committee (IASC) Group on Mental Health and Psychosocial Support (MHPSS), the Child Protection Cluster, formal and informal mental health and psychosocial professional groups and NGO partners and civil society to promote psychosocial assistance for children and youth, as well as to contribute to collective efforts to reduce avoidable morbidity due to emotional distress of the affected population and to prevent the stagnation of relevant behavioural, emotional and cognitive outcomes, and guarantee that basic psychosocial awareness informs the assistance provided.'

Based on the overall objective of the PSP, IOM designed a comprehensive programme with the following aims:

- To improve needs identification of youth population, with a particular focus on psychosocial well-being, including the health, social, cultural, educational sectors.

- To increase Libyan capacities to develop appropriate community-based programmes, addressing the needs of crisis-affected children, youth and their families, and the social and cultural complexities associated with them. This includes strengthening capacities of local professionals and NGOs in dealing with children and youth-related issues.
- To support and to facilitate harmonization of the existing co-ordination and information-sharing systems in the MHPSS domain in Libya, in particular the IASC Working Group or any future government-led coordination structure, at national and local level. These may include lobbying and support to wider governmental representation in the various coordination bodies and forums of the various regional coordination groups; training and emergency activities.

Project activities include:

1. rapid needs assessment at the start of the programme
2. the establishment of three recreational and counselling centres (RCC) for families, in Benghazi, Misrata and Tripoli
3. the establishment of psychosocial teams, with training provided by in-house specialists and other professionals identified within the IOM's psychosocial expert network in the Middle East
4. the establishment of an academic programme - a 'Higher Diploma in Psychosocial Responses in War-torn Societies.'

This 12-month project officially started in January 2012. In line with the project's objectives, IOM Libya initiated an evaluation process in August 2013.



Multakama Centre, Tripoli

3. RATIONALE AND METHODOLOGY OF THE EVALUATION

3.1 Scope of the evaluation

The purpose of this evaluation is to document the development and present operations of the PSP, analysing its key strengths and weaknesses, with a view to identify areas for improvement and to advise on future direction.

The evaluation team was asked to focus in particular on the two PSP centres in Tripoli and Misrata, with the aim to assess the extent to which the centres have contributed to community empowerment and in creating capacities amongst the centre's staff and the communities they worked with. With a view to the future sustainability of the initiative, the IOM also asked the evaluators to identify positive aspects that could be sustained over the long term so as to facilitate the centres' future hand-over to local actors.

This evaluation does not include consideration of the Higher Diploma in Psychosocial Responses in War-torn Societies, nor does it include an assessment of the effectiveness and efficacy of the programme resource management, including the effective use of financial resources allocated to the programme.

3.2 Limitations

The evaluation team encountered problems in gaining entry visas and were also subject to security restrictions in travel within Libya. This meant there was less time to complete the evaluation process than anticipated and limited scope to visit both centres in country. Changes to the methodology (see 3.3 below) due to these limitations meant an in-depth analysis within the centres was not possible. The evaluation team was only able to visit the PSP centre in Tripoli. The voices of beneficiaries are therefore limited within the findings of this evaluation.

3.3 Methodology

The original planning of the evaluation based on a desk review and field visits to the centres in Tripoli and Misrata included a mixed methods approach, using:

1. A desk review of project documentation, IOM background materials and country data.
2. Participatory assessment focus groups with staff and community members
3. Key informant interviews (MoH, MoE, WHO, EC, etc.)
4. In depth, semi-structured interviews with key stakeholders, project beneficiaries and project staff.

A revised methodology was agreed in dialogue with IOM staff and included:

1. In-depth semi-structured interviews with stakeholders and key persons identified by the IOM mission and the evaluation team and conducted in December 2013 before the field visit (see annex 4)
2. Desk review of project documentation, IOM background materials and country data (see annex 3)

3. In-depth interviews with a sample of staff and beneficiaries and conducted at the RCC in Tripoli in January 2014 (see annex 4)
4. Interviews with key informants and observation of selected activities at the RCC in Tripoli in January 2014. (see annex 4)

The interviews were conducted using a set of questionnaires developed by the evaluation team, based on key evaluation questions related to psychosocial programming using the OECD/DAC evaluation criteria (UNICEF, 2010) (see annex 1). The questionnaires were in particular geared at assessing:

- the relevance of the IOM programme to the needs of the local community
- its effectiveness in reaching the programme's target groups
- the long-term sustainability of the programme
- its coverage in terms of local population, and the target group of the programme.

Participants were informed of the purpose of the interviews and that personal identifying information would not be included in any evaluation reporting.

In total 25 individual interviews and 7 group interviews were conducted, for a total of 45 interviewees. Interviews were carried out remotely via Skype in December 2013 and during a five-day visit to IOM Libya in January 2014. Data gathered through the in-depth interviews were read twice by members of the evaluation team and emerging topics were coded. Underlying themes and trends were identified and analysed.

This report is therefore based on an analysis of responses from the pre-visit interviews conducted in December 2013, the findings of the desk review, and the interviews and observations that took place during the field visit to Tripoli in December and January 2014.



Multakama Centre, Tripoli, children's drawing

4. GENERAL FINDINGS

4.1 Overview of the centres

The three PSP centres are situated in Tripoli, Benghazi and Misrata. The evaluation team was asked to concentrate on the two centres in Tripoli and Misrata, but was only able to visit the Multakama Centre in Tripoli in January 2014 (see 3.2).

The Benghazi Centre had a supportive relationship with the Ministry of Social Affairs (MoSA) and it was reported as providing supportive services for beneficiaries. However the centre had to scale down its activities due to the deteriorating security situation in February 2013. Preparations were thus made for an early hand-over to the MoSA, which did not take place and the assets were thus delivered to another institution.

The Tripoli centre

The Tripoli centre is based in the Abu Slim area, which has been heavily affected by the conflict (2011). Tripoli is a complex community comprising a mix of tribes or groups from other parts of Libya, some of whom live in distinct regions of the city. Abu Slim is considered to be home predominantly to people from the Tarhouna and Warfalla tribes.

Some districts of the city are associated with being pro- or anti-revolution. For example, Tajura, Suq al Juma (which saw substantial anti-Qaddafi protests on the 20 and 25 February 2011) and Fashlum are closely associated with the revolution, while Abu Slim (which was the last area of Tripoli to be liberated) and Hadba were associated with Qaddafi. As a result, there is no coherent voice within Tripoli. In fact, due to the various associations of different districts, there can be difficult relations between the districts (Civil Society Dialogue Network, 2012).

Originally the centre was a military location. It was used before the revolution and the war by the security military to torture people who had been apprehended or kidnapped.

"When we got there the first time, there was still blood in there. The place was given to the IOM by the local authorities and while the IOM staff started cleaning and renovating the place, people walking around it started asking, "What is it?" "What are you going to do here?" That's how they first started to get to know the place. Then we started targeting the kids in schools, and we did the same by going to the local authorities. (Abu Slim is divided into 17 districts, each represented by a person, who form the local authority). So we described to them what we wanted to do and we asked these 17 people to tell their communities about this centre and its activities. The centre also has a Facebook page, and in the last three months we have had more than seven interviews with radio and TV channels, wanting to know about the centre and through this we have talked to people, explaining who we are, what we are doing, what kind of activities we carry out." (Interview with PSS Centre staff)

The Misrata centre

Misrata, an important trade city, with a substantial freight harbour and a large business community, was on the frontline of the conflict and suffered a

good deal of physical and psychological damage. Residents in the city claim that Qaddafi's security forces committed human rights abuses and war crimes, including systematic rape. In particular, fighters from Tawurgha who actively supported Qaddafi's forces during Misrata's siege, have been accused of the most serious crimes. As a result, the town's population has been displaced since the end of the siege. The centre in Misrata is in Alzarog.

"Because the war in Misrata affected the infrastructure and a lot of houses and buildings have been destroyed, there is a shortage of premises, so it was difficult to find one place. I don't know why the IOM didn't rent a place from the beginning. They took this place for free, because this is a public building. It belonged to the old regime, then it was donated to the local community, and then there was an agreement between the local community and the Ministry of Social Affairs. There are a lot of other stakeholders who now want to control the building. So it was a big fight to find a small place, which is actually outside Misrata, kind of 13 km away from downtown. Not a very populated area compared with the city centre." (Interview with PSS Centre Staff)

4.2 Establishing the centres - initial challenges

The first challenge in establishing the centres was in translating the IOM approach to the Libyan context. On a global level, IOM implements various interventions that fall into the category of PSS. Information and guidance from some of these projects, particularly the IOM programme developed in Lebanon and Haiti, was used. However, there was limited knowledge and experience of implementing PSS in emergency settings within IOM Libya and a new staff team to IOM.

The IOM Libya senior management team agreed that one of the biggest challenges was simply 'getting off the ground.'

"It was a new concept for all of us...we had IOM support, space, money, staff but no-one on the ground had run this kind of project before. There was no time for proper induction and both locals and expatriate staff had no prior experience with IOM." (Interview IOM PSS staff)

There were consequently some problems understanding internal IOM administrative procedures in setting up the programme (i.e. regarding acquisition and procurement, security regulations, etc.) and in assessing needs. During the first phase of the programme (June 2012), a rapid needs assessment (RAP) was carried out using established IOM methodology. The assessment aimed to 'evaluate the general level of distress in the population, to highlight its possible sources and list existing coping mechanisms and possible responses'. The orientation to the assessment tools is a compulsory reading in the IOM Winter Course that two of the IOM Libya Senior project staff attended in Italy during their induction period. However, although the assessment provided invaluable insights, and two workshops were conducted in Tripoli and Benghazi to modify the tools with the teams, some of the interviewed staff regretted that the tools and methodology used for the assessment did not fully reflect Libyan needs and context.

The objectives of the assessment were: a) to increase psychosocial awareness and sensitivity of all humanitarian actors working with crisis affected Libyan population; b) to help psychosocial professionals to design specific psychosocial programs targeting the psychosocial needs of crisis affected Libyans, and c) to provide a framework for designing specific programs and activities to be carried out within the Recreational and Counseling Centers in Tripoli, Benghazi and Misrata, as a part of the IOM Psychosocial Programme.

A second challenge was IOM Libya's capacity to handle a project of such a complexity at the required

pace in a fluid and unstable context like Libya. This was frequently mentioned by respondents.

"We have around 50 staff for this project alone who are contracted as IOM consultants and within the IOM Libya office we are 20 – 25 people at most. It is difficult for the office staff to manage this number of people. This is the first time we have had to manage so many people and these kinds of contracts. For example, as IOM staff there are security implications. Staff have to follow the UNDSS rules, so if you go from Tripoli to Misrata, you have to go with two armoured vehicles, two drivers, satellite phones. You have to constantly report if you go from place A to B. You need to have a radio all the time with you, so the administrative part is extremely heavy." (Interview IOM PSS staff)

A third challenge was in having a cohesive team in place at the start of the programme. Ideally it was hoped to have both international and national staff who could deal with the very fluid and demanding situations in the three proposed locations for the centres. However in reality it was difficult to recruit sufficiently qualified staff in a short time span. According to some respondents, a key challenge was represented by the fact that local staff recruited to work in the centres were not professionals with sufficient expertise in their specific areas of work.

"So for instance a psychologist should be able to structure and hold a therapeutic conversation. The same with social workers, having a framework on how to do things. This would have been the only way possible for this kind of project to work as planned from its very beginning. The availability of local expert staff is quite low overall (and this is also recognized by other organisations and the local government.) People are not only not used to working for organisations such as the IOM, as psychologists and social workers, and so on. This has been therefore extremely challenging, although at times also

very stimulating for the staff who have experienced a different way of working". (Interview IOM PSS staff)

Although the expectation of established professional proficiency in the centre teams is not part of IOM modus operandi, and in fact great emphasis is placed on capacity building of local staff, especially the direct implementers from the local communities, the above assumption seem to have led to a certain degree of frustration both in IOM programme management level and local staff. An added complexity compounding the difficulty in recruiting suitably qualified local staff were the low salary levels in the budget proposal, which by Libyan standards would not attract professionals with a good track record and where volunteerism and work for social causes is still a new phenomenon seen by many with a degree of distrust.

**Multakama Centre,
Tripoli, 2014**

Several respondents also mentioned how social cultural norms vary from city to city, and from region to region. Misrata seemed to become more conservative after the war. One respondent said: *"In Misrata, we were visited by*



armed groups because they have heard music coming from the centre. ” It was essential in the start-up phase therefore that the recruitment of staff and the programming of activities were planned taking these norms into account. It was important in a country where women do not usually work and are not able to travel alone, for example, that when women were recruited to the staff teams, there was careful planning in gender relations in terms of programmes and activities.

Objectives of the collaboration between IOM and SCT

1. To map community resources around the centres

Mapping includes expressive/creative/ social resources in each locality e.g. looking for musicians, rather than listing organisations that provide classes etc.

2. To activate training for beneficiaries and for staff

Opportunities for learning are activated for beneficiaries of the centre (where staff of the centres are side by side with the trainers in order to be trained on the job – ‘training in action’) and for the staff of the centres (where training is centred on team building to create a cohesive group plus training on some techniques of social theatre that could then be used in their own activities).

3. To create a theatre event with and for the community

The objective is to present the centre’s aims and philosophy to the community involving a wide range of beneficiaries.

4.3 Collaboration between IOM and the University of Turin Master of Social and Community Theatre programme (SCT) – a turning point

Initially, the IOM Libya’s training strategy was based on the principle of short workshops (maximum duration of five days) facilitated by external professionals, where the programme manager would have a supervisory role, while the centres would operate more or less autonomously. *“When we realized that this was not possible in Libya and that much more concentrated and long term capacity building effort was needed, things started improving a lot”.* (Interview IOM PSS Staff)

A collaboration between IOM and the University of Turin Master of Social and Community Theatre (SCT) programme provided longer-term support. Two experienced consultants already acquainted with IOM psychosocial approach as a result of the long-standing collaboration between the two entities, were selected and trained over a two-day period in Geneva by the IOM Mental Health lead. They were given an overview of IOM, and an orientation to cultural issues and current challenges in opening up the centres in Libya. Some delays were experienced in sending the consultants to Libya and in defining the MoU between IOM and the university due mainly to university procedures. Three missions took place between March-May, May-July and September-December 2013.

The Turin team initially experienced more difficulties than originally expected, especially due to security issues and restrictions on movement. They always had to go out with a security escort and by car. The theatre event was restricted in its scope and the consultants found they were not able to use some of the techniques to connect with people directly in the streets. For instance, they often organize a community event by inviting people to donate fruit so as to make a big fruit salad together. Everyone is invited to come and eat

The PSS Centres

The centres offer both structured activities, which are scheduled every day at regular times, and unstructured activities, which can be improvised in order to welcome people. "Whenever someone comes during the working time, he is welcome." The centre also hosts activities in line with its spirit of being a community centre, "So we announce to the other NGOs and local authorities we are working with, whenever there is a need for a place for you to do your activity, just inform us and we will provide you with the space." The centre opens every day officially from 9 am to 5 pm. However the caretakers open up the centre at 6 am, so as to allow people go jogging, especially women. "Women in Libya do not have spaces to do sport and play games. So we open the centre at 6 am to give people an opportunity to do this kind of activity." The boy scouts in Abu Slim also hold their own activities at the centre. They have a safe space at the centre for the scouts to go camping."

Interview Tripoli PSS Centre

and at the same time they exchange objects with one other. However, although this idea was discussed and agreed upon initially, because of security reasons it could not be implemented.

"Nor we could distribute leaflets on the streets, so we have decided to work more in depth on the convocation to the event through a direct mediation approach, i.e. I talk to the student who then talks to his/her parents and so on, because the objective of the event in July was also that of reaching and involving the people living in the neighborhood, i.e. the first possible users of the Centre." (Interview SCT consultant)

Local authorities have also been invited, while at least not intentionally, the same communication has been made to other similar organizations which are operating in the community.

Despite these difficulties, some organisations and people were contacted. Some were traced through the Internet (for instance a martial art school); others were found by going to schools and a centre for disabled people. Students and residents of the centre were asked if they knew other people or resources that could be involved. A painter was identified who was willing to collaborate voluntarily and ran a workshop for children with the Turin consultants and accompanied by the centre staff so that they could learn in action.

It was challenging to work in communities where there was so much distrust, especially regarding outsiders, resulting from 42 years of living under the Qaddafi regime. A lot of time is needed to build up trust and work directly with people in the community in these circumstances. However, all the staff interviewed reported the Turin collaboration represented a real turning point in the implementation and setting up of the centre's activities. In the words of one of the respondents:

"The Turin collaborators spending their time in the centres from 8 am to 5 pm every day, accompanying the staff, mentoring them in their daily work, has really made a difference... it is not only about providing information, but it is learning by doing." (Interview PSS Centre staff)

4.4 Centre staff and activities

At the start, the staff at the centres needed assistance in team-building and basic organizational processes. One of the SCT collaborators worked extensively on these aspects, building trust and group cohesion, and focusing on how to organize and manage work, like keeping appointments and “for instance, having on board all the activities planned for the week, or ensuring that drivers would be available at the right times to allow for outreach activities.”

IOM project staff had to oversee the start-up of three centres simultaneously, plus the development of the Master’s course. So it was difficult for them to be always available at the centres.

“We have instead noticed that the difference is really made by continuity. Being there every day and assist them to structure their work, explaining them how this structured work should be carried forward, really made the difference”. The interviewee continues, *“The need identified was very much on strengthening the management of the centre’s activities, not so much in the sense of generating proposals of activities, since the proposals have always been deemed as interesting, but on how to make them work.”* (Interview STC consultant)

Despite the initial organizational difficulties and issues related to the female staff due to their limited previous experience in public roles, the centre staff have made *“incredible improvements and this has been much more evident in the last month of work where we have helped them revisiting their competences regarding these three levels:*

- *management level*
- *planning/programming of activities*
- *awareness of the role that the centre can have in relation to the psychosocial needs of the community.”* (Interview STC consultant)

“if you compare the analysis made in the first reports with current reports, these three levels have increased. Not so much in terms of therapeutic elements, but rather more on the acknowledgment and realisation that there is a way of working that is greatly supportive in terms of relationship-building. For instance, the traditional way of working with disabled people, in particular with people affected by Down’s Syndrome, was to give them gym equipment and that is the model of support usually employed in Libya. Now, by working with the staff of the centre, the disabled club is now employing different approaches that emphasise expressivity. This approach was recommended by the centre staff and it is now used.” (Interview STC consultant)

Another example of success is “leaving traces of the work done in the physical space of the centre, so that this becomes a means of communication in itself.” For example, important work has been done with disabled children on ‘Who we are’ that has resulted in a fresco on the walls of the centre. This fresco is a living testimony to the children that can also be used to talk about children and disability more generally.

4.5 The identity of the centres

Psychosocial support is a completely new concept to the local population. IOM project staff encountered a lot of difficulties in finding the correct terminology in Arabic. In the words of one of the staff: *“Although we use the term in official papers, we do not use it within the centre. We do not tell people that we are opening a psychosocial centre.”* As a result the centre in Tripoli is called ‘the Multakama Centre for Social and Rehabilitation Activities,’ so that people do not feel ashamed to come to the centre. *“If we mention the word psychological/psychosocial, the people would be afraid to come, they will feel shy to come, so we are trying to avoid the terminology, even if we do our activities with this approach in mind.”* Multakama in Arabic means “the place where

coming together, the gathering place". The centre in Misrata is called 'Abdaa Mana for Social and Recreational Activities.

It was also a challenge to deliver the message that the activities offered by the centre were not simply single activities, but were guided by a principle of supporting psychosocial wellbeing. This had to do with a lack of cultural vocabulary to discuss psychological or psychosocial problems. This would be overcome by teaching skills around communicating about emotions, but as one of the respondents from Misrata put it: *"The main idea of the centre is to provide psychosocial support. But this aim is under the table, it is hidden, it is not very clear. What is clear is that the centre is meant for leisure activities. The main aim of the centre is very hidden for people."*

Misrata, Abdaa Mana for Social and Recreational Activities -
photo from the Centre facebook page

Cultural factors were often mentioned as barriers to understanding the centre's intended goal and activities. One respondent, for instance, mentioned listening to music as *'haram'*, i.e. unclean and not acceptable.



On a whole, the accepted identity of the centres is therefore more of a recreational and leisure centre, providing a context for community people to gather. This avoids the stigma associated with psychological or psychiatric assessment. *“People felt shy to go to a psychologist, to a psychiatrist, but they do come to us to talk. Even by phone and we are supporting them.”* (Interview PSS Centre staff)

4.6 Areas for improvement

One of the most common issues observed and reported by staff in both centres were the physical limitations of the buildings. For example, there are few spaces for activities needing more privacy for participants and staff alike. As a result, some activities are implemented outside, or at other venues in schools or other organisations’ facilities. For the future it will be important to consider ways of improving the physical structure of each centre so as to facilitate the management and implementation of the range of activities planned.

Although the relationship between the centres is generally good, some respondents reported that there was not a sustained exchange of experience and ideas. This seems to be due not only to restrictions in movements between Misrata and Tripoli but according to some of the respondents, it is also the result of cultural and historical factors (including the role of the two cities in the toppling of the former regime.) In the words of some of the respondents, at times the two centres actually seem to compete with each other:

“On a daily basis they publish their activities on Facebook. They are not cooperating for a lack of maturity (professionally). Sometimes they said they wanted to visit the other centre, but with IOM regulations they need to have security clearance, which is difficult to issue sometimes, then they needed accommodation in Misrata which costs a lot, and logistic support again. They wanted to come. When they visit here in Tripoli, they share information, but they don’t coordinate, do not work together, don’t develop a model together, not to that extent, but relationships are good with each other. Sometimes they enquire how the others are doing, but sharing experience is not structured.” (Interview IOM PSS staff)



Tripoli Centre, 2014

5. SPECIFIC FINDINGS

5.1 Relevance

Against the backdrop of a traditionally conservative society, emerging from 42 years of an oppressive regime, the psychosocial programme being offered to the Libyan population is in the opinion of some of the respondents one of the few examples of an effective and relevant intervention in this moment of great transition. It is significant in having had an impact directly on the population affected by the revolution and the current state of turmoil. *"It is dedicated to the Libyan population, to the kids, families, women. There is a real return for them, that's absent in other programmes implemented by international organisations for the benefits of migrant populations so there is a strong interest to take this programme forward."* (Interview IOM Libya staff)

A question remains for IOM in light of its mandate as to whether the centres could also be oriented in the long term towards the inclusion of both migrant and settled populations in Libya.

Respondents who are directly involved in working in the centre and in the communities all mentioned that the concept of psychosocial work was hard for them to conceptualise. They found it hard to explain when they met people in the communities, but youth, children, mothers all come to the centre because it is a safe place where they feel protected.

“Yes, it’s a new idea. A social support network exists, but it is more at a tribal level, e.g. if someone gets hurt or someone dies, you will find all the community to support and comfort them, they stay in the house for weeks {...} The support is there, it is working, is effective and strong, but it is the in-kind support, but the intangible, the psychosocial, the psycho...social support does not exist...done in a methodological way, in a professional way, no. This is the first time that is being done by a psychosocial centre.” (Interview IOM PSS staff)

In a country where the security situation is in constant flux, where cultural restrictions make it difficult for people to talk about emotions, and for women to participate in activities intended to provide them with psychosocial support, the sheer existence of a space in which these activities can take place is seen as vital and unique.

When asked about how the centres compare with existing services in Libya, respondents highlighted that the centres are functioning in a more effective way.

“The centre in Misrata, for example, is the first community centre for recreational, social, psychosocial support. The MoSA has centres for vulnerable groups, like older people, orphans, girls, persons with disabilities and those with hearing loss. But

these centres are much less effective and have been seeking the assistance of the Misrata centre in providing quality activities. So the impact is good, not to Libyan standards, but compared to Misrata standards, I would say very good. But if you compare with (national) standards, the centre is still struggling to find a way to come up with a kind of approach which is consistent and adaptable to the community and the culture.” (Interview IOM PSS staff)

When asked about the relevance of the centres, many IOM senior staff also highlighted how relevant the project has been to the needs of the staff working within the centres. Respondents indicated that while the beneficiary group is composed of the civilian population living near the centres and in refugee /IDP camps, the staff of the centres themselves may arguably be seen as key recipients of the programme. These staff members are themselves drawn from the affected population, and live in the same difficult security situation as the rest of the population. For instance, it has proved to be a vital resource for the staff themselves to see that once trust has been built, skills in talking about emotions can be taught and supported, despite considerable cultural barriers.

Although there have been some obstacles in reaching affected populations, mainly due to security and cultural issues, offering psychosocial assistance to a group of IDP women from a nearby camp in Tripoli has been a significant achievement.

There was some initial resistance by the community to these women participating in the activities at the centre, but an agreement was made through an invitation from the centre being sent in response to a request for help from the women themselves.

Respondents felt that the work of the centres was generally successful. Children have been invited to play sessions, and the work with local women has

Example of a successful initiative

“Partners in Change’ is another activity which has proven very successful and was born out of an idea from the staff itself. The idea is that everybody should understand that each person can change society and he/she should not wait for the government or whatever to change things. He should start by himself and he can {...} so for instance the team visited a school and gave some presentations to the kids, talking about self-confidence, how to build personality, how to be strong, giving examples of people that have made a difference in the world. Then they started doing small initiatives in the school with a small number of kids, simple things that do not require lots of money and are suggested by the kids themselves, like taking care of the yard, building simple things. Then, they involved larger numbers of people, even involving local authorities, for instance, collecting tyres from the roads. In Libya “it is common to set tyres on fire, which create lots of air pollution. So they started collecting the tyres and used them in creative ways like making chairs or tables. They have also used them as big pots to plant small trees and have decorated the road in front of the centre”. Now other schools in Abu Salim are asking to participate in this project.”

Interview IOM PSS staff

been a success. Some children with disabilities (not necessarily resulting from the war) who used to stay at home are now coming to the centres. In spite of some local stigma around the idea of psychosocial problems and seeking help for them, the centres have also shown it is possible to reach adult men, especially those who are heads of household.

When respondents who work at the centres were asked if they would change or omit certain activities that they have done to date, they said: “*There are no activities that we think we should not do again. The work here is like working on dry land. When you do something, people will ask for more. One thing I would not do again: I asked one women in prison to talk and she started talking and I did not now what to do. I really needed to have psychologist with me.*” (Interview PSS centre staff). The issue of being able to set boundaries regarding what the centres can and should do for their communities is a sensitive one and will be explored in more depth in the final recommendations (section 6).



5.2 Coverage

The choice of the locations for the centres in Tripoli and Misrata, was done in close cooperation with local authorities. In Tripoli, a conscious decision was made to open the centre in Abu Slim, considered by authorities and partners alike as the most vulnerable, stigmatised and underserved area in Tripoli. In Misrata the allocation of the facility by the local authorities to IOM was instead to a large extent based on the availability of facilities rather than the particular needs of certain communities. IOM also chose to work in the cities most affected by the war, where the IOM had or was planning to have a sub-office. This notwithstanding, some of the respondents felt that *"The idea of opening the centre is a great idea, but nobody asked us at the beginning, what is your idea of how to implement things, for example, nobody said that. When we joined the IOM, it was fixed that we opened three centres in Tripoli, in Misrata and Benghazi. It was not negotiable, it was a decision made. So we had to work on this."* (Interview PSS Centre staff)

The respondent also cited the example of meeting other Libyans during meetings who regretted that there was not a centre in their area, asking, *"Why did you decide to open the centres in Misrata? Why in Benghazi? Why not in my area? I didn't have an answer to that quite honestly, because it was decision made before me. Even if I understood the point and why these locations were chosen, it was difficult to persuade others."*

Not much population census data or analysis could be found in the project's documentation regarding specific groups (for example, youth, families, IDPs, different ethnic groups etc.) in the catchment areas that the project intended to reach. It is likely that because of the chaotic situation in the immediate aftermath of the Revolution, reliable data was hard to find or may not have been available.

The initial intention of the project was to have two teams per centre, one that could work at the centre and the other team to do outreach activities in the communities. However, from interviews with the centre staff it appeared that respondents did not have a very focused approach, especially so when related to reaching specific groups of beneficiaries outside the centres. As one of them put it, *"The idea was that we just started the centre. We had to talk to as many people as possible. Not all the people who came to the centre needed psychosocial support. But lots of people came, for example, soldiers who fought in the war, children, women who do not have a job. Misrata is a big city and we cannot meet all the needs of the people."* A possible reason for this could be that the concept of outreach activities is fairly new in the Libyan context.

To counteract this problem, IOM and SCT proposed working with specific groups (such as children or persons with disabilities etc.) rather than offering activities to whoever happened to come into the centres. The SCT team identified two specific groups – firstly, children in the IDP camps and then IDP women (Tawargua). Targeting specific groups seems to have led to tangible improvements in the ways the centres operate. According to SCT, it has helped increase the autonomy of the staff in initiating new activities and adapting these activities to the cultural context. Staff also began to anticipate what steps would need to be taken in the longer term in planning activities.

An example given was of some theatre activities that had originally been implemented with children. The staff had briefed the children's teachers, giving a background to psychosocial work and the activities they had done with the children. The staff then suggested doing these activities (with some adaptation) with the women of the IDP camp. Initially there was some concern about this idea, as theatre activities are culturally not particularly valued. They were only

acceptable for children if they were seen as recreational activities. But with the support of the children's teachers, the women did the activities and it was considered a big achievement.

Due to its location outside the city centre, the centre in Misrata now largely focuses on outreach to schools. Respondents were able to give examples on how the PSP activities have impacted social identity and this in turn has translated into concrete action to improve the context. The outreach teams in both centres also reach out to IDP camps, especially in Misrata where many of the Tawergha people are residing, together with other groups from other countries such as Sudan. The problem for IDPs is in accessing transport to go to the centre themselves (this is approximately 70 families). There are therefore plans to open a centre or create a safe space in the IDP camp to reduce the risk of security incidents in travelling.

While respondents generally felt that the project achieved the necessary coverage in relation to its target groups, further work in reaching women, male adolescents, older people and people who are physically challenged was seen to be needed. One group that was felt to be seriously under-represented are male adolescents and ex-combatants. Respondents noted that while children could be invited to play, and men could be targeted as the heads of families, and women for specific women's activities, male adolescents were difficult to reach. An avenue for future development could lie in a specific programme for adolescents. This was seen as a very real need, as many adolescents had participated as combatants in the 2011 revolution, and were struggling to reintegrate successfully into society.

Some respondents said that the difficulty in reaching this target group was in part because the activities proposed were more suitable to children or adults. The main reasons however were cultural factors. For example, activities that could attract adolescents -

such as breakdancing - are often not culturally acceptable. Another important consideration for young people in this age group is the relationship between boys and girls. *"So, for instance, the staff of the centre in Tripoli did not want to invite male adolescents unaccompanied by their family, because they may try to form relationships with the girls attending the centre and this is not allowed."* The difficulties associated with gender therefore make it very difficult to engage this group in the centre's activities.

Although it is not within the IOM mandate to work long-term in prisons, another target group for IOM are those held in detention centres. This group would certainly require a more focussed approach than what is currently provided in the centres. Most detainees are likely to have experienced violence and maltreatment in the detention centres, which are usually overcrowded and have very poor physical infrastructure and facilities. They are likely to need urgent attention and psychosocial support. The staff at detention centres would also probably benefit from training and support. They are working in very stressful circumstances and are often not adequately trained in relation to human rights, health, etc. Training the detention centre staff about human rights violations might be a focus for IOM, as well as highlighting these problematic and involve other agencies that might be in a better position to address them over the long term.

One key informant felt that IOM should also focus more on improving the mental health of migrants and use its position as IGO and its mandate to lobby more for this very vulnerable group. They noted that IOM had responded positively to emergency calls from the international community during a recent emergency situation in which the security situation deteriorated. IOM had provided capacity development to staff of other (I)NGOs. This role in providing vital expertise was recognised and appreciated.

5.3 Sustainability

Three key elements emerged from the interviews which impact the sustainability of the programme:

- the commitment and motivation of staff
- the availability of suitably qualified staff
- future funding and coordination.

At a personal level, the commitment and motivation of staff was obviously seen as crucial for the future sustainability of the programme. One of the most striking features that became apparent from talking to the respondents who are directly involved in developing and implementing activities in the communities and in the centres, is the feeling of pride of what respondents felt in what they had achieved on a personal level and how they perceive their role in the post-Qaddafi era. *"We know now many things, we will continue for at least another two years."*

They feel proud of how they are working in the IDP camp, describing especially how the women are involved in developing activities. They indicated too how they had changed as staff members from working as individuals to working as team, and how they felt the support and strength of being able to work together. This is not something that came about easily. As mentioned earlier, most staff have been affected by the conflict themselves.

It is also important for the staff that they are acknowledged by external actors. They experienced significant changes when external people came in and worked alongside them, providing on the job coaching and learning. The visit by the Italian Ambassador was viewed very highly for the status of the centre in the community.

One of the issues most frequently raised concerning the future sustainability of the project was the avail-

ability of sufficient human resources with expertise and motivation.

"In Abu Slim, for example, the local authorities said that they will take the centre over and will continue supporting the activities if we get the people with relevant training and experience. To get psychologists here in Libya is a nightmare. Psychologists are very few, and even if they do graduate from the university with certificates, they are not qualified. We met, for example, with these people in the orphan houses and they asked us, 'Please - I am a psychologist, I don't know what to do.' or 'I am a social worker. Can you give me any kind of training that can help me in my work?' That was the request actually. They repeat the request everywhere we go. So the ideal is to have a team qualified with the training they deserve for a long time. But that's difficult. Also in our centre. You need to find people that do it, not just because they need money. it is not difficult to find jobs, but what we are looking for are people that want to do something to help others, which is quite a challenging matter to be done." (Interview PSS staff)

Problems with recruiting and maintaining qualified staff were thus clearly indicated by respondents. The general level of education is very low, and is possibly lower in Misrata than in Tripoli. New staff are usually not able to use a computer or type. There are also challenges of working with staff from an affected population. Local staff therefore require intensive capacity building before any responsibility for a psychosocial activity could be handed over to them. But as one external respondent commented: *'The staff have immense personal resources that could be built upon.'*

English speakers are very difficult to locate as a result of the policy of the former regime in banning the speaking or teaching of English. This means that there are significant barriers to working with international agencies or consultants.

Continued funding was cited as a key pre-requisite to the sustainability of the project and closer coordination between the psychosocial programmes in the area was also felt to be desirable.

A cluster group was funded and organised by WHO, but stopped a year ago, because of the reduction in the number of organizations working in MHPSS and the fact that NCDC was seen as the responsible body to coordinate this initiative. To date, one of the working groups in the Health Sector Reform Programme (human resources in health) may have the potential to function as a platform for mental health and psychosocial support.

As a final point, it was also noted by some key informants that although most CSOs seem to suffer from a real lack of funds, they share a common skepticism about international donors, which they fear will earmark their donations in order to promote their hidden agenda. At the same time, there seems to be a general acknowledgement that new CSOs need capacity building not only in their specific area of expertise, but also in knowing how to actually manage and use funds efficiently. Capacity building in the following areas were highlighted: defining a vision, mission and goals; strategic planning, project development and management; leadership and consensus-building; training of the trainers; civic and political education; advocacy campaigning; corruption and government monitoring.

5.4 Conclusion

It is commendable, considering the Libyan context where organised social work and CSOs are new phenomena and with the initial difficulties in recruiting and maintaining a motivated staff, that the programme has established centres where the application of the aims and values of PSS are clearly apparent. The evaluation team has witnessed great enthusiasm and has seen a capacity for generating ideas, capitalizing on local resources.

Inspired by a genuine desire to help rebuild the social fabric of their own communities, there is however a risk in responding to any request for help. The reasoning is: *'We told the community this is their centre and we are here to help the community so we cannot say no when they ask us to do something with them or for them.'* However, in order that people and resources are not over-stretched, an assessment of the centre and its staff capacity should be undertaken, together with a strategy for scaling up activities. This exercise should also involve other CSOs in a spirit of partnership that would be beneficial for all in planning services together. Much of the information generated through the RAP assessment is still relevant and could be used to guide the development of relevant activities.

Certain target groups have not been included to date, based on staff perceptions of what was appropriate and what not. For example, it was felt that the decision to target children was an appropriate one based on the skills and experience of the staff team. However, as the reach of the centre expands, new skills will probably be needed. Staff already recognised a need to refer more serious cases, but currently have no specialised services to consult with. It is therefore recommended that the IOM facilitate access to services, such as MoH and other MHPSS initiatives.

The IOM PSP started in a chaotic emergency context, which has proved to be very challenging in creating stable, cohesive teams. During the initial six months of the PSP, staff turnover has been high and much effort has gone into getting the much needed and essential buy-in from the local authorities and other actors such as school management and educational authorities. It is remarkable that in a relative short space of time (one year) the centres have gained credibility, evident in the range of participation in activities. The two centres in Tripoli and Misrata provide a safe and protective environment for children's and women's activities, together with work with families, and outreach activities with IDPs. Staff have overcome considerable cultural barriers amongst themselves, as well as from their beneficiaries, in overcoming prejudices against the concept of psychosocial support.

Most of the respondents who work directly with beneficiaries indicated that they are also working with local authorities and other organisations. They regularly seek the involvement of local actors and have good networks within local communities. Based on the findings of this evaluation, however, there does not appear to be a clear project strategy for working with local agencies, the business community, etc. The centres have gained the support from local authorities, which is indeed a prerequisite for functioning. It is not clear, however, that local resources have yet been accessed to their fullest extent. The experience and local knowledge of centre staff could therefore be built upon more consistently going forward.

The centres reach distinct groups of beneficiaries, each with their own characteristics, including school children; their mothers; IDPs, widows from the IDP camp near Misrata; the Syrian refugee community, particularly the women and fathers of children. Respondents also identified groups that currently are not reached: adolescents; men between 15 – 25

years of age; older people; children who are physically challenged and often stigmatized and isolated at home; women who are socially isolated (for example, those do not have jobs and stay at home). Based on findings from staff working directly with beneficiaries and external actors, it is apparent that the centres have reached out to their local communities. This could be an excellent starting point for the next phase, in focussing on groups not reached to date. Strategies for targeting groups should also include the involvement of the intended beneficiaries.

The IOM PSP has gained sufficient leverage and credibility such that their experience could be used as an example for other community initiatives, illustrating how links to different levels of services and appropriately trained staff are needed to build a comprehensive health sector. A key informant said, *"Their professional growth and attitude is remarkable. They are the people who know how to mainstream MHPSS in services, they show sincerity in how they work and good leadership."* The IOM PSP should therefore become more proactively involved in coordinating with other actors in MHPSS and contribute to MoH discussions on health sector reform.



Tripoli Centre, music lesson in progress

6. RECOMMENDATIONS AND LESSONS LEARNED

6.1 Introduction

Whilst operating in extremely challenging circumstances, the IOM PSS is achieving remarkable changes for communities and children. Significant progress in meeting existing standards has been made in a short period of time, and clear areas for improvement have been identified. The vital role of sustained mentoring and supervision has been emphasized through the changes achieved for the communities surrounding the centres. Lessons have been learned that will benefit not only the IOM team in Libya, but also other similar IOM initiatives internationally. The recommendations below thus serve as suggestions and guidance for IOM in ensuring that psychosocial support continues to thrive and improve, and that IOM emergency programming more broadly may benefit from learning gained in Libya.

6.2 Recommendations

Recommendations for improving adherence to IASC standards

1. It is recommended that IOM PSP take an active role in the Working Group on Human Resources in Health (Health Sector reform)

Recommendations for improving partnerships and coordination

1. It is recommended that centres conduct a comprehensive mapping of local resources (including social, economic, educational, disarmament, networks etc.) to increase the effectiveness of programmes for recovery and to promote collaboration between local actors.
2. It is recommended that IOM PSP develop clear written guidelines for the establishment and management of psychosocial centres. These can then be used as a frame of reference in future settings.

Recommendations for safety and security

1. It is recommended that IOM PSP consider how the protection benefits of psychosocial support (in particular in providing a safe space) could be extended to other target groups, such as vulnerable migrants. Due to the current security issues, it seems unfeasible to open more centres targeting migrant communities only. Running awareness-raising sessions on the role and benefits of migration to Libyan society and migrants' rights, for example, may be possible and could be conducted in schools aimed at parents and the wider community.

Recommendations for improving outcomes for beneficiaries

1. It is recommended that the centres develop strategies to reach out to other groups such as older people, young adolescents (especially male) aged between 15 - 25 years and ex-combatants.
2. It is recommended that representatives of beneficiary groups be included in developing these strategies.
3. It is recommended that IOM PSP and the centres' management Information systems be im-

proved to monitor beneficiaries' needs, record and monitor service provision, etc.

4. It is recommended that centres work with the MoE in the schools within their catchment area. It is recommended that centres discuss with school management the possibilities of working alongside the social workers attached to the schools. By supporting social workers in providing a protective environment at school, other issues that affect children such as domestic violence could be addressed.
5. It is recommended, in line with the mandate of the IOM, that IOM PSP explore if and how psychosocial support services could be provided to migrants in the communities where the centres operate.
6. In the immediate future, the PSS centres might focus on involving more actively parents in their programs and supporting them in being good-enough parents. Moreover, PSS centres might focus even more on training other adults who are important in the daily life of children, offering tailor-made capacity building also for volunteers.

Recommendations for capacity building in human resources

Given its experiences gained in the PSP, IOM is well placed to play a vital role in building human resource capacity and influencing reform in MHPSS in Libya. The centres themselves and the community-based facilities that they use could become appropriate entry points to provide PSS services.

Nearly all respondents mentioned the need for ongoing capacity building of staff. To address this holistically, the recommendations here go beyond the outcomes of interviews with IOM staff:

1. It is recommended that IOM Libya develops a PSP learning and staff development framework

for the PSP after it is handed over to local actors. This includes:

- Developing a framework in close cooperation with the operational staff and the organisations that will be running the PSP.
- Focussing the human resources development plan on 'on-the job' coaching, and setting up viable staff support, culturally appropriate peer support and supervision mechanisms.
- Developing with staff an in-depth learning assessment system to identify skills and resources and to highlight gaps in learning amongst staff.
- Developing a knowledge sharing network, between the centres and other organisations, and setting up a database (such as the one in Lebanon).
- Focussing on long-term learning, building consistency and cohesion and drawing on local resources and capacities.
- Creating a referral system, extending capacity to support both migrant and local population groups.
- Contributing to the overall HSR programme by participating in the Working Group on Human Resource Development in Health.
- Extending the use of Facebook and Twitter and other social media for awareness-raising, improving access to the centres, for coaching of staff.
- Designing a separate learning strategy for staff working in detention centres and IDP camps.
- Improving broader staff development and support. The IOM expressed a strong desire to be able to "spend more time on staff development, by providing technical training to centre staff on such aspects as project management, accounting and reporting, project development, thinking about their future and their long term sustainability."

6.3 Lessons learned for future replicability in similar contexts by IOM

1. More preparation and support in relation to the internal procedures and requirements of IOM could have helped the team, which was new to IOM. Training specifically on the psychosocial approach used by IOM and an orientation to the tools commonly used, for example, in psychosocial assessment, have indeed helped the team.
2. More attention should be paid to target populations in need carefully and determine who will serve as comparison populations. Robust monitoring systems with unique identifiers that could foster better evaluation data with carefully constructed comparison populations, would improve the quality of evaluation work.
3. It is strongly recommended that IOM provide a comprehensive model of organisational and institutional capacity-building for programme partners. Training would be just one component of the model. It is also recommended that IOM provide quality assurance tools for programmes offering technical assistance, such as those available through INTRAC.

ANNEX 1

Key Evaluation Questions Related to Psychosocial Programming based on OECD/DAC Evaluation Criteria (UNICEF, 2011)

Domain	Guiding Questions
Relevance	<ul style="list-style-type: none"> • Did the program articulate objectives related to changes in children's well-being and lives, and that of their family and community? • Were clear needs defined with respect to required 'levels' of psychosocial support? • Were potential beneficiaries involved in developing programming? • Is program response relevant to identified needs?
Efficiency	<ul style="list-style-type: none"> • Have inputs resulted in the outputs targeted? • How did costs compare to other programs targeting similar outputs?
Effectiveness	<ul style="list-style-type: none"> • Have stated program outcomes been achieved? • What difference has come about for beneficiaries in terms of skills and knowledge, emotional well-being, and social well-being? • What factors contributed to success or failure with regard to targeted changes?
Impact	<ul style="list-style-type: none"> • Has the central goal of the project – the needs that provided the rationale for intervention – been met? • What lasting changes – attributable to programming – can be identified in the lives of individuals, families, communities and the broader environment? • Did any negative changes result from programming?
Sustainability	<ul style="list-style-type: none"> • What new capacities within services or communities have been established or restored? • Are these capacities being actively used in the psychosocial support and development of children? • Have root causes (such as attitudes to children) been impacted?
Coverage	<ul style="list-style-type: none"> • Has programming reached all geographical areas targeted? • Have potentially vulnerable or marginalized children and communities been reached? • Have the needs and capacities of different age groups been appropriately addressed?
Coordination	<ul style="list-style-type: none"> • Have agencies worked well together towards the common goal of improved psychosocial well-being amongst children?
Coherence	<ul style="list-style-type: none"> • Has work been consistent with the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings?
Protection	<ul style="list-style-type: none"> • Does the project contribute to protecting children by strengthening the child protection mechanisms such as legislation, services, community norms etc?

ANNEX 2

List of Key References

1. BBC Libya Country Profile www.bbc.co.uk/news/world-africa-13754897 25 November 2013
2. Brookings Doha Center Publications: Reconstructing Libya: Stability Through National Reconciliation, 2013 <http://www.brookings.edu/research/papers/2013/12/03-libya-national-reconciliation-sharqieh>
3. Civil Society Dialogue Network (CSDN) Libya Conflict Assessment: Gathering Civil Society Input. 26 July 2012 in Brussels www.eplo.org/civil-society-dialogue-network.html David Wood david.wood@peacefulchange.org
4. International Crisis Group: POPULAR PROTEST IN NORTH AFRICA AND THE MIDDLE EAST (V): MAKING SENSE OF LIBYA Middle East/North Africa Report N°107 – 6 June 2011
5. International Crisis Group: TRIAL BY ERROR: JUSTICE IN POST-CONFLICT QADHAFI LIBYA. Middle East/North Africa Report N°140 | 17 April 2013
6. IOM Evaluation Guidelines. January 2006
7. IRIN: Analysis: Libyan minority rights at a crossroads. May 2012. www.irinnews.org/report/95524/analysis-libyan-minority-rights-at-a-crossroads About Tuareg communities.
8. Psychosocial needs Assessment in Emergency Displacement, Early Recovery and Return. IOM Tools. 2010
9. UNICEF: Interagency Guide to the evaluation of psychosocial programming in humanitarian crises. 2010
10. Unicef: Inter-Agency Guide to the Evaluation of Psychosocial Programming in Emergencies. New York. 2011
11. WHO: Country Cooperation Strategy for WHO and the Libyan Arab Jamahiriya 2010–2015

ANNEX 3

List of key reviewed documents

Type of document	Name	Owner	Date
Project Planning	Psychosocial assistance for crises affected children and youth and their families in Libya. Annex 1	IOM	2011
Training report	Needs Assessment training report, 9-11 July 2012	Internal IOM Libya	2012
Assessment Report	Draft. Assessment of the Psychosocial needs of Families affected by the 2011-2012 Libyan Crisis. July – September 2012	IOM	2012
Project Report	Report on Psychosocial Activities 'Humanitarian response to the Libyan Crisis'.	IOM	March 2012
Project Report	Mid-term report to the Government of Italy. Psychosocial assistance for crises affected children and youth and their families in Libya. January 2012 – 31 July 2012	IOM	2012
Training report	Psychosocial Workshop Report	Internal IOM Libya	December 2012 (translated)
Activities report	Psychosocial Programme bi-weekly report	Internal IOM Libya	14 March – 5 April 2013
Activities report	Psychosocial Programme bi-weekly report	Internal IOM Libya	7 April – 2 May 2013
Activities report	Psychosocial Programme bi-weekly report	Internal IOM Libya	5 May -1 June 2013
Report	Psychosocial assistance for crises affected children and youth and their families in Libya. May – September 2013	Internal IOM Libya	2013
Report	Final report to the government of Italy. Psychosocial assistance for crises affected children and youth and their families in Libya. January 2012 – May 2013.		2013
Report	SCT in IOM Psychosocial project in Libya. 10 march 2013- 9 May 2013. Final report	Torino University	2013
Report	SCT IN IOM Psychosocial project in Libia. 1 June 2013 – 7 July 2013. Final Report	Torino University	2013
Activities report	Assessment report, needs of migrants in detention centres	Internal IOM Libya	22 July 2013
Project planning	Strategic Planning Meeting 27-28 October 2013	Internal IOM Libya	2013

ANNEX 4

List of interviewees

n.	Group / Code	Interviewee
	I	Group I: IOM Psychosocial Staff
1	I.1	Guglielmo Schinina` - Technical Supervisor/Head, Mental Health, Psychosocial Response and Intercultural Communication Section
2	I.2	Marcio Gagliato, Programme manager
3	I.3	Khaled Hamidi - Programme Assistant Tripoli Center
4	I.4	Abdulahkim Atiwa - Programme assistant Misurata Center
	II	Group II: IOM Libya Staff
5	II.1	Othman Belbeisi- Chief of Mission
6	II.2	Taymour Saghah - Security Advisor
7	II.3	Arun Kumar - Resource Management Officer
8	II.4	Massimo Ramanzin -Int. Project Officer
9	II.5	Mariam Khokar - Int. Project Officer
10	II.6	Besim Ajeti- IOM head of operations
	III	Group III: Misrata Center Staff
11	III.1	Group 1: Mohamed – Center Director ; Kamila Elgaddari - Educator; Amal Esmail Alzzabati - Social worker
12	III.2	Group 2: Khairi Abdalla Daghadanna – Music teacher; Najua Assiriti – Social worker; Abia Sulaiman Al-Aar – Artist ; Saeda Hosni – Educator
13	III.3	Group 3: Nadia Subka – psychologist; Medhat Elgellay – driver; Thuria Milad Essreeti – Educator
	IV	Group IV: Tripoli Centre Staff
14	IV.1	Group 1: Abdorazak Ahmed Melos – Center Director; Ezzadeen Ben Musa – Educator; Rafia Gahman - Social Worker
15	IV.2	Group 2: Huda Almabrok - Educator; Afaf - Fatima Elwalwal – Social Worker; Fathi Al-Riani – Music teacher; Ziad EL-Koja – security guard
16	IV.3	Group 3: Nagia Ahmed Altanashi – Artist; Abdusalam - driver; Zinab Abu miniar - Educator
17	IV.4	Group 4: Mr Alhakim Almabsott - Representative of Ministry of Education; Fathi Mohammad Shabor. - Director Disabled Club; Mr. Alahir Otman El Ngrash - School Director
	V	Group V: Stakeholders
18	V.1	Amjad Shogrouni - NCDC
19	V.2	Nina Boroufk -Hilfswerk Austria International -Youth Centre
20	V.3	Dr. Fahmy Bahgat - Technical Advisor WHO Libya
21	V.4	Edda Costarelli - EU Health Expert
	VI	Group VI : University of Turin Master of Social and Community Theatre (STC) programme
22	VI.1	Alessandra Rossi Gighlione - SCT Coordinator
23	VI.2	Cristina Carniel - SCT Consultant
24	VI.3	Maurizio Bertolini; Federica Tripodi; Fabrizio Stasia -SCT Consultants
	VII	Group VIII: Former Staff/Others
25	VII.1	Nagia El-Waseea -former IOM Programme Assistant
26	VII.2	Ali Greebi- former IOM Programme Assistant
27	VII.3	Sarah Craigs -IOM Senior Regional Advisor in Cairo

Multakama Centre ,
Tripoli 2014





Mental health and migration. Definitions and complexities

Guglielmo Schininà

According to the World Health Organization (WHO), mental health is “a state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community” (WHO, 2004).

A migrant is defined as “any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person’s legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is” (IOM, 2019d).

For migrants, the state of well-being that characterizes good mental health is challenged by factors that are inherent to the very definition of mental health and the circumstances of some migration paths. This is particularly true when individuals and groups are forced to migrate due to war, conflict, persecution, natural disasters and famine, such as people who are displaced in emergency situations.

Migrants often cannot realize their full potential, due to bureaucratic barriers, stigma and discrimination. The stressors they are subject to can at times be abnormal, and invest the entire migration cycle, from the reasons that brought them to leave, to the conditions of their travels, to the way they are received, assisted and integrated at transit and destination. Very often, forced migrants can’t work or are forced to work under the table, because of their legal status and other circumstances. Finally, migrants are supposed to contribute to more than one community – including the community of origin, the migrants’ community at destination and the host community – each with its own expectations on the migrant, and with some of these communities possibly hostile to migrants to the point of preventing their contributions.

For all references please see bibliography.

Psychosocial support after adversity: A systemic approach.

Renos Papadopoulos

The approach presented in this short contribution is based on four interrelated perspectives (frameworks) that are informed, mainly, by systemic principles:

- (a) The examination of the epistemological effects of being exposed to overwhelming forms of adversity;
- (b) The distinction between events and circumstances, and the experiences of them by individuals, families, groups and communities;
- (c) The range of responses to adversity;
- (d) The distinction between individuals, families, groups and communities becoming victims of events and circumstances, as opposed to developing a “victim identity” (systemic, organizational perspective).

(a) When individuals, families, groups and communities are exposed to overwhelming forms of adversity (as the ones generated by emergency, displacement and repatriation situations), they experience a variety of different pressures, demands, distress and anxieties. The needs are not only multiple but also multifaceted, including: the urgency to reduce or eliminate the occurrence of such adverse events and circumstances, to minimize their damaging effects, to provide assistance to those who were worse affected by them, to grasp the complexity of the situation, to digest the radical new reality that the adversities produced, to absorb the shock of the changes that were emerged, to deal with the painful mixture of distressing and perplexing feelings accompanying all these, to cope with the new restrictions of functioning, and to manage the new identity that the new circumstances have imposed.

It is impossible to reduce this multifaceted complexity to only one effect, whichever this may be. People are shaken to the core of their being by such upheavals and are affected in a wide variety of ways. What is essential to appreciate, even before examining any specific effects that such devastating sets of circumstances have on persons, is the impact they have on how people comprehend (or not) and process such upheavals and changes. Under all these pressures, people tend to oversimplify their perceptions of what happens to them, around them, among them and inside them, in order to retain some grip on their reality (however partial or incomplete), in order to maintain some semblance of control (regardless of how effective this may be).

Failing to grasp in any satisfactorily coherent form the barrage of such devastating events and experiences, with all their complexities, people tend to develop a special type of uneasiness that can be called “epistemological panic” (Bateson, 1979). This refers to what happens when people realize that the usual logic and frames of reference that they use in their ordinary lives are no longer applicable in producing any satisfactory understanding of these fundamental changes in and around them. Their usual modes of conceptualizing phenomena fail them. This leads them to a specific type of discomfort and distress that forces them to oversimplify their perceptions, imposing simplistic logic in order to prop up a sense of mastery (at least in terms of seeming

comprehension) as they cannot maintain mastery of their actual fate. These hasty forms of “comprehension” (regardless of their accuracy) serve as useful and temporary crutches. The most common form of oversimplification is gross polarization, viewing phenomena in terms of black or white, good or bad, either/or instead of both/and. Accordingly, the affected persons would experience themselves just as victims or survivors, vulnerable or resilient, unable to hold on to the complex reality which is that, to varying degrees, they are both resilient as well as vulnerable, survivors as well as victims, damaged as well as enriched. More specifically, the oversimplification of their perceptions makes it very difficult for them to discern that, in addition to their helplessness, they have also been able to retain some of their previous strengths.

The importance of identifying this form of epistemological distortion is that, before they even begin to grasp what has befallen them, before they begin to formulate any account of their needs and ways of addressing them, their very conceptualizations are most likely to be affected by the enormity of these pressures, leading them to skewed perceptions and inaccurate ways of understanding the complexity of their predicament. Unable to grasp reliably the multifaceted complexity of their situation creates many complications. It is for this reason that rhetorically, it can be said that the first casualty of trauma is complexity.

In such situations, gross forms of polarization become endemic, spreading like a virus in all shapes and forms, and at all levels. Then, the tendency is to perceive the fundamental alterations to the realities of those who were exposed to such forms of adversity as producing either exclusively negative or exclusively positive effects. These polarized perceptions are the result of an epistemology, a way of conceptualizing phenomena, which itself becomes “traumatized” by all these pressures. Therefore, such “traumatized epistemologies” traumatize the conceptualizations of both the adversity-affected persons as well as all “those who are trying to help them, insofar as they lead to various forms of hasty pseudo-understanding” (Papadopoulos and Gionakis, 2018).

(b) The oversimplification which is produced by traumatized epistemologies is not limited to polarization. Another important consequence is the lack of differentiation between understanding the precise nature of the relevant adverse events (with all its multiplicities) and the way these events are experienced by the affected persons, families and communities. Blurring this distinction is not only logically incorrect, but also leads to inappropriate causal–reductive explanations, creating the erroneous impression that it is solely the events themselves that *cause* directly whatever lasting distress people may experience, thus ignoring the host of other contributing factors. Inevitably, such mistaken conceptualizations lead to ill-informed conclusions with unfortunate effects on the interventions that are offered to ease the affected people’s plight.

The belief that everybody is affected in the same way by the adverse events themselves, regardless of any factors affecting individual variations, is widespread, is accepted unquestionably and is taken for granted. Yet, the moment one considers this equation more carefully, one realizes its illusory effect very easily. Everybody knows that each person experiences events differently and according to a wide range of contributing factors: personal, historical, societal and so on. Everybody knows that, following a catastrophic event, some people are devastated for a long time

afterwards, or even for life, while others bounce back and even thrive. Human beings are not passive bodies like inanimate objects that obey the laws of physics. If you hold up an object and then release it, gravity is going to force it to drop to the ground. This is pure and deterministic causality. With humans, no such simple causality applies. Instead, the complexity of outside factors and the person's own idiosyncrasies will create a multifaceted cluster of variables that will affect the outcome of how each person, each family or community will experience emergencies, displacement and return situations. In short, a need exists to differentiate between the events (in their own right) and the experience of the events, what contributing factors affect the way the events are experienced the way they are.

(c) In order to counteract the tendencies that the exposure to adversity has (such as destroying complexity, oversimplifying and polarizing our perceptions and conceptualizations), it is important to identify the range of responses when people are exposed to adversity, and not limit it just to the negative ones. The "Adversity Grid" (Papadopoulos, 2007) provides a framework that identifies three categories of effects, consequences and responses to adversity by individuals, families, communities and the wider society/culture.

(i) Negative responses to adversity:

The tendency is to identify, almost exclusively, these negative responses to adversity because these are the ones that are considered to form the field that society wishes to address, redressing the damage inflicted by the adversity. This is understandable. Following any catastrophic event or any emergency, the focus is on identifying the losses and destruction, and the ways people have suffered and were affected negatively. The needs assessment exercises are geared, precisely, to specifying such damages to the affected people and their environment. This is correct and appropriate. However, this is only one category of the consequences of these adversities. In addition, at least, we need to ascertain what existing strengths people were able to retain, despite their exposure to adversity. This will enable us to have a more realistic picture of the totality of the situation in order to formulate more suitable interventions.

Not all negative responses are of the same type, severity and strength. Thus, it is important to identify various forms and degrees of negative responses. The most severe one is when people develop actual psychiatric disorders. However, not everybody develops a psychiatric disorder as a result of being exposed to adverse emergencies, displacement and repatriation situations. Moreover, we need to consider the duration of such conditions. There are also many persons who have different combinations of psychological symptoms who do not suffer from the precise cluster of the prescribed symptoms that constitute a certain psychiatric disorder. Therefore, this should be considered as forming another category of negative responses to adversity which is less severe than a psychiatric disorder. This subcategory of negative responses can be called "Distressful Psychological Reactions". In effect, these can be called psychological as opposed to psychiatric symptoms and, although they may be equally negative, their negative effect would be less severe on the person's daily functioning.

The least severe subcategory of the negative effects can be defined "Ordinary Human Suffering". People can be affected negatively in ways that cannot be characterized as either psychiatric or

psychological; instead, taking these effects into their own stride, although they still accept them as negative, the affected persons give them meanings within the context of life misfortunes, conceptualizing them within systems of meaning such as political, religious, ideological or even existential. People may say that it was “Allah’s will” or that “Allah is punishing me” or “testing me” or that it was a life hardship that they had to endure, for instance. They are not saying that these effects are positive, but they are experienced as part of the tragedies that happen in life.

(ii) Unchanged responses to adversity:

Regardless of whatever negative ways every person, family and community responds to adversity, to varying forms and degrees they also retain some of their previous strengths: abilities, qualities, characteristics, behaviours, functioning and relationships, for example. It is essential to discern this category because, under the distorting effects of the “traumatized epistemologies” that are developed in these adverse circumstances, the exclusive focus tends to be on the negative effects, forgetting that people always also succeed in holding onto some previous forms of functioning. Moreover, it is critical to remember that our systems of aid are based exclusively on the negative effects. We all know that in order for any form of assistance to be offered to the affected persons, they need to be identified by some specific form of vulnerability. Therefore, addressing their needs, in effect, means identifying the negative ways they were affected by the adversity, leading to interventions to rectify the damage inflicted. Within the category of unchanged, I differentiate two subcategories: the negative and positive ones.

Not all the difficulties that persons experience following adversity are a direct or even indirect result of their exposure to adversity; some of these negative ways of functioning existed even before the emergency or displacement. For example, persons may have suffered from a physical or mental ailment which continued unchanged after they were exposed to the specific adversity that is not examined. In addition to the “negative unchanged”, there are the “positive unchanged”, and these are of extreme importance because they are the ones that constitute the resilient facets of a person. Indeed, resilience, according to physics (from where the term originates), is the ability of a body to retain its previous positive functions despite its exposure to adverse conditions. Resilience has become a very popular term in recent times, and there is a great deal of confusion as to what it means precisely. Defining it in this way, as the retained positives (Papadopoulos, 2007), offers a tangible and operational way of identifying the specific resilient functions, qualities, characteristics, relationships, behaviours and abilities of a person, family or community, without resorting to idealized and intangible portrayals that refer to global and unspecific states of being.

Identifying such positive facets that were retained, despite the exposure to adversity, helps us ascertain, in a more reliable and specific way, the complexity, uniqueness and totality of the actual state of the persons, families and communities that we wish to assist in times of emergency, dislocation and return situations.

(iii) Positive responses to adversity:

This category is often neglected. In addition to the negative and unchanged responses to adversity, every person who is exposed to adversity also gains something to some degree from these

experiences. The saying in most languages and cultures “whatever does not kill you, makes you stronger” conveys the reality that the experience of devastating events also has a transformative power. The enormity of such experiences shakes people to the core of their being, making them question and review almost every aspect of their lives. The fact that they lost so much, that they came so close to death, that they witnessed extreme forms of human behaviour as both “evil” as well as “good”, that they saw their life efforts, plans and ambitions being destroyed, makes them pause, wonder and reflect. It is then that they begin to view life differently, re-evaluating their fundamental *Weltanschauung*, their priorities in life, their values and beliefs, their very identity. This is why I have called these types of responses to adversity Adversity-Activated Development (AAD), because they refer to those positively transformative aspects of development that are activated specifically by the very exposure to adversity. There are endless examples of AAD in real life in individuals, families and communities, which alter their previous individualistic styles of life by appreciating the importance of human contact and support, widening and deepening the scope of their previous life goals, and correcting wasteful and meaningless pursuit of goals that proved worthless, leading to the adoption of more meaningful life goals.

It is difficult, indeed, to consider anything positive when one is struck by any severe form of adversity, and this is the actual problem. Under the weight of all the losses and painful experiences, it is almost impossible to even contemplate that anything good can possibly come out of such catastrophic events. However, if we do not consider the complexity, uniqueness and totality of a person, a family or a community in these difficult times, we risk skewing our perception of who they are, what they are capable of doing, with detrimental effects on our interventions.

The Adversity Grid provides a helpful framework to remember the complexity, uniqueness and totality of all persons affected by adversity, thus counteracting unhelpful polarizations and generalizations. In this way, the Grid offers an effective antidote to the ill effects of the traditional traumatized and traumatizing trauma discourse, which views adversity survivors exclusively as helpless victims.

How can the Adversity Grid be used and how can it be applied? Primarily, it serves as a framework to remind practitioners not to be trapped within the negative spectrum of responses to adversity. By keeping in mind the complexity of effects, practitioners can view the affected persons three-dimensionally and not as mono-dimensional caricatures of trauma victims. This means appreciating that, in addition to the devastating effects of adversity, people always retain some positives from their previous ways of being, as well as gaining something, in some way and to a certain degree.

The Grid can be used in Rapid Assessments or any other form of assessment where the intention is to map out the entire range of effects following an emergency. This enables practitioners to develop a picture that is as accurate possible of the actual reality on the ground, so that they can plan interventions that address most appropriately the losses, while also actualizing the retained strengths (resilience), as well as the new gains (AAD) at all levels (individuals, family, community and culture). The benefits are not limited to the designing of interventions. By identifying the strengths (retained and new), aid workers de facto develop a respectful attitude of the affected populations and they do not see them just as helpless victims. This also constitutes a real and actual

form of empowerment that is based on reality and substance, not on empty slogans or idealized formulations.

Similarly, at the level of working with affected persons, an aid worker endeavours to discern all three categories of adversity consequences that the Grid specifies. The following important considerations need to be emphasized in relation to the practical application of the Adversity Grid:

- a. One cannot possibly access or even make any hints of any strengths of a person or a family before addressing sufficiently and absorbing substantially the pain and suffering they experience as a result of their negative responses to adversity. The main connection with persons in need is through their distress. They ask for help and helpers are there to offer it. However, while addressing their anguish, at the same time one should always keep in mind their complexity, uniqueness and totality, which also include their resilient and AAD parts, remembering that if one relates to them exclusively focusing on their deficit parts, the efforts will be inappropriate and ineffective.
- b. The identification of resilient and AAD aspects of functioning can be carried out using any appropriate form that is available, according to the specific context of the interaction. Ideally, it should be done collaboratively, combining not only practitioners asking persons of concern questions about their strengths, but also practitioners sharing their observations with them of the resilient and AAD parts they see, notice and become aware of, in addition to whatever else they actually tell us. This identification needs to be done with extreme sensitivity and respect.
- c. Once the other two Grid dimensions are identified, such as the retained strengths and the new strengths (resilient and AAD parts), then extreme caution is required as to how practitioners relate these to persons of concern and how they interact with them using these two categories. In short, these should be communicated *at the appropriate time* and in the appropriate way, using *appropriate language*. These two dimensions should never be presented either to contradict or minimize or divert their attention away from what they say about their pain and suffering. These should be introduced with sensitivity in order to supplement what the affected persons tell the practitioner, not instead of what they are saying to the practitioner.

In an effort to restore the complexity that was damaged by the adversity, practitioners should also remember that adversity tends to freeze time. Therefore, it is important to assist the affected persons to reconnect with the totality of their lives, their past, their present and their future. Again, this should not be done as an abstract exercise, but practitioners should ensure that the overall way of engaging with their clients is based on all three categories that the Grid provides. This means that when any strength is identified, concrete ways to actualize that particular strength have to be found.

(d) The last framework (perspective) is the distinction between developing a “victim identity” and appreciating that one is a victim of actual events and circumstances.

In colloquial and even professional language, when saying that a person is a victim of displacement, a disaster, violence, or any adversity, that means that the person has suffered various

forms of damage and loss as a result of these external events and circumstances. These damages and losses can be visible and identifiable (such as the loss of family members or material goods, or of employment and social positions), or can be of a different, more intangible nature (such as disorientation, anxiety, loss of confidence). The problem is that when one says that a person was a victim of any adversity, the inevitable understanding that emerges is, by extension, that the person, in effect, is now a “victim”.

This linguistic and conceptual slippage and inaccuracy has many negative implications because a person always remains a whole person, and the fact that he or she has been victimized by events or circumstances or by others would always be a secondary characteristic and should not replace one’s central sense of self.

However, once a person is characterized by others as well as by oneself as a victim, the tendency is that such a person is perceived as a “victim” in her or his totality, and all the other facets of one’s being become not only of secondary importance, but even of no importance at all. This erroneous shortcut is also the almost inevitable result of the organizational realities of how aid, in its various forms, is offered to the persons affected by displacement, emergency or return situations. As they have to be identified in terms of their needs, which are dictated by their losses, the trend is to overidentify the affected persons with being “victims” and, by doing so, inadvertently, to bestow onto them the “victim identity” and seal and encapsulate them in it.

Once a person assumes a “victim identity”, then one behaves as a victim and perceives everything around one and even oneself from the perspective of a victim. Similarly, others see the person as a victim and, thus the “victim identity” becomes a convenient mode of interactional exchange with others (individuals and organizations). In this way, the victim identity becomes further entrenched.

The negative effects of victim identity include the development of “learned helplessness”, with everything that this entails, such as losing self-confidence, blaming others, avoiding personal responsibility, perceiving oneself as incapable of many tasks and depending on others for most forms of support. In short, developing a victim identity is a most debilitating condition that we needs to be undermined in the best possible way.

The most tangible way to avoid relating to affected persons through the “victim identity” mode is to use the Adversity Grid as a conceptual framework, to remind that, in addition to all the real losses and damages that they experienced, the affected persons have also retained strengths from their previous ways of being, and developed new strengths because of their very exposure to adversity.

For all references please see bibliography.

Basic structure of a committee

Mariam Tankink

The basic structure of an effective committee comprises a chairperson and a secretary, and 8 to 20 other members who carry out tasks such as:

- attending meetings.
- giving feedback on assessments.
- supporting planning and coordination.
- supporting the implementation of project activities, including monitoring.
- implementing advocacy and lobby activities in the communities.
- and others, depending on the terms of reference of the group.

The specific responsibilities within the group are as follows:

- Chairperson: S/he is the named leader of the group and provides motivation for its members, chairs the meetings of the committee, and is responsible to the community and its stakeholders for supporting the interventions in the interest of the community. The chairperson is elected by the group members.
- Secretary: S/he is the person who keeps records, takes notes during meetings and handles all correspondence.

Once the committee has been established, it can support IOM with assessing and designing a plan that will be used as the basis for operational plans for activity implementation.

A member selected at the start might not still be a good representative some years later. Over time, the role of a group will change in response to the changing needs of the community. Members may become disinterested, may be interested in changing their role in the committee or other community members, or may become interested in joining the committee. For this reason, the system and/or timing for reviewing the function of the committee, and the roles of committee members and membership, should be determined in a transparent way that includes representatives of the general population when the group is formed, and included in the group's terms of reference. Newly created positions of power can be taken advantage of, if a system of accountability was not put in place when the group is formed. Regular, fair and transparent elections should be encouraged.

For all references please see bibliography.

Elements that support the benefits of engaging committees

Mariam Tankink

Engaging the communities is particularly effective to:

- Validate the results of the assessment.
- Identify local resources and services that did not stem from the assessment.
- Discuss local values in relation to the issues raised by the assessment.
- Prioritize needs emerged from the assessment.
- Explore ways of coping and response that communities have used in their history.
- Support in developing a plan, taking into consideration the following issues:
 - Training and supervision as important component of planning;
 - Including marginalized groups, discussing how to empower these groups and how to prevent or reduce stigmatization or discrimination;
 - Providing support to national structures to integrate into existing systems the needs rather than establishing separate services, and discussing the actual likelihood that the target group can access those services and what will be needed for this to happen;
 - Providing understanding of emotional consequences of disruptive events and forced migration.
- Assist communities in resolving conflicts and decreasing tensions: For instance, by getting agreement of the community members that a committee member or someone trustworthy helps to resolve the problems if they arise.
- Use a strength-based approach: All resources available in the communities should be clearly spelled out and incorporated in the action plans.
- Support community initiatives: Locate them and discuss if they need training or materials, but be cautious about making them dependent.
- Make sure everyone's voice is heard; people with power might dominate discussions but are not always the best people to decide on a specific topic, or that raised issues are charged by the community.
- Respect gender equality based on cultural sensitivities:
- Be mindful of diversity and inclusiveness: Have a clear reason not only why specific groups are target groups, but also why other groups are not, and explain this with the respective groups.
- Pay special attention to young children and their caregivers: Check how to prevent separation and/or reunite caregivers and children, and facilitate alternative care arrangements if needed.

For all references please see bibliography.

Religious and spiritual leaders and MHPSS

Kathi Angi and Theresa Jones

1 Religious and spiritual leaders. Who's who

Religious and spiritual leaders (RSL) are people who are recognized either by a formally recognized religious organization as their leader or are recognized by community members as someone with religious or spiritual wisdom. This definition includes persons who are ordained, blessed, educated or employed as leaders of a group of people. It also includes persons who may not have official recognition but are leaders within their community, such as priests, monks, imams and holy people, many of whom are men, but also women leaders of groups, religious teachers, youth leaders who are either male or female, and local spiritual guides.

RSLs are found in virtually every community worldwide. Though there is often a dominant religion in a culture or locality, typically there are a number of other belief systems. It is also common to have a wide variation among the believers of one religion in the ways that the religion is practiced.

2 Benefits of engaging with religious and spiritual leaders, groups and communities

The benefits of working with RSLs are numerous, though they come with challenges, as with any other group of people who have their own agenda. They include

(a) Connection to the community:

- Religious leaders are deeply embedded and are greatly respected in their respective communities. “Congregations and their leaders have deep community roots and serve as regular gathering places for congregants (and) local faith leaders are often trusted community figures.” (UNICEF, 2012:9).
- The sheer size of the networks of faith-based communities make them ideal partners for communicating with and engaging the local population. They have the ability to influence the population to support those in need through volunteer action, financial support and the use of buildings and facilities. RSLs have worked in a number of well-documented instances to influence and change harmful practices. (Le Roux and Bartelink, 2017).
- Religious communities pre-exist the disasters. They are already deeply integrated into the social fabric, the infrastructure, the culture and the politics of the area. They know the people, the neighbourhoods, the problems and the roadblocks to solutions, and the local power structures of politics and economics. They can be a helpful source of information about how the community works and how to get things done.
- Faith communities are often effective intermediaries between the community and the national and international humanitarian response network in the case of a large emergency. Affected communities may be cautious of outsiders and their motivations, beliefs and politics. Having a trusted leader as the intermediary helps to build trust.

(b) Spiritual life or religion is part of well-being:

- Well-being is multifaceted and spiritual life or religion is commonly recognized as one facet of it. This also highlights the intersecting domains of social life, spiritual life, cultural life and emotional life, which are fulfilled with participation in a community of persons sharing common beliefs.
- Displacement tears the social fabric, disconnecting people from the network that cushions their daily functioning. Local faith communities are often part of the social fabric, providing “pastoral care” and social connection with like-minded others. When seeking a safe harbour, displaced people may seek out the faith community. Recognition of the need for items with which to practice one’s religion is reported regularly as a basic need.

(c) Faith-based communities can provide community-based care:

- Religious communities and RSLs can be strong partners in giving care and support at the community level.
- Death, loss and bereavement are experiences in which religious communities have great strength to offer. Religion and religious leaders have for centuries accompanied individuals and families on the journey through loss and grief. Each religious tradition has its understanding of death and loss, and each in its own cultural context has rites and rituals for accompanying the surviving people as they come to grips with these realities.

3 Challenges of engaging with faith leaders

The challenges of engaging with faith leaders are similar to those that one encounters working with any community leader who has strong views and power within the community. One must get to know them, understand their perspective and determine whether there is sufficient common ground and desire to work together. There are some common areas of challenge in working with religious and spiritual leaders:

(a) Faith literacy and humanitarian response:

A frequent challenge for humanitarian workers is to know the language and practices of local religious persons, and for local religious leaders to understand the guiding principles and systems of the humanitarian world. RSLs and religious institutions are not humanitarians and do not primarily function as humanitarian actors. Their values are different but often overlap those of the humanitarian world. Likewise, they have different sources of funding. Religious leaders and spiritual leaders are experts in their own disciplines of working in theology, rites and rituals, with knowledge of their spiritual traditions and of the people of their congregation. They often are deeply embedded in the community, knowing families for multiple generations, the history of local areas, the power dynamics, the culture and the economic realities.

The local practice of a particular religion will often have its own unique expression and practice that must be learned. Local people may have specific practices that bring

comfort and solace in times of trouble. The relationship between the local, regional and national representatives of a tradition may be strong or may not exist. This information can be learned through meeting with different religious leaders at different levels of responsibility.

(b) Organization:

Moving from local response “to scale” is often a challenge. On the whole, individual RSLs or local groups become involved in humanitarian work because their religious beliefs lead them to respond to the needs of others with compassion. As such, their humanitarian work often begins spontaneously with someone arriving at their door in need. That need is addressed, to the extent possible, either by resources immediately at hand or by contacting others within the faith network for additional supplies, funds, volunteers, shelter or food. The humanitarian response grows from there, locally, organically, unplanned. Rarely does the initial response start with an assessment or by linking with the wider humanitarian community. Often, local religious leaders and their followers do not even coordinate with other local religious organizations. Though there may be support and resources coming from the network of the religious organizations, establishing the systems to efficiently run a humanitarian response is difficult.

Faith-based/inspired organizations may have more capacity organizationally depending on their terms of reference. Those that are development organizations often have many of the organizational structures in place, such as finance departments, operating standards and the ability to screen for those most at risk. A discussion about the Sphere standards and the ICRC Code of Conduct will reveal if these standards are used in this organization. There is potential opportunity to develop partnerships and for them to expand capacity, as they already have existing networks in the community.

(c) Knowledge and skills:

It is unusual for religious leaders to have training in humanitarian response, international standards such as the ICRC Code of Conduct or IASC MHPSS guidelines or SPHERE standards. It is therefore not surprising that at times there are misunderstandings arising between religious leaders and their communities, and the humanitarian professionals whose work is ordered much differently.

Religious and spiritual leaders commonly have long-standing relationships with people within their community and culture. Many, though not all, have experience in providing support, guidance and comfort to people in need. Due to the wide range of religious and spiritual leaders, they also have a wide range of training or lack of training. It is possible to find RSLs who are illiterate, teaching and preaching from memorized scriptures and lived spiritual experience. Others have multiple academic degrees, including in mental health.

(d) Values are different from secular organizations:

Religious and spiritual leaders, like other influential community leaders, have their own values that guide their actions and opinions. These values may originate in holy writings or long-held traditions. Humanitarian workers have values that guide the work and interactions with people in need. Our respective values are not always exactly the same, but they may not be in conflict, either.

In other situations, religious and spiritual leaders and faith-based/inspired organizations may fall short in providing assistance without proselytizing. From the perspective of the religious leader, saving souls is life-saving, and a humanitarian response to people in need. However, from the perspective of IOM, this is violating a person's right to access basic services based on need alone. It is entirely possible to come to an agreement that for collaboration purposes, both may agree on a common approach – perhaps distribution of aid based on need without proselytizing but that affected populations would be welcome should *they* initiate a conversation about the faith of the donor, which could be held away from the location of distribution.

It is also important to discuss these issues of values, as staff are hired or people are referred for counselling or mental health care and psychosocial support. Different value systems may include or exclude different approaches to conversations about different issues. Examples might include roles of women, issues around death and dying, GBV, and acceptance of LGBTQI persons. Many positive examples exist of RSLs and humanitarian organizations coming together to care for the community.

4 Facilitating dialogue to explore solutions to specific challenges

Religious groups are often most open to such dialogues when initiated by someone of the same religious tradition. In Lebanon, Islamic Relief and World Vision together are working with Islamic and Christian leaders on issues of child protection and early marriage.

Dialogue can be quite successful when “experts” of different disciplines bring their information to the whole group. An example is of religious scholars and public health experts working together to talk about early marriage and pregnancy on the health of young women. For more information see Channels of Hope (<https://www.wvi.org/health/publication/channels-hope>).

5 Religious and spiritual practices of healing

In many societies, informal and traditional, as well as tradition–modern hybrid systems, are the main form of mental health care provision outside of the family. Even when biomedical services are available, people may still prefer to use these, as they can be cheaper, more accessible (inside their community), and also potentially effective. They often fit with the models of causation communities have and so are socially and culturally most acceptable. Practitioners for mental health care in a community can include religious leaders using prayer or ritual, specialized spiritual healers using similar methods, or healing by specialized healers operating within the local cultural framework. This might involve the use of herbs, other substances, massage, rituals and/or magic. Importantly, there can be blending between paradigms and practices: for example, some local pharmacies may also stock herbal medicines (IASC, 2007).

People with severe mental disorders and their families are especially likely to refer to these healing systems. Some can be more vulnerable to negative treatments: for example, involving beating, prolonged fasting, cutting and physical restraint. Before supporting or collaborating with such services, it is essential to determine what those practices involve and whether they are potentially beneficial, harmful or neutral (ibid.).

Collaborating with these systems is important as it can help increase understanding of how mental health and disorder are experienced and expressed, provide opportunities for collaboration to increase the effectiveness of care, and help with identification and monitoring of human rights abuses and care standards at the community level (see section 14.4.2.2). See the IASC MHPSS Guidelines (IASC, 2007) Action Sheet 6.4 for more details.

The mhGAP–HIG notes, “Consider discussing the messages with local indigenous and traditional healing practitioners who may be providing care for people with MNS conditions and who may be willing to collaborate and refer certain cases” (WHO and UNHCR, 2015). See the IASC MHPSS Guidelines (IASC, 2007) Action Sheet 6.4 for more details.

To conclude IOM MHPSS managers in the field will include these resources in mapping, and partner with these resources, involving them in ongoing trainings, and in the work of the teams, for two-ways referral, or as community anchors whenever suitable. The IASC (2018) suggests that formal MHPSS interventions should also establish mechanisms for referral back to local religious actors for the provision of psychosocial support and spiritual care. It suggests that local faith leaders can also be oriented to key psychosocial principles and PFA.

For all references please see bibliography.

Community as a system

Renos Papadopoulos

Systemic thinking enables to become aware of the whole as well as of its constituent parts, of how these parts are interconnected among themselves and with the encompassing whole, and of how that same whole relates to other wholes, while it is also an element of even bigger wholes. In this way, systemic thinking provides a framework, a perspective and a sharper way of seeing the entire network of interrelationships that include both the hierarchical (vertical) as well as same-layer (horizontal) interrelationships of any forms of human systems.

The family is considered the most fundamental form of human system, a unit that is composed of a number of interrelated parts, where the whole is more than the sum total of its constituent elements. Each nuclear family has its own subsystems (such as parents and siblings), and is also part of an extended family. Community is a composite of clusters of nuclear families, extended families and individuals, but also of other forms of human systems, such as institutions, associations, organizations, clubs, parishes, societies, companies and such, that share some of the crucial and defining commonalities with that particular community. As such, both hierarchical and non-hierarchical interrelationships characterize each community. What makes community a unique form of human systems is the diversity of its composite elements, which are not limited to actual human beings, but also include (as discussed above) history, cultures, belief systems, epistemologies, ideologies, spiritual and religious convictions, sociopolitical interests and perspectives, patterns of rituals, historical artefacts and monuments, societal discourses and narratives, to name a few.

One of the most important systemic principles is that meaning is related to context. As Bateson (1979:15) expressed it, “Without context, words and actions have no meaning at all. This is true not only of human communication in words but also of all communication whatsoever, of all mental process, of all mind, including that which tells the sea anemone how to grow and the amoeba what he should do next.” It is obvious that words change meaning depending on their context, but the same applies for actions and behaviours, too. The same animal species tend to develop and behave differently, depending on their surrounding context, which is referred to as ecology. People’s actions and behaviours are also dependent on their own ecologies, not only in terms of their geographical habitat, vegetation and climate, but also in terms of collective narratives, beliefs and identities. For example, an elderly African Muslim woman’s reluctance to speak to a young European man about her dislocation plight may not be the result of defiance but of a sense of inappropriateness. However, the same behaviour in a different a context may, indeed, convey an intended mark of defiance.

Every community project, like any other expression of a human system, does not exist in a vacuum and is not the product of just its own intended and explicit aims and objectives. Instead, it is embedded in its own unique context and epistemology, of which some aspects can be visible and explicit, whereas others are less noticeable. This context includes the wider belief systems that are specific to the group of those who created the project. This means that any intervention in a community encompasses two different but interrelated ecologies of meaning – those of the affected

populations and those of the organizations that provide the support. These ecologies are composed of wider discourses and clusters/networks of meaning. For example, one of these less visible wider discourses may include the humanitarian programme's (explicit or implicit) stance in relation to human suffering: is human suffering something that needs to be eradicated at all costs or is it the duty of the humanitarian assistance to facilitate the community's own connection with its appropriate meaning, within its own cultural context?

Another basic systemic principle refers to the presence of at least two competing discourses that govern most functions of any system: a "dominant" (or "hegemonic") discourse (also called "master narrative"), which is responsible for forming the main position of the system; and at least one alternative, "subjugated" discourse (or "marginalized narrative") that is different if not contrary to the dominant one. The key dimension that distinguishes these two types of discourses is power. Power is visible not only in the raw suppression of the human rights of others; it is also present and operative in many aspects of subtle forms of behaviour in families and communities, and in the very formation of how reality is conceptualized. For example, in a family, the "problem behaviour" of a child may be the dominant discourse, whereas what is "subjugated" may be the stance held by the mother and children that the father's abusive behaviour is more problematic than anything else in the family, and the cause of the child's unsettling behaviour. At a wider societal level, we have well accepted dominant discourses that are held unquestionably, such as that belonging is healthy and desirable, and non-belonging is harmful, leading to pathological symptoms. Yet there is an equally well-articulated opposite discourse, which is subjugated, according to which moving to the margins, extricating oneself outside one's community can be very refreshing, enabling one to distance oneself from and question the widely accepted truths, so that it enables the development of one's own unique stance. Many creative writers and artists had to do just that in order to move onto more individuated positions.

Any community interventions need to be acutely aware of these two different types of discourses. This awareness leads to the proper understanding of the various subtle forms through which power is exercised in communities among its various subgroups, but also, in particular, of the power dynamics between community members and their humanitarian helpers. Even the definition and delineation of a certain community should be questioned and the various assumptions behind any classification should be examined carefully. For example, if one were to assist a Bosnian in the United Kingdom to connect with his community, which would this community be – fellow Muslims from Asia or Africa, or people from other Balkan countries regardless of their religion? Also, when people are on the move, which is their community? That of their country of origin, of the country where they are in transit now, or of the country of their intended final destination?

A closely related notion to community is home. Although any detailed discussion of home is beyond the scope of this Manual (see Papadopoulos, 2002, 2008, 2018), what is of relevance here, and related to what was already discussed above, is that one does not have one static home but different and multiple homes, each defined by the particular context in which one is situated at the time. Moreover, one also have different gradations of her-his sense of home, of "homeness". Accordingly, homeness can be defined as the degree of the strength of the feeling at home, of experiencing a place as home, in terms of stronger or weaker, more powerful or less powerful, in

terms of its centrality in our lives or not. This means that home is not just a location but also the result of the dimension of homeness, of the quality and gradation of the sense of being at home.

More specifically, in working with dislocated persons, it can be very useful if, under appropriate circumstances, they are assisted to understand the complexity of the dimension of homeness, not in an abstract and didactic way, but in addressing directly their plight. Such assistance can rescue them from the tyrannical imposition of a dominant discourse that fixes their identity and sense of belonging to one concrete and static home, which is defined exclusively by one dimension, such as geographical location or cultural affinity. The notion of homeness, if introduced sensitively and at the right time, can be very liberating for people who are weighed down by the burden of an essentialist understanding of one home, as if it were the only “objective” reality, and devoid of any systemic co-construction. The reality is that different places are experienced as different types of home and with a different degree of intensity.

Systemic thinking also helps to understand communities and dislocation in their diachronic transformation, away from fixed and static perceptions. Any form of involuntary dislocation involves a wide variety of responses, activating many different aspects of the individual’s being, as well as of the community’s characteristics, most of them changing during time. Not only do the very needs, aims and tasks of the affected populations alter along the way and over time (depending on their external circumstances, the reception they receive, the supporting systems that they access, and their own ability to adapt and develop), but their identity also changes. The changes in identity can be considerable: for example, fluctuating between victim and survivor, crushed by despair or driven by hope, friendly and communicative, or withdrawn and suspicious. It is understandable that when developing community projects, one needs to plan based on a relatively stable state of affairs; however, the inevitable changes at almost all levels should not be forgotten. It is essential to appreciate that, along the way, dislocated persons can become fairly disoriented precisely because of these fairly frequent and radical redefinitions of their aims and of themselves with regard to many facets not only of their functioning, but also of their very being, experiencing themselves differently.

All systems, including communities, need a degree of both *stability* and *change* in order to survive and thrive. Systems that are not constantly refreshed by innovation and change tend to become unreliable and defective. In systemic terms, they develop entropy; that is, they implode from within and disintegrate. This delicate balance is particularly pertinent and very crucial during times of transition, which is what happens to communities during emergencies, displacement and return situations. Keeping in mind both change and stability in working with communities during such critical periods is not easy and can be very challenging.

The balance between change and stability is closely related to another important systemic principle about open and closed systems. In short, an open system is a system that maintains communication, interaction and exchanging information with other systems and its own subsystems, whereas a closed system does not do that and, instead, remains isolated from its environment within its own boundaries of predictable outcomes. A closed system is characterized by deterministic and familiar interactions, retaining its own identity, which is based on the past. In this sense, a closed system is characterized by excessive stability without sufficient change. By contrast, open systems maintain

the channels of communication, the exchange of feedback loops with the outside, resulting in becoming sensitive and receptive to difference and newness. Communities in transitional and difficult times, seemingly paradoxically, fearing the unpredictable, tend to hold on to their closedness, thus endangering their own survival.

Appreciating the importance of all these systemic considerations about communities, one becomes aware that, in effect, any intervention in a community involves an entire network of interrelationships which can best be characterized as an Interactional Matrix of Intervention (Papadopoulos, 2007). In summary, this matrix includes not only the target population and the humanitarian workers who attend to them, but also the large number of related others and the wider society. Related others are the many persons, families and communities that are closely connected with the first two groups. Although it is fairly obvious that the affected population is embedded in the wider society and many more persons are affected by their plight, it is less obvious that the humanitarian workers' own related others are also affected directly and indirectly by what happens to them. Systemic thinking enables us to appreciate that any upheaval in the community through a ripple effect spreads and affects a much wider range of people than the narrow group of the affected persons. Moreover, the way people are affected is not only in predictable and exclusively negative ways, but also in many other forms. More specifically, it is instructive to note the impact that humanitarian workers have on the affected persons in terms of the human relationships, expectations and hopes and the identities that are formed. In a comparable way, one needs to examine the impact affected persons have on humanitarian workers. At the same time, from a systemic perspective, one needs to be mindful of how all these interrelationships and reciprocal impact interact with the wider discourses in society: for example, if the predominant political opinion where humanitarian workers come from considers the affected persons as victims or aggressors of political or inter-ethnic violence.

This brief examination of the complexities of the Interactional Matrix of Intervention helps to appreciate the value of investigating these community phenomena from a systemic perspective. It helps to identify the multiplicity of this impact in terms of formation of positions, attitudes, roles, conceptualizations and identities of all the implicated parties that are constructed and reciprocally co-constructed. Ultimately, this identification enables to alter the negative impact and strengthen the positive impact in order to make whatever community intervention is undertaken more effective.

The final consideration regarding community as a system refers to the complexities involved in assessing the community needs: who expresses and represents the “voice” of the community and what are the dynamics of accessing this “voice”?

Often, fairly simplistic perceptions that either one does or does not know the community needs, or that the community itself knows or does not know its own needs. Identifying the real needs of a community requires a much more complicated procedure that is based on the axiom that, at the beginning, neither the humanitarian actors nor the community itself is fully aware of the actual needs. This means what is required is an active and open engagement between everybody concerned in order to arrive at the actual needs. The first impression that everybody has of these needs is, often, an erroneous product of many factors that need to be explored, so that clarity is

reached about the real needs. The initial impression is based on a wide variety of factors that include the following:

- Personal/psychological, such as anger, frustration, various psychological defences (trauma), shame and guilt;
- Sociopolitical, such as a sense of injustice, of own social status, and a mistrust of authority, institutions and members of different social classes;
- Gender, such as what can and cannot be talked about and to whom, where and when;
- Cultural, such as what can and cannot be talked about and to whom, where and when;
- Timing, such as how long after the adversity occurred, at what phase of one's own processing (internal and communal) is the approach made for people to talk about their needs;
- Expectations and perceptions, such as what the affected populations think we expect to hear from them;
- Gains, such as using affected populations' state of being "victims" to maximize their benefits (in appropriate and inappropriate ways);
- Socioeconomic position, such as how economically disadvantaged they have become;
- Existing strengths, such as how well they feel they have been functioning.

It is for all these reasons that it is imperative to create the appropriate conditions to embark on a process of facilitative exchange and fruitful interaction in order to co-explore the realm of the community needs. This is a proper systemic approach to understanding the complexity of the identification and expression of the community needs in times of emergency and return situations.

For all references please see bibliography.

Terms of reference and desirable qualifications for IOM psychosocial mobile team – Core members

1 Team leader

Terms of reference:

- Coordinate a psychosocial mobile team (PMT) to ensure timely and effective execution of a programme's activities, equitable and appropriate allocation of tasks and responsibilities within the team, technical support and supervision of community focal points and volunteers, as well as transparent and accountable use of allocated financial resources.
- Ensure the needs of the programme's sites and assets are collected and reported to management.
- Organize the maintenance of dedicated assets, materials and spaces, keeping inventory, attendance sheets, logbooks and simple administrative records.
- Organize and chair teams' coordination meetings.
- Organize and chair case management or activity management meetings.
- Identify training needs and resources of the teams and volunteers, and report them to the manager and the technical supervisor.
- Maintain established coordination and partnership with other PMTs, civil society organizations, including local NGOs, faith-based organizations, women's and youth groups, and parents and teachers' associations, as they relate to the work of the team.

Desirable qualifications:

- Degree in general, clinical, counselling, social or educational psychology, counselling, anthropology, humanities or social sciences.
- Previous experience in MHPSS work, community work and in managing small teams.
- Experience in communicating and working with a wide range of people, including people of culturally diverse backgrounds.

2 Counsellor

Terms of reference:

- Provide individual and group counselling to the affected population in need.
- Coordinate with the team leader and other members of the team the integration of mental health and psychosocial support considerations in community-based activities along the full spectrum of the intervention pyramid.
- In collaboration with the educator, design psychoeducation sessions for the communities, based on identified and emerging needs.
- In collaboration with the artist, supervise artistic mediation activities for vulnerable cases.
- Provide training sessions in PFA and basic counselling skills to humanitarian actors, community focal points and volunteers, and other team members.
- Identify and refer people with severe mental disorders, in coordination with the referral team, if existing.
- Coordinate with the referral team and other team members the inclusion of people with mental disorders in other activities promoted by the teams.

- Develop awareness messages/campaigns related to mental health and psychosocial support to be disseminated to communities. Coordinate with other members of the teams the most efficacious ways to convey those messages.
- Organize support and discussion groups and forums.
- Facilitate MHPSS needs assessments, surveys and research in the concerned communities of the project to enhance access to community-based psychosocial services and specialized mental health care for refugees, IDPs, migrants and returnees.
- Map existing support provisions at the microlevel and design, together with the supervisor, initiatives to reinforce their capacity.
- Report daily activities.

Desirable qualifications:

- Degree in clinical, counselling or educational psychology, counselling social work, pastoral counselling, or related subject.
- Previous experience in counselling and protection activities in related areas of intervention is an advantage.
- Experience in communicating and working with a wide range of people, including people of culturally diverse backgrounds.

3 Social worker

Terms of reference:

- Keep on mapping the provision of basic services and protection activities at the microlevel, and disseminate information on how to reach those services–resources.
- Provide direct assistance to the most vulnerable individuals and families of the affected populations, such as women, children, elders, persons with disabilities, survivors of violence, and economically destitute and socially marginalized persons.
- Organize, together with the educator, sensitization, information and problem-solving group sessions on identified social problems encountered by the community.
- Strengthen existing social networks and promote participatory initiatives aimed at activating protective, restorative and transformative psychosocial factors at the community level, such as mutual support, intrafamily and interfamily cooperation, public gatherings and dialogue.
- Map socially supportive structures and resources at the microlevel, mobilize them and envisage, together with the team leader, and the manager and the supervisor, ways to build their capacity further.
- Identify vulnerable cases, ensuring their access to available protection services.
- Coordinate with the team leader and other members of the team the inclusion of vulnerable cases in community-based activities along the full spectrum of the intervention pyramid.
- In coordination with the team leader, provide technical guidance and supervision to community focal points and volunteers in the concerned communities, ensuring that the programme’s activities are effectively communicated and carried on in participatory and inclusive ways.
- Facilitate MHPSS needs assessments, surveys and research in the concerned communities of the project to enhance access to community-based psychosocial and protection services.

- Organize and coordinate activities of integration of MHPSS and livelihood support, either directly or mainstreaming MHPSS considerations in existing livelihood programming.

Desirable qualifications:

- Bachelor’s degree in social sciences or social work.
- Previous experience in social and protection activities in related areas of intervention is an advantage.
- Experience in communicating and working with a wide range of people, including people of culturally diverse backgrounds.

4 Educator

Terms of reference:

- Organize non-formal education activities for communities. This can include, but is not limited to, extracurricular activities and school help for children, informal literacy and numeracy, or language courses for children, youths, adults and the elderly in general, or those with specific needs.
- Map, at the microlevel, existing educational and vocational opportunities or educational resources, mobilize them and support them in reaching populations of concern.
- Identify both informal educational needs among target groups and educational resources within the community, and promote educational activities accordingly.
- Support other team members in the design and delivery of inductions, sensitization and psychoeducation sessions.
- Coordinate with the team leader and other members of the team the inclusion of children and youths with slow learning or learning disabilities, and illiterate or low-literate adults in community-based activities along the full spectrum of the intervention pyramid.
- In coordination with the team leader, provide technical guidance and supervision to community focal points and volunteers in the concerned communities, ensuring that the programme’s activities are aimed to enhance educational opportunities, skills-based capabilities, learning attitudes and inclusive teaching abilities, and playing and recreational practices.
- In coordination with other team members, develop awareness message/campaign activities related to MHPSS.
- Facilitate MHPSS needs assessments, surveys and research in the concerned communities of the project to enhance access to community-based psychosocial, educational and vocational services for refugees, IDPs, migrants and returnees.

Desirable qualifications:

- Bachelor’s degree in educational sciences or humanities.
- Previous experience in educational and protection activities in related areas of intervention is an advantage.
- Experience in communicating and working with a wide range of people, including people of culturally diverse backgrounds.

5 Artist–animator

Terms of reference:

- Ensure creative, cultural and spiritual activities are organized for the communities and specific groups within the community.
- Map creative resources and existing creative processes within the community, mobilize them, give them visibility, train them in MHPSS mainstreaming, and help them open their activities to be inclusive of populations in need.
- Strengthen existing cultural, religious and creative practices, such as civic commemorations, religious rites, sports, theatre and arts events, and processes.
- Help displaced communities revive their own cultural rituals, traditions and activities, which may be on hold due to the displacement.
- Promote cultural initiatives, such as social theatre performances, visual arts and music courses, handcraft workshops, storytelling and poetry contests, sports tournaments and explorations, based on identified needs and resources within the community.
- Design a plan for structured creative activities to be offered to various segments of the community, in collaboration with the psychologist and the educator.
- In coordination with the team leader, provide technical guidance and supervision to community focal points and volunteers in the concerned communities, ensuring that the programme’s activities are aimed at enhancing creativity, communication, sports, and cultural and religious practices.
- Develop awareness messages/campaigns related to MHPSS (community-based approaches, sports and cultural practices, creativity and psychosocial well-being), to be disseminated to the affected population and host communities.
- Facilitate MHPSS needs assessments, surveys and research in the concerned communities of the project to enhance access to community-based psychosocial, sports, cultural and recreational services for refugees, IDPs, migrants and returnees.

Desirable qualifications:

- Bachelor’s degree in arts and media.
- Postgraduate studies in arts, media and/or psychosocial support in emergency settings is an advantage.
- Previous experience in community mobilization in related areas of intervention is an advantage.
- Experience in communicating and working with a wide range of people, including people of culturally diverse backgrounds.

6 Community focal point

Terms of reference:

- Support PMTs in daily communication with affected populations, ensuring two-way communication and facilitating activities as a peer.
- Support the PMTs in ensuring accountability, receiving continuous feedback from affected populations through established channels, and sharing information regularly with people of concern. Also, ensure an adequate perception of the organization and services providers.

- Bound to a specific camp sector or neighbourhood, support PMTs in maintaining effective communication with community committees and community representatives, promoting formal and informal meetings.
- Support PMTs in carrying out needs assessments, research and surveys, and mapping and monitoring exercises, aimed at identifying individuals, families and subgroups in the affected community most in need of mental health care, and psychosocial and protection support.
- Support PMTs in the overall execution of the programme's activities, and management of its sites and assets, awareness campaigns and social gatherings.

7 Community mobilizer

Terms of reference:

- Support PMTs in understanding the political, socioeconomic and cultural backgrounds of the affected population, identifying local resources and available services, underlying tensions and potential (or actual) conflicts due to the crisis, displacement and/or emergency response.
- Understand the community very well and assist mobile teams in the mobilization of its various sectors, helping to identify and appreciate interventions, and facilitate second-level MHPSS activities.
- Support PMTs in establishing an effective two-way communication and coordination system between the MHPSS programme and local stakeholders, affected populations and concerned groups, promoting formal and informal meetings with traditional and religious leaders, camp and families' representatives, women and youth leaders, teachers and cultural activists, artists and media professionals.
- Support PMTs in liaising with intended affected populations, sharing information about the aims, methodologies and activities of community-based MHPSS, promoting consultations and inclusion of vulnerable individuals and families in the programme's activities, as well as participatory decision-making processes.

8 Conflict mediator

Terms of reference:

- Work with the MHPSS team to identify community resource persons with basic knowledge and experience in conflict mediation, broadly defined.
- Develop a mapping of community stakeholders, their needs, MHPSS resources, local service providers and programme partners.
- Assist in the mediation of interpersonal and community-based conflicts in support of MHPSS activities.
- Work with community leaders to make use of alternative conflict resolution mechanisms effectively.
- Contribute to the safety of MHPSS programme participants.
- Convene and facilitate community meetings to support MHPSS activities.
- Coordinate with the team to identify MHPSS cases that need attention.

- Work with the team to develop culturally appropriate and conflict-sensitive MHPSS activities.
- Produce oral and written reports on community-based activities and meetings as required.

Far Away, So Close. Psychosocial and Theatre Activities with Serbian Refugees

This is the original manuscript for the article 'Far Away, So close'. Psychosocial and Theatre Activities with Serbian Refugees. It was written by Guglielmo Schininà; published in the Drama Review, 48:3, (T183), Fall 2004, pp.32-49. The use in the manual has been kindly authorized by the publisher due to the humanitarian scope of the publication.

The published article can be found at:

<https://www.mitpressjournals.org/doi/10.1162/1054204041667686>

The Theatre [...] is the craft and art of transforming what one looks at into something that regards us. Its raw material is relationships. [...] I have never believed in a theatre that claims to transform a number of individuals into a communion. Collective identity may perhaps have had positive aspects in social communities characterized by small numbers. But mass civilization has produced such monstrous surrogates of this fabled unity that we have no nostalgia for them. The image of theatre that guides me is not that of an action that unifies, but that of a circle of encounters and barter. Various people gather around an action that binds them and allows them to debate, to discover a territory, a time, in which to exchange something. It is the very fact that each one can deepen his knowledge of his own specificity that creates the solidarity between them. [...] The fact that today cohabitation with the different is often felt like a dramatic historical situation must not make us forget that it is the matter on which the theatre has always worked, on which those who make theatre their profession must know how to work [...].

Eugenio Barba (2001:n.p.)

Introduction

Since April 1999, I have been living in the Balkans where I have worked as a workshop facilitator, trainer, and supervisor with psycho social and cultural integration projects. These efforts are a part of the emergency relief services that focus on the persistent problems caused by the recent wars. All of the projects have included theatrical components and some were centered on the communication and relationship-building logic of a "theatre game."

It is impossible to summarize a professional and human experience that is now over four years old and includes various us projects within which I played a number of different roles. Therefore, I have decided to concentrate only on my experience in Serbia in 1999. This choice has been made primarily for two reasons. The first is technical: my experience in Serbia led to the emergence of some convictions that have become fundamental to my overall approach. The

second can be defined as political: in the Kosovo crisis, the international intervention (first and foremost the military and journalistic one) was centered on the victim/perpetrator/savior structure (Losi 2002). Within this framework, the victims were the Albanians, the perpetrators were the Serbian population as a whole, and the saviors were the NATO Forces and international humanitarian workers. Writing about the experiences of some of the people considered to be the "perpetrators" enables us to understand the groundlessness of this simplistic schema/ classification and, perhaps, to understand the groundlessness of any "humanitarian" or "anti-terrorist" military attack.

Serbia, August- December 1999

I arrived in southern Serbia on 4 August 1999, two months after the end of the war in Kosovo. Places and people showed clear signs of the NATO bombings; at that time, one would still run into groups of Serbs escaping from Kosovo following the end of the "humanitarian war." In unfinished buildings, and in the mud under bridges there were groups of Roma who were also fleeing from Kosovo but were by no means welcome in Serbia. In total, during this period, there were some 80,000 people living in these conditions. When I entered Serbia, hundreds of refugees from Bosnia and Croatia were arriving daily. Previously, they were sheltered in collective centers in Kosovo but after the war there, they had to flee to Serbia as "double refugees"-refugees for the second time.

My task was to create a psychosocial project consisting of creative activities for children, adolescents, and elderly refugees living in the collective centers in southern Serbia.

When I arrived in 1999, a total of 400,000 refugees from Bosnia and Croatia who fled from their own countries following the previous wars in the Balkans lived in Serbia, where roughly the same number remain today. The most unfortunate among them, around 40,000 people, had spent the last six to ten years of their lives in hundreds of collective centers scattered around the country, living sometimes with up to 30 people per large room. They were accommodated in what were once hotels, motels, schools, or former construction yards located many kilometers from the nearest small villages, without any public transportation. There was only one bus per day to take the children to and from school-but often the children did not go at all. They survived thanks to the assistance given by the national Red Cross, but even that became unavailable as each war and economic crisis meant that feeding the army became the top priority. Only a few were able to work and earn the average wage for local underpaid jobs (about 40 Euros-U.S.\$40 at that time-per month for 10 hours of work a day, six days per week).

Alcoholism and depression were rampant among adults and adolescents who did not see any prospect for the future.

Unfortunately, from a bureaucratic point of view, the Serbians that had just come from Kosovo, except for the "double refugees," could not be defined as refugees and instead were classified as IDPs (Internally Displaced People), because Kosovo was formally still part of the Yugoslavian federation. For this reason, they could not officially be included in the project. These are the kinds of political contradictions and constraints one often faces when working in emergency relief services. Therefore, our project had to focus on the actual and double refugees, trying to involve the IDPs as much as possible without being too obvious about it, because this would have caused political problems with the local government.

The deep poverty of southern Serbia was intensified by the embargo and became intolerable during the war. In contrast to what was happening at the same time in Kosovo, due to the international perception of the Serbians as the "perpetrators," there were very few international humanitarian agencies and NGOs in Serbia. My car was the first one in many months to visit the collective centers in the southern part of the country.

Immediately upon our arrival, the staff and I were barraged with questions, requests, and demands regarding the problems that had been brewing for a long time and for which we had no answers. Worse still, the IDPs from Kosovo, who we encountered during our trips, had basic, urgent needs to be satisfied before turning to the psychosocial ones. In a context in which the beneficiaries had primary needs that no person or agency was able to satisfy, it was very difficult to concentrate solely on a creative program. Additionally, I felt the pressure of limited time: given the political situation it was likely that I would have to abandon the country and the project in a short while.

Theoretical Background

This type of project is tightly bound to practical and urgent action and leaves little time for theoretical elaboration. In this case, I was guided by my previous experience, four main ideas, and by a simple ritual model. I would be lying if I said that all the theoretical implications were clear to me before designing the project. It was, as it always is in these cases, a trial-and-error experience. What theory exists has been derived from my experiences.

Sustainability and community-needs sensitivity vs. pre-packaged models

I do not believe in international "saviors" who take action according to a predetermined model, think they can "save" a group with a one- or two- month workshop, and then disappear or maintain only feeble contact. Unfortunately, this harmful approach is very common in emergency relief services. But to improve what is no longer a short-term crisis but rather an endemic emergency, efforts must be made to ensure that the community takes its destiny into its own hands according to its own models. Therefore, it should not be "fed" coping tools or, even worse, helped to cope with a situation that is unacceptable. Instead, one first asks the community what its priorities are in order to understand its resources. Then one must adapt one's competencies to meet those needs. Simultaneously, one tries to ensure that the expectations, which will emerge as a consequence, can in fact be met, at least to some extent.

Therefore, I do not impose theatre. My experience and my know-how are in the area of using theatre in the process of community-building, but I always try to respect peoples' existing abilities and goals. In this case, the communities living in the collective centers were more interested in sport and handicraft activities than in creative arts; and even then, only a few of the creative arts involved the theatre. I respected these choices and tried to take advantage of the existing resources. Theatrical activities remained only an informing logic, a communicative reference model, and my way of passing that model on in the training.

Individual vs. group in the construction of roles in war-torn communities

While visiting the centers, I realized that regardless of their very strong common history, the inhabitants' sense of community was destroyed to such an extent that the refugees were unable to collectively claim their rights. Community building needed to be one of the first aims of the project.

Psychosocial activity aimed at community building in difficult circumstances has to focus on three components: relationships, communication, and creativity. The objective is to reconstruct roles - on the individual, group, and community level. However, when we work on reconstructing a sense of community in conflict situations, we must always keep in mind certain implications, which I often encounter in my experiences in war-torn societies. An example illustrates the point. Working during and just after the war among groups of Kosovar Albanians interested in the creative arts, it was necessary to interact with an incredibly compact community/communion that never doubted its nationalistic values and seemed to reduce its existence only to such values. All the international trainers with whom I talked were frustrated with the workshops since they found themselves interacting with a collective body that responded collectively. This led to rhetorical and standardized results but also made dialogue between the trainer and the group and, above all, between members

of the group impossible. In my opinion, the emergence of this dynamic had two causes:

1. Political-The war in Kosovo was called "humanitarian" so it implied a relational triangle: victim/perpetrator/savior, and this had an effect on the relationships between individuals. Every person, when relating with someone else, had to follow a precise narrative, according to the group-identity to which s/he belonged. The workshops were run by international trainers (the "saviors") for Albanian groups (the "victims"). Within this triangular frame, it was impossible to raise multiple voices.

2. Technical-The trainers were used to working in Western countries where the creation of a group and an emphasis on rituals are the prerequisites of any workshop. Therefore, they did not understand that in these situations, deconstruction of the group's rhetoric, the empowerment of individual differences, and criticism of the rituals of war would be the only actions that could lay the foundations for long-term intercultural and interethnic processes. Happily, these actions are also effective in the very short term. However, in a war-torn situation, there is no free expression of multiple voices, and differences within the same ethnic group tend to be suppressed in a process of self-censorship. Thus, the group must be given the opportunity from the very beginning to experience its own limits. This is done in order to counteract the fact that anger or nationalistic feelings, reactive racism, justification of hate, and self-victimization often become the only prerequisites for belonging to the group in these circumstances.

In an endemic situation, like the one involving refugees in Serbia, even this "negative" sense of community no longer existed. In fact, building their sense of community from the wrong perspective might throw them back into a situation similar to the one just described. More likely in this case, the arrogance of the winning group would perhaps be replaced by the depression and anger of the group defeated and recognized internationally as perpetrators not victims. For these reasons, the process must be understood, as indicated by Barba, as a circle of encounters and barter and not as a search for communion. The first act of a workshop or a creative process was therefore to bring people back to an awareness of their individual value and own means of expression.

Creative communication/social communication vs. coping mechanism

In situations where social problems and discrimination have strong political implications, artistic activities and especially theatre are of special value because they create a relationship between creative communication in the group and social

communication in the more political sense. In this specific case even if we could have recreated a sense of community among those living in the centers, this would not have solved their problems. It would have only improved an unacceptable objective situation. Once a process of creative communication had been initiated, leading to the reformulation of individual and group roles, we had to help the people develop this into a larger social communication exercise connecting effectively with the society outside the centers.

The first objective was information. Most Serbs did not know of the existence of the collective centers. The Milosevic government had used the media to focus on the refugees in order to enhance nationalistic feelings and the acceptance of suffering inflicted upon the common enemy. However, the media had hidden the conditions these individuals lived in to avoid the dramatic evidence of political contradictions. Consequently, exhibitions, shows, concerts, photographic displays, ritual tales, and so forth produced in the centers and presented outside were designed to lead to the recognition of the existence of the centers and of an "other" Serbian history. This we hoped would also help to overcome some of the prejudices and stigma that had put additional weight on the refugees.

The second objective was political. Publicizing the creative identity of the refugees and displaying the conditions in which they lived were both in themselves acts of opposition to the regime and agitation for change.

Therefore, in this case, the creative arts were chosen not only as one of the privileged tools for the development of coping mechanisms (see Dokter 1998; Jennings 1999) but rather for their "performative" and "eventual" possibility: the possibility of initiating processes within the group that would establish them on the basis of individual difference with the ability also to communicate this to a wider social arena.

The Complex Circle Model

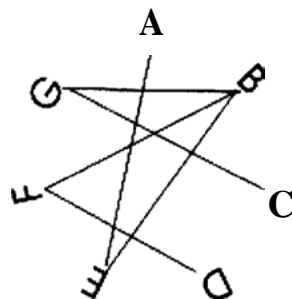
For the Serbian project, I used the ritual model of a complex circle (Schinina 2002). Its basic principle is to consider theatre as a means of communication, which, regardless of the activity undertaken, brings about a circle of barter and encounters and is also able to present these barter and encounters to a reality outside the circle. The ultimate goal is to begin to change perceptions of certain problems and to include multiple voices and narrations in a collective act of communication.

Technically, everything starts with a group of individuals, each of whom has his/her own characteristics. To form the circle, they construct relationships according to the inset model:

A						
A						
A	B					
A						
A	B	C				
A						
A	B	C	D			
	B	C	D	E		
	B	C	D	E	F	
A	B	C	D	E	F	G

The individual (A) is always himself/herself and free but his/her actions interact with the actions of others (B,C,D,E, ...); thus, they change and are changed by one another in a linear relationship. This continues until the line contains the entire group. At this point, a ritual circle is created, in which each person retains his/her individuality and his/her own characteristics but also develops personal relationships, and expresses feelings and questions that are shared with the entire group.

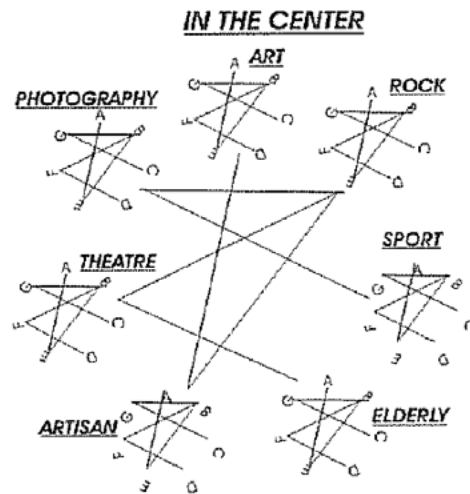
IN THE GROUP



The group becomes the place in which diversity is respected and personal or collective relationships are recognized by everyone in the group. The process develops with problems being pluralized and the resources of every individual member being shared. The same circular mechanism can also be established among groups and institutions.

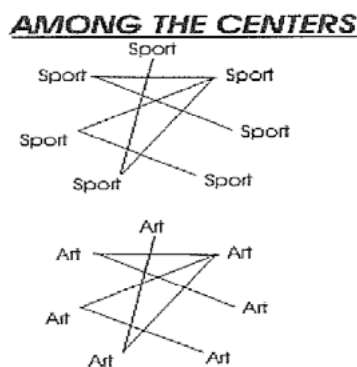
In the Serbian project, this model can be applied within each group of children, adolescents, and elderly people living in the centers. Each letter is an individual, while the lines represent some of the possible creative relationships. The circle is the symbolic structure of the group and the setting. The same

model applies to the other centers.



The various groups of activities build the circle; they develop their linear relationships through creative exchanges and the display of the creative results.

Additionally, the same process is valid for the entire community of refugees living in the various collective centers. The different groups involved in the same activities -for example sports or art- in the centers create a circle, with the lines representing their possible creative encounters (or sports clashes, as we will see).



The circle is a symbolic but also a practical space in which to create relationships and a sense of identity. This led to the idea of utilizing a large room in a social center in Nis (the largest city in the area) as the common room for events. This way, whenever one of the centers' groups wanted to present something, there would be enough space to invite all the other centers. But the circular relationship had to be expanded within the region of Nis. The Nis common room had to become a significant point in the dynamic between the associations, the formal and informal groups, and the region's political bodies.

Implementation

Assessment: selection of the centers and identification of which creative activities to run

In the first weeks, I repeatedly visited 20 centers, which were selected because they had the highest degree of vulnerability among the hundreds located in the area. In addition, without being too obvious about it, we included in the activities two spontaneous centers (the name given to those structures used for refuge by the IDPs from Kosovo) and three Roma communities.

Initially, I wanted the people living in the centers to identify their own needs and address them, but I had to be very precise about the limits of what I could offer through the existing guidelines of the project. I did not want to create false expectations and subsequent frustration. The only way I could accomplish this was by going and talking with people and developing close relationships, without which the entire process would have been impossible.

In all the centers, I gathered the adolescents, the women, and the elderly and started by trying to understand what activities the residents were organizing themselves. This included finding possible trainers within the community and trying to help young people to identify their creative interests. Bringing people together, due to long-standing tensions, was not always easy and took time. What I found most surprising was that very often the adolescents, when asked to identify which activities they would like to do, were not able to understand the concept of choice. My collaborators and I tried to find different words and metaphors, but in some cases we never succeeded. It took us a while to make the painful discovery that for people whose wishes had never been granted, the act of making choices and identifying desires was foreign. Some- times we had to make proposals ourselves. Other times we asked the most responsive adolescents and elderly people to identify the groups' interests and prepare lists of activities with the names of the people who had expressed those choices.

The Staff

In all of the centers, we tried to identify refugee intellectuals, artists, and artisans so that we could train them to work with children, thus giving them a social role while at the same time allowing them to recuperate interests that often had been neglected for years. In addition, we offered facilitator roles in the project assisting our experts to the adolescents who were helping compile the lists. Some, but not all of them, accepted.

It was also necessary to find outside expertise to facilitate the activities skillfully. As soon as I arrived in the country, I began to look for artists, actors, animators, intellectuals, musicians, teachers, instructors, psychologists of the arts (a discipline that once existed in the former Yugoslavia), and anyone else with previous experience in community work. We spread the word in bars, cultural centers, associations, scout groups, and so on. We put up notices in theatres, in newspapers, in front of cinemas, and at the university.

In order to start, I needed to identify what resources were available. I needed to know that the technical terms I had to use were understood. I needed to learn about the existing approaches to creativity and working with communities. Then, I needed to locate professionals who were among the best in their fields, with an attitude conducive to community and group work. Finally, I wanted people who belonged to different segments of society but were all creative and, above all, committed to social communication. In this way, they could facilitate the social communication process, even if this was not their specific task, disseminating the work they were going to do in their respective communities. The selected team consisted of photographers, playwrights (from alternative theatre, commercial theatre, and television), local rock stars, members of NGOs in visible opposition to the regime, a doctor, a movie animator, some scouts, and graduates of the Sports Academy. Although the group included refugees and IDPs, the majority was from the local population. This group became what we referred to as the "central team."

Training

I trained the central team, asking them to pass along the model that emerged from this process to the adult refugees living in the community centers who were willing to work with us. As soon as young facilitators in the centers were identified, each began training in a program specifically designed for them. I asked an experienced local NGO specializing in youth development to train the young facilitators.

The first time the central team came together, even before talking about their contracts, I decided to test them. I explained the terrible situation in which some Roma IDPs were living. I asked them to go, without me, to these Roma settlements. The objective was to carry out creative activities with the children that had as their objective the prevention of skin infections, which were caused by the insect bites that were ravaging their faces. A doctor provided the content and we prepared a program built around the story of a bird without water, which through songs, stories, drawings, and a workshop offered advice to the children as well as to the adults. We came up with the idea of leaving a birdcage in the camp, along with bird food and hygiene instructions. Our assumption

was that if the children could take care of the birds, they would take care of themselves. I knew the squalor the team was likely to find and its political implications. The Roma were kept in terrible conditions so that they would return to Kosovo rather than stay in Serbia - even if at that time it meant certain death. I knew that in this context such a program would not have significant results but I needed to evaluate the team's reactions. When they came back, they were shocked and offended by the conditions in the settlements but already they were thinking about how to improve the program. I realized that through this test of fire, we now had a team. Later, Roma activists themselves facilitated the activities in their settlements.

I will not dwell on the various aspects of what amounted to on-the-job training. This training was loose, taking place in variable settings and groups, including long conversations in the car and at dinner. However, I would like to emphasize a great richness that this form of training has in emergency situations. The lack of a specific structure and thus the informality, leads to a less rigid border between professionalism and the human experience of a group, even while the professional objective remains steadfast. Interpersonal bonds are strengthened by all that is learned. Each discussion and each achievement has an immediate effect on the work and on the group. The urgency forces you as a trainer to quickly come up with and transmit a reproducible tool that can be used by the trainees in their field work, and can coincidentally present examples of more general processes. This leads to a circularity that, I can say from experience, brings more benefits than confusion.

The Activities

As mentioned previously, after some weeks we had lists of activities that the different groups wanted to take place in the collective centers. They varied from hairdressing to percussion, from theatre to rock music and photography, from football to volleyball and basketball. Many mothers asked us to run activities for very small children so that they could have some time for themselves. The actual plan of activities tried to balance the requests made by the communities, the theoretical assumptions behind the project, the logistical implications of each activity, and the expertise and personal attitudes of the staff. We attempted to put into practice the model of the complex circle-creating safe spaces in the centers for creative expression and exchanges between individuals who had differences. We tried to create events that fostered mutual exchanges between the different creative groups within the centers, between the individual centers, and between all the centers and the wider Serbian society.

The process and the results are outlined in the short description below.

Creative Corners

In 20 collective centers, 2 informal IDP centers, and 3 Roma settlements we created safe spaces for children, adolescents, and elderly refugees. A space would be created in a room, when possible, or otherwise in a corner, next to a wall or, in the worst case, such as in the Roma settlements, in a tent. These spaces were rehabilitated and equipped in order to run the different activities. They had to look nice; the community had to take care of them. In these spaces, the children and adolescents found a way of expressing their feelings and abilities by painting, singing, playing instruments, performing in plays, participating in photography and video workshops, and any other activity they selected. Each was carried out for an hour and a half, twice a week. At least two activities were held in each "corner" according to the specific requests of the centers' inhabitants. In some of the centers, adult refugees with artistic or artisan skills led workshops for the youngest in addition to the weekly program. These included icon carving, painting, piano classes, and crocheting.

Adolescents and young people carried out activities for the younger children on a voluntary basis. They had been trained to do so and worked with the central team. The adolescents participating in a creative activity during the week organized the same activity for younger groups, thus improving their sense of responsibility.

"What a Fucking Place"

The common room in Nis became the space where the results of the activities from the various corners of the different collective centers were performed for the public. It was also the place where young and old refugees and the IDPs, even those not involved in our project, could show, perform, and meet each other (by organizing concerts, parties, solo exhibits, fairs, etc.). It was the place where the different stages of the project were presented and discussed. Each time an event was organized, the inhabitants of the centers were invited to attend (with financed transportation), helping to establish a circle of creative communication. The media, journalists, politicians, and other townspeople were invited as well, thus enlarging the circle to the level of social communication.

The beneficiaries, through a written questionnaire following informal discussions, chose the name of the common room. The name created some problems with our donors and with the local authorities, but we were able to keep it. "What a Fucking Place" opened in October 1999 with a concert by a refugee rock band and the exhibition of paintings and photographs produced in the corners. Adolescents and their families from all the centers were invited, as well as representatives from local youth authorities, organizations, and the media. It was a great party.

Memory

In the centers, embroidery and sewing activities for elderly women as well as card and chess tournaments for elderly men were organized. A memory activity was carried out in seven centers. During the sewing and card tournaments (daily rituals for the Serbian community) our animators encouraged the elderly who were so inclined to tell their stories and express their feelings. They used affective memory games and an autobiographical method, partially inspired by Duccio Demetrio (Demetrio 1997). A dramatist, involved in all phases of the process, wrote each story into a short story or monologue in the third person. The short story or monologue was then given as a gift to the person involved. Ifs/he agreed, this person could tell her or his story or have it told by an actor during a special storytelling evening that took place once a month in each community center.

All the stories told throughout the month were presented during a special memory night that was held every month in the common room of Nis. The elderly "owners" of the stories and their communities were invited to Nis for the event. They could tell their stories or listen to them being told, or could also decide not to present the story. The memory project created stronger relations between adults, as well as between the elderly and youngsters in the centers, re-affirming the role of the elderly within their communities. More generally, the memory evenings held in the common room of Nis, in front of a mixed audience of refugees from the centers and the local population, including artists, the authorities, and media, were of a political as well as social relevance.

After several weeks, it became clear that in some centers-not surprisingly the ones with the worst living conditions-the memory sessions provoked collective outcries, even though the program tended to work on positive memories and to avoid the subject of the war and loss. Because of this, a special program was developed for these centers, where the activities of the memory program were accompanied by psychological support and a psychologist was added to every team.

Health Education

In the Roma settlement a team of animators, directed by Doctor Nebojsa Brankovic and Nejsha (a marionette doctor), carried out a special health education program. The purpose was to explain, using games and marionette shows, how to maintain a minimum level of hygiene given the terrible conditions in which they lived. Of course, the children paid much more attention to Nejsha, who had the same facial features as Doctor Brankovic. Later, the program focused on sex education, mother-child relationships, HIV/ AIDS prevention, and contraception.

There was an immediate evaluation of the project: each time our car appeared in a Roma settlement, the children would run around the vehicle to greet us; after a while they did so with the palms of the hands completely open and still. It was to show us that they had washed their hands. This education program was closed when the national health authorities were finally allowed to take care of the health situation in the Roma settlements and the IDPs were included in the national health-care plan.

Soccer and Basketball Leagues

In each center we organized one or two sports teams. Adults as well as youths participated, and the teams ultimately included a very large number of players of all ages. There were two leagues between all community centers, one for children and one for adolescents and adults. It was a huge success, except for some organizational problems (for example, some players received their shoes too late and demanded to replay all the games!). On every day of the league, all the teams and their fans would arrive in Nis to play in various combinations. Teams from the town also participated. After the games, recreational activities were organized in the common room. These sports activities were based on the model of the complex circle and we tried to have a very performative approach to the leagues-creating events and exchanges. After the first year, the leagues were no longer organized. The teams were incorporated into the different leagues taking place in the municipalities where their centers were located. Mutual matches between the teams of the various collective centers were and are organized directly by them.

Cinema Club

A movie club was organized in the common room of Nis. A children's film was shown every other Friday afternoon, while a film for everyone else was shown in the evenings. Experimental films for students and adolescents were shown on the last Saturday of the month. On all occasions, a debate followed the film. The programs were also shown in eight remote centers, in a kind of traveling cinema that also included post-film discussions as well as organized games. The films were selected according to their subjects. Two participants, Sasa Stefanovic and Srdjan Vresnik, were involved with the games, as well as with choosing the videos and facilitating the debates. Vresnik was a refugee from Croatia living in one of the collective centers. He began as an adolescent volunteer and is today a creative facilitator and a student of psychology.

2000

The Classic Theatre, a private theatre company associated with the government, started a program focused on children's visions of the end of the millennium. Twenty-five workshop-rehearsals were held in various community centers. The children were supposed to direct the rehearsals and create the drama. The result was presented in the common room of Nis in January 2000. All the children involved and their families were invited to participate. Unfortunately, because the Classic Theatre was not trained for this type of work, instead of a process the result was a prepackaged product. The theme for 2000 inexplicably focused on Cinderella.

But if the free and creative communication mechanism failed, the social communication mechanism worked well. When I arrived in Kosovo in May 2000, I was invited to attend the same show in the Serbian enclave of Gracanica. The Classic Theatre, though not paid to do so, continued to present the show, and also provided material assistance in the Serbian enclaves in Kosovo and to refugee centers throughout the federation. This part of the project ended after the first year however, while the centers involved continue to host community theatre workshops for children.

Three and a Half Years Later

Three and a half years later, Serbian society has undergone great changes. In 2001, after a very heavy electoral defeat, Milosevic became a prisoner in The Hague and the embargo of Serbia ended. Refugees and their plight were among the top priorities on the new government's agenda (at least until the new Prime Minister was assassinated). The project is still alive because the centers still exist, even if the new government has begun to close some of them and resettle the refugees in private homes. The government wanted to close all of the centers by the end of 2003. Indeed, almost all the hotels have been privatized in the meantime and the new owners are lobbying for new solutions for the remaining refugees. Those who still live in the centers are now suffering hardship due to increases in the cost of living.

I completed the final training and the last supervision with the team in December 1999. Two other internationals and then the Serbian staff itself managed the project after I left. The core of the team remains in place even though some left because the project was not given proper support and others because they were just worn out. There were moments of extreme poverty in which the group worked on a voluntary basis and other phases in which the project received substantial funds. In the first few months of 2000, a lack of funds meant no opportunities to improve the program. This was followed by a phase in which, for logistical reasons and by choice of the international manager, the work inside the centers got done but the transition to the subsequent circles stopped

(Segre 1999/2000). Therefore, the common room was used more as a safe place for the refugees being hosted in and around Nis than as a place for building relationships between the various centers and making connections to the outside world. The sports activities continued but without any leagues. The memory project continued successfully in the centers, but no more memory evenings were held in the common room. The itinerant Cinema Club turned out to be the most popular activity.

From October 2000 to the spring of 2002, the social communication component was again established as the essential part of the process, but there was no further analysis or training on the psychosocial component of the work. Finally, in the spring of 2002, the project was handed over to a group of local NGOs, many involving the former central team and some including former adolescents who had been part of the activities over the years. Overall, the project continues to reach its beneficiaries through its model of intervention. For instance, the rock groups of the creative corners of some centers recently released their first CD. All this can be considered as a positive and important achievement for the group.

However, what are truly surprising to me are the facts:

1. The group did not receive any training or any form of supervision about the content of the work and their experiences for two years. Psychosocial and creative activities are not like other types of work; they keep you constantly involved, burning energies and capacities. I am firmly convinced that the priorities of this type of project must include some structured exchanges, supervision, and training of the staff, not only at the beginning, but throughout.
2. The project has been duplicated almost identically every year. Some activities were shifted from one center to another, and new centers have been involved, but the structure and the activities remained the same, even when the reality outside has developed and changed radically. I believe that a project has to be linked to its social and historical context and should be reevaluated and redesigned constantly because the needs of the beneficiaries keep changing.

Conclusions

Working on rituals, on the construction and reconstruction of individual, group, and collective roles, on community building, on the creative re-elaboration of mourning and anger should all be vital activities for war-torn and war-displaced communities. It is also essential to support the empowerment of internal differences and work on the collective

limits and borders of each of the communities involved in war. This is from the perspective of strengthening individuals, increasing the diversity of their experiences, and for long-term intercultural goals. Theatre and theatrical actions are able to satisfy these needs. Theatre has to be understood here as a means of developing relationships, communication, and expression that concentrates on the construction of roles. It contains the possibility of creating a circle of barter and encounters between differences and a real ability to work on the "borders"- to forge passages and relationships between individuals, groups, and communities.

This opportunity is the proper domain of the theatre because theatre's natural outcome is social communication. This process is fundamental when working with communities in war-torn situations, but it is also fundamental when, in order to change the status of a group or wider society's perception of a group, it is necessary to introduce its problems and ethics into the circle of communication between political subjects and decision-making powers. This process, starting with individuals and arriving at institutions, facilitates the construction of plural communities that contain extreme differences among members. This process has the capacity to reveal differences even in closed social systems that are characterized by an intense cohesion forged in the name of "compulsory" values/ non-values.

The above-mentioned process is linked directly to ritual. Theatrical ritual has always had a capacity to create a collective space for peaceful confrontation and dialogue among differences. The modern practice of theatre and psycho-social animation in war-torn situations is therefore nothing new. Theatre has always dealt with confronting the limits of human experience.

For all references please see bibliography.



culture&health

making the link

LONDON
HEALTH COMMISSION

contents

	Page
Introduction	4
Linked agendas: definitions and policy contexts	5
The links between culture and health	8
Summary	17
References	18
About the London Health Commission	20
Health Impact Assessment	20

foreword

The need for a holistic approach to tackling health inequalities is now widely accepted.

Policy makers are developing a much clearer understanding of how the health agenda can be linked with economic, environmental and transport policy for example, to tackle the underlying causes of ill-health.

To date however, there has been little attention given to understanding how cultural policy impacts on the health of communities and how it can contribute to achieving health objectives.

The positive benefits to physical and mental health of participating in more tangible and 'active' aspects of culture such as dance, sport, or music are relatively well documented, but what of the more indirect impacts of other elements of culture?

In fact, culture has a significant contribution to make to health, not least because in all its forms it helps to provide the social fabric of communities, making them 'communities' in the real sense and sustaining the individuals within them.

The scale and diversity of London's cultural resources present excellent opportunities for positively influencing the health of Londoners. This booklet is intended to help stimulate further consideration of how this potential can be realised at a time when local authorities are developing strategies that will guide the use of their own cultural resources.

introduction

- *How do aspects of culture make a difference to people's health?*
- *How can cultural policy contribute to improving the health of the population?*

This booklet provides an introduction to the links between culture and health, drawing on the available evidence and literature to highlight ways in which local cultural strategies and the activities which they guide might affect the health of the population.

It is intended primarily as a reference point for those working within and with local authorities to develop local

cultural strategies in line with current government guidelines.

In preparing such strategies, local authorities have been encouraged to identify and promote the contribution of cultural activities to their communities' economic, social and environmental well-being.

A key aim is to demonstrate the ways in which culture can help to deliver the main local agendas as set out in the community strategy. Improving people's health is one of these key agendas.

This booklet has been developed from a paper, commissioned by the London

Health Commission and South East London Strategic Health Authority, which provides a rapid review of the evidence to inform a health impact assessment of the Mayor of London's draft Cultural Strategy for London.¹

The paper, and more information about the London Health Commission and health impact assessment, is available at: www.londonhealth.gov.uk

¹ Cave, B. and Coutts, A. Health evidence base for the Mayor's draft Cultural Strategy. (in press). 2002. Greater London Authority, South East London Strategic Health Authority.

linked agendas

Defining 'Culture'

'Culture' is redefined each time the term is used. In its guidance on the development of cultural strategies, the Department of Culture, Media and Sport (DCMS) states that culture has both a material and a value dimension (see box) which are inextricably entwined and constantly inform each other.

The scope of culture

Culture has a material dimension

- the performing and visual arts, craft, and fashion
- media, film, television, video, and language
- museums, artifacts, archives and design
- libraries, literature, writing and publishing
- the built heritage, architecture, landscape and archaeology
- sports events, facilities and development
- parks, open spaces, wildlife habitats, water environment and countryside recreation
- children's play, playgrounds and play activities
- tourism, festivals and attractions
- informal leisure pursuits

Culture has a value dimension

- relationships
- shared memories, experiences and identity
- diverse cultural, religious and historic backgrounds
- standards
- what we consider valuable to pass on to future generations

Creating Opportunities: Guidance for Local Authorities in England on Local Cultural Strategies. DCMS 2000.

Culture is by definition complex, multi-faceted and, particularly in its value dimension, contentious. This booklet aims to inform the development of local cultural strategies and so it focuses on the more material aspects of our cultural life. This emphasis does not diminish the importance of the value dimension of culture.

Policy context: Cultural Strategies

Local authorities are expected to prepare a local cultural strategy to promote the cultural well being of their area.

DCMS guidance places this task within the context of ‘tackling social exclusion, contributing to regeneration, promoting safer communities and encouraging healthier lifestyles.’, and highlights the potential links with health improvement programmes among other key policy initiatives which share similar objectives.

The cultural strategy should ‘integrate, implement and monitor the major cultural goals, policies and actions of the authority and its partners’. It should link with and be informed by the community strategy, advocate the value and importance of culture to the community, and demonstrate the ways that it can deliver the main local agendas.

Defining ‘Health’

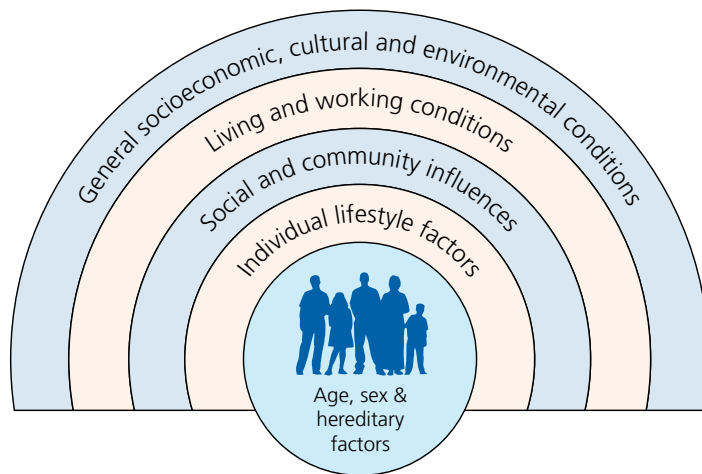
This booklet employs a social definition of health in keeping with the World Health Organisation’s definition of health as:

“...a resource for everyday life, not the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities.”

Health has many determinants: economic status, education, employment status, the environment, housing, transport, social links and others. The diagram opposite shows why efforts to improve the health of communities need to encompass the contributions of many agencies beyond the boundaries of the National Health Service.



The main determinants of Health



Dahlgren and Whitehead² (Figure 3.1, p. 23 in Whitehead³).

Policy context: Primary Care Trusts

NHS Primary Care Trusts (PCTs) are now in place in all London Boroughs. PCTs are responsible for linking closely with Local Strategic Partnerships to improve their population's health and deliver wider objectives for social and economic regeneration. They will be developing a strategic view of local priorities for improving health and programmes of action to tackle the root causes of ill-health, targeting in particular communities with the poorest health in efforts to reduce inequalities. Increasingly, these plans are being aligned with local authorities' community strategies.



links between culture and health

This section provides an overview of where culture or elements of cultural policy have or may have a bearing on health.

With a view to supporting those preparing local cultural strategies, it is presented to reflect elements of a typical cultural strategy as proposed by the DCMS guidance document *Creating Opportunities*.⁴ It begins with a general assessment of how cultural activity and participation can affect health, in which its contribution to social

capital is key, before identifying the potential health impacts of specific cultural services. The third and final strand highlights issues of relevance to the processes employed by organisations within the cultural sector and how these can help to foster better health.

The original evidence review¹ on which this overview is based drew on international research that includes several major evidence reviews and other published literature. Care was taken in drawing conclusions for Britain

and the local level from studies conducted in other countries and on a national scale.

The general benefits of cultural activities to health

Cultural activity contributes to the overall well-being of the community, and participation is associated with better individual health and well-being.

Cultural activity contributes to social capital

Cultural activity is beneficial to the health of communities and individuals within them because of its significant contribution to the development and maintenance of social capital. Social capital is an important determinant of health.

Defining social capital

There are many ways of defining social capital, but 'community co-ordination', 'co-operation', 'reciprocity', 'trust', 'social integration' and 'supportive relationships' feature as key words in much of the literature on the subject.

Three different forms of social capital have been identified, namely bonding (close ties between members of families and ethnic groups); bridging (relations with wider networks of friends and associates); and linking (hierarchical relations

between different social strata).⁵ These are useful in understanding ways in which social capital can encourage or hinder social cohesion. For example, strongly bonded groups may hinder the development of wider contacts and social cohesion.

Social capital and health

There is a wealth of evidence suggesting links between social capital, or its components, and health. For example:

- Higher levels of social integration and social connectedness (the degree to which individuals form close bonds with relations, friends and acquaintances) are associated with personal well-being, higher life expectancy and lower death rates from all causes.^{6,7}
- Better social support is also associated with lower levels of anxiety and depression, and may help people to

cope better with illness and to have better prognoses when ill.⁸

Safer communities

Although it is not entirely clear *how* good stocks of social capital in a community has a positive effect on health, its contribution to creating safer communities is seen as important.

Studies have shown that most forms of civic engagement help to create trust, reciprocity and co-operation in local communities, which in turn helps to discourage anti-social or criminal behaviour.^{5,7} Communities which are characterised by anonymity, limited acquaintances among residents and low levels of civic participation face increased violence and crime.⁷

The fear of crime, which can be seen as an indicator of social capital⁹, is associated with higher blood pressure

and increased anxiety, and is significantly associated with poor self-rated health.¹⁰

How cultural strategies can help

‘Social cohesion is not something that a community generates in isolation from government or regional policies’¹¹ and the cultural sector has a lot to contribute to agencies working against social exclusion.¹²

While the arts play an important role in building social capital, traditionally, they have been more successful in supporting internal group bonds than in helping to bridge the barriers between groups.¹³ Activities are often segregated in ways that reflect existing social divisions because of people’s desire to be with those like themselves, and because of the way the arts are funded and presented.

Policies and resources can encourage opportunities for forming supportive social networks. For example they can:

- foster established networks and include newcomers;
- provide a range of meeting places;
- distribute resources equitably, helping to reduce tension between different ages or other groups;¹⁴
- respond to the needs of different groups within the community, for example through greater community participation and representation.¹⁵

However, even highly cohesive communities with high levels of social capital can be detrimental to those people who do not participate or who appear different from the rest of the community. As art and culture often rely on this ‘being different’ as a source of creativity, cultural strategy may be well placed to include linking members

of the social strata, eg. rich/poor among its aims.

Participation in cultural activities is associated with better individual health

A number of studies suggest an association between people’s participation in the social, civic and cultural life of the community, and their health; feeling part of the community is associated with better health.¹⁶ For example:

- One longitudinal study found that individuals who were culturally inactive or those who became less culturally active during the course of the study, reported poorer health compared to the culturally active.¹⁷
- It suggested that people’s experiences of culture, including literature, film and music, or cultural events can have physical, mental and social effects through the reduction in



tension and the arousal of attention, alertness or excitement.

- Another study found that attending cultural events is linked to longevity. People who rarely attended such events ran a 60% higher mortality risk than those attending most often.¹⁸
- Community-based arts projects have reported anecdotal evidence of enhancing participants' sense of well-being.¹⁹

Barriers to participation

However, the benefits of participation are not felt equally across the population because of the economic, cultural, educational, environmental (eg transport), physical and other barriers faced by disadvantaged individuals and communities. An understanding of who does and does not participate and why is crucial in ensuring that cultural activity is inclusive and cultural policy is to help in tackling social exclusion.

The health impacts of specific cultural services

There are many opportunities to influence good health in the development and implementation of policy relating to specific cultural services.

i) Built heritage/urban design

The environment in which we live is an important influence on health, directly and indirectly. Evidence here holds pointers for all those concerned with the built environment whether from a practical or aesthetic perspective, across the sectors.

For example, we know that poor design of built environments creates opportunities for crime and decreases residents' willingness to use and defend local space.²⁰ Planning and design that stifles urban street life will undermine the sustainability of communities. Deprived neighbourhoods including signs of

incivilities (vacant property, unmaintained housing, graffiti and visible signs of criminal activity) are strongly related to the fear of crime^{21,22} which is in turn associated with poor health.

Conversely, good design can encourage greater ownership and involvement of communities and can reduce vandalism and the under use of facilities.²³

We also know that the nature of the environment is important for healthy child development. Environmental factors such as the distance between houses, access to facilities such as parks, the density of the child population, and safety all influence measures of children's behaviour.²⁴

A review of mental health and the built environment found that depressed women were significantly more likely to be living in flats with raised walkways

than in brick or concrete houses, or in tower blocks.²⁵ However, other studies suggest that it is 'problem' estates that impact most on people's mental health, rather than the style of housing.²⁶

ii) Sport, exercise, physical activity

Increasing the uptake of physical activity and exercise among the population will contribute to reducing levels of illness and death rates:

- A lack of physical activity is linked to a range of adult conditions so promoting physical activity in childhood may be important.²⁷
- Studies have shown that physical exercise can be beneficial in the prevention and treatment of some of the most common causes of physical ill-health including coronary heart disease (CHD), hypertension, obesity, osteoporosis (brittle bone disease), diabetes mellitus and asthma.²⁸ For example:

- The incidence of CHD in middle-aged men is approximately halved in the most active compared to the most sedentary groups.²⁹
- In overweight adults, aerobic exercise causes a modest weight loss even without dieting³⁰. Regular physical activity combined with dieting is one of the most effective means of managing mild to moderate obesity and maintaining an ideal body weight.³¹
- Being physically active reduces the risk of later hip fracture by 50%.³²
- Physical activity may also play an important role in the management of common mild-to-moderate mental health diseases, especially depression and anxiety.^{28,33} Regular participation in an exercise programme has been found to be associated with measurable increases in self-esteem in adults and children³⁴, and regular exercise may also reduce memory loss in older people.³⁵

- Strenuous physical activity improves perceived health and it reduces the risk of heart disease, stroke, hypertension, atherosclerosis, colon cancer, lower back pain, osteoporosis and adult onset diabetes.³⁶

The provision of a variety of opportunities, acceptable to people of all ages, abilities and backgrounds, to engage in appropriate physical activity can therefore have a direct and positive impact on population health.

iii) Parks and open spaces

A recent review of the health effects of green space³⁷ reported both positive and negative effects on health:

Potential positive effects included:

- Improved exercise levels in a community, thereby contributing to the reduction in obesity, cardiovascular disease, diabetes and arthritis. The

impact on exercise levels is likely to be greatest in children.

- Improved social interaction and community activities. This can contribute to reducing levels of stress-related problems, and can contribute to reducing autistic spectrum disorders and attention deficit disorder in children. Other studies²⁴ have shown that access to parks is among the environmental factors that influence measures of children's behaviour including the number and nature of friendships and characteristics of play patterns.

Potential negative effects included:

- Criminal, social or psychological aggression often take place in green spaces, drug abuse and conduct offences may be centred in these: this may lead to a restriction of use by certain age groups or ethnic groups. Other studies have confirmed

the fear of crime as an important factor in people's willingness to use open spaces in general.

- Hayfever, which causes loss of work hours for adults and is a significant cause of missed schooling, is increasingly frequent in urban and rural populations for reasons that are not entirely clear. However, it is suspected that the effect of pollen in urban populations is exacerbated by atmospheric pollution.
- There are risks of toxic contamination from traffic pollutants to some vegetables and fruit grown in the inner city, and some allotment sites have been found to harbour rodents in winter, possibly resulting in a negative health impact on neighbouring communities.

The benefits to health of parks and open spaces outweigh the negative impacts. Policies and management

practices that encourage their use and overcome barriers to access such as poor transport links and safety fears may help to maximise these benefits, and enable them to be shared more equally.

iv) Play

Research has highlighted the reduction of children's play territory as roads and pavements become more and more dangerous³⁸, and that there has been a dramatic reduction in opportunities for independent play and exploration due to the fear of crime.³⁹

The provision of play facilities that allow expression of independence and personal mobility may have positive behavioural and mental health benefits for children.



v) Large-scale events, festivals and tourism

Studies of large-scale events⁴⁰ have shown that their impacts can be complex, variable and create winners and losers. Where community and user involvement in resource and funding decisions are weak, the risks of negative impacts are higher.

For example, in the Sydney Olympics there were positive benefits in giving the city a sense of pride; (anecdotally) in an increased interest and active participation in sport and physical activity by its residents; and in the use of the media spotlight by indigenous people to highlight issues facing them.

But there were more negative impacts: inadequate consultation and information for affected community groups; exposure to dust and possibly toxic wastes from building work; economic

and social costs fell disproportionately on lower income groups; the diversion of funding from government services like health and education; and mistrust over the financial and political benefits.

Citizen participation was minimal in the bidding for US Olympic events and although the Mayor of Atlanta stated that the its staging of the Games would lift people out of poverty, there was no strategy or funds for anti-poverty programmes.⁴¹

Strategies are needed to ensure that the potential benefits of large events are realised and widely enjoyed.

vi) Informal Leisure

Leisure is essential to an individual's psychological health. 'Leisure lack' has been equated with a diminished sense of well-being.⁴²

Alcohol

Alcohol is an integral element in many informal leisure activities, and there is a wealth of evidence about its impact, positive and negative, on health:

Negative effects

- Heavy drinking has been associated with ill-health and deaths from coronary heart disease, accidents and chronic conditions such as liver disease.⁴³
- Although alcohol can cause crime, usually it is merely associated with offending. Drunkenness as a crime appears to cross all age boundaries but is associated mainly with the young, particularly young males where the offence involves aggression.
- Alcohol-related aggression often results in facial injury, with beer glasses used as weapons. Men, particularly young men, are the

most likely victims and are more likely to be injured near licensed premises. However, there is also a strong link between domestic violence, where women are the victims, and alcohol. Men who drink heavily are more likely to physically abuse their partners. Consequently, women are more likely than men to be injured in the home.

Although the relationship between alcohol and aggression is a complex one, it has been suggested that the potential for alcohol-related violence can be reduced by measures such as ensuring that licensed premises are attractive and well maintained, avoiding discounted alcoholic drink promotions, serving food and staggered closing times, and by staff expecting good behaviour and actively discouraging anti-social behaviour.⁴⁴

Positive effects

- Moderate alcohol consumption has been associated with a lower risk of coronary heart disease, stroke and sudden death.
- A net health benefit from alcohol use can be expected in people aged at least 40 and drinking no more than 2-3 drinks per day⁴⁵ (although this would exceed the 14 units per week which is generally accepted as a safe limit for women).
- People who are at high risk of coronary heart disease (CHD) can benefit from moderate alcohol intake; conversely, the health risk to individuals at low risk of CHD is potentially worsened. However, it is not known how long moderate alcohol consumption must continue for these benefits to occur, and there is no universal safe threshold for intake.

Drugs

Social patterns and acceptance of drug use are changing. The average age of first illegal drug use is falling⁴⁶ and there is a strong correlation between the early use of alcohol tobacco and volatile substances and the use of illegal drugs. Almost half of young people are likely to try illegal drugs at some time in their lives although only a fifth go on to develop a long-term pattern of use. Reasons given by young people for their initiation and use of illegal drugs centre around peer group influence.⁴⁷

It has been suggested that specialist arts organisations can assist in a debate over ways to address changing patterns of drug use.

Healthy processes

Healthy Employment

Employment is a significant determinant of health. Cultural industries, as employers of hundreds of thousands of workers in London, have an important contribution to make to the health of Londoners in this respect.

One study found that workers in arts projects demonstrated high levels of skill and commitment, but described employment conditions among artists who work with people as 'lamentable'. They found many areas requiring improvement: pay, contracts, work environment, training, career development, management and professional support.⁴⁸

Negative impacts of employment on physical and mental health are associated with:

- lack of control over work;
- lack of social support;
- imbalance between effort and reward;
- lack of job security.

Levels of health risk are related to the quality of the work. They are higher among dissatisfied workers and lower among satisfied workers.⁴⁹

Stakeholder involvement

There is ample evidence that demonstrates the potential benefits of participation itself in processes that affect people's lives. Increased stakeholder involvement in cultural policy development and specific activities may help to maximise benefits to health – not only in contributing in itself to stocks of social capital, but also because:

- Local community involvement in the development of community facilities (the material base for social capital) can help to ensure that they are able to meet constantly changing social

conditions and a range of needs.¹⁵

- Fair and open partnerships between cultural organisations and relatively wealthy public agencies which are increasingly interested in their potential to deliver wider objectives, will help to ensure the success of projects by building a shared understanding of the actual outcomes of cultural action and the processes by which they are achieved.⁴⁸

Evaluation

As the economic case for participatory cultural projects rests on their contribution to social policy objectives (by facilitating empowerment and creativity), evaluation is needed to assess the benefits including whether they are cost effective.

Longitudinal evaluation is recommended by PAT10.⁵⁰ Evaluation strategies should consider health as well as other outcomes, and the 'insider knowledge' of 'stakeholders' is as important here as other sources of information and evidence.⁵¹

summary

- Culture has both a *material* and a *value* dimension; these are inextricably entwined and constantly inform each other.
- Whilst culture in its material forms has both positive and negative effects on health (and the research tends to highlight the negatives), the benefits outweigh the drawbacks: it is generally good for health. However, the evidence is mainly associative.
- There are direct and indirect mechanisms by which cultural activity contributes to the health and well-being of communities.
- There may be considerable potential for cultural activity in building links across social boundaries; traditionally

it has been more successful at supporting bonds within groups. Cultural activity that encourages strong group ties may hinder the development of wider contacts and social cohesion.

- *Individuals* may gain direct health benefits as a result of their participation in cultural activities. However, wider benefits to the *community* will not accrue unless these are pursued as explicit goals using appropriate processes including stakeholder involvement.
- We need to identify and understand patterns of participation in cultural activities to avoid reinforcing patterns of social exclusion and to support initiatives that facilitate greater inclusion.

- The size and diversity of London's cultural sector presents a considerable challenge and opportunity to contribute to the well-being of Londoners through the adoption of healthy employment practices.
- Since health and well-being are affected by such a variety of factors, cultural strategies need to be integrated with other local strategies, such as economic and spatial development strategies, to maximise their benefits for health.
- Health outcomes should be included in the evaluation of cultural policies and activities.

references

1. Cave, B. and Coutts, A. Health evidence base for the Mayor's draft Cultural Strategy. (in press). 2002. Greater London Authority, South East London Strategic Health Authority.
2. Dahlgren, G. and Whitehead, M. Policies and strategies to promote social equity in health. 1991. Stockholm, Institute for Future Studies.
3. Whitehead, M. "Tackling inequalities in health: a review of policy initiatives" in *Tackling inequalities in health: an agenda for action* eds. Benzeval, M., Judge, K. et al. London, King's Fund Publishing. 1995: pp.22-52.
4. Department of Culture, Media and Sport. Creating opportunities: guidance for Local Authorities in England on local cultural strategies. 2000. London, DCMS. available at http://www.culture.gov.uk/PDF/cultural_strategy.pdf
5. OECD. The wealth of nations: the role of human and social capital. 2001.
6. Siahpush, M. and Singh, G. K. Social integration and mortality in Australia. *Australian and New Zealand Journal of Public Health*, 23 pp.571-577, 1999.
7. Putnam, R. *Bowling alone: the collapse and revival of American community*. New York, Simon Schuster. 2000.
8. Stansfeld, S. A. "Social support and social cohesion" in *Social determinants of health* eds. Marmot, M. and Wilkinson, R. G. Oxford, Oxford University Press. 1999: pp.155-178.
9. Kawachi, I., Kennedy, B. P. et al. Crime: social disorganization and relative deprivation. *Soc.Sci.Med.*, 48 pp.719-731, 1999.
10. Chandola, T. The fear of crime and area differences in health. *Health and Place*, 7 pp.105-116, 2001.
11. Witten, K., McCreanor, T. et al. The impacts of a school closure on neighbourhood social cohesion: narratives from Invercargill, New Zealand. *Health & Place*, 7 pp.307-317, 2001.
12. Council of Europe. In from the margins: a contribution to the debate on culture and development in Europe. Strasbourg, Council of Europe Publishing. 1997.
13. Argyle, M. *In pursuit of the quality of life*. New York, Oxford University Press. 1996.
14. Cattell, V. and Evans, M. Neighbourhood images in East London: social capital and social networks on two East London estates. York, YPS for the Joseph Rowntree Foundation. 1999: 1-61.
15. Campbell, C., Wood, R. et al. *Social capital and health*. London, Health Education Authority. 1999.
16. Mitchell, R., Gleave, S. et al. Do attitude and area influence health? A multilevel study of health inequalities. *Health & Place*, 6 pp. 67-79, 2000.
17. Johansson, S. E., Konlaan, B. B. et al. Sustaining habits of attending cultural events and maintenance of health: a longitudinal study. *Health Promotion International*, 16 (3) pp.229-234, 2001.
18. Bygren, L. O., Konlaan, B. B. et al. Attendance at cultural events, reading books or periodicals, and making music or singing in a choir as determinants of survival: Swedish interview survey of living conditions. *British Medical Journal*, 313 pp.1677-1680, 1996.
19. Health Development Agency. *Art for health: a review of good practice in community-based arts projects and initiatives which impact on health and well-being*. 2000. London, HDA. available at <http://www.hda-online.org.uk>
20. Newman, O. *Defensible space*. New York, Macmillan. 1972.
21. Box, S., Hale, C. et al. Explaining fear of crime. *British Journal of Criminology*, 28 (3) pp.340-356, 1988.
22. Skogan, M. G. and Maxfield, M. G. *Coping with crime: individual and neighbourhood reactions*. Beverley Hills, Sage. 1981.
23. Evans, G. and Shaw, P. *A study into the impact of Lottery Good Cause spending in the UK. Draft final report*. 2001. Centre for Leisure and Tourism Studies, University of North London for the Department for Culture, Media and Sport.

CULTURE & HEALTH: MAKING THE LINK

24. Parke, R. D. and Bhavnagri, N. P. "Parents as managers of children's peer relationships" in *Children's social networks and social supports* ed. Belle, D. New York, Wiley. 1989: pp.241-259.
25. Halpern, D. *Mental health and the built environment*. London, Taylor & Francis. 1995.
26. Freeman, H. "Mental health and high-rise housing" in *Unhealthy housing: research, remedies and reform* eds. Burridge, R. and Ormandy, D. London, E & FN Spon. 1993: pp.168-190.
27. Rowland, T. W. and Freedson, P. S. Physical activity, fitness and health in children: a closer look. *Pediatrics*, 93 pp.669-672, 1994.
28. Thomas, G. S., Lee, P. R. *et al.* Exercise and health: the evidence and the implications. Lee, P.R. edition. Cambridge, Mass, Gunn and Hain. 1981.
29. Berlin, J. A. and Colditz, G. A. A meta analysis of physical activity in the prevention of coronary heart disease. *American Journal of Epidemiology*, 1990.
30. Hill, J. and *et al.* Evaluation of an alternating calorie diet with and without exercise in the treatment of obesity. *American Journal of Clinical Nutrition*, 1989.
31. Reybrouk, T. and *et al.* Exercise therapy and hypocaloric diet in the treatment of obese children and adolescents. *Acta Paediatrica Scandinavica*, 1990.
32. Joakimsen, R. M. and *et al.* Physical activity and predisposition to hip fractures; a review. *Osteoporosis International*, 1997.
33. Paluska, S. A. and Schwenk, T. L. Physical activity and mental health – current concepts. *Sports Medicine*, 29 (3) pp.167-180, 2000.
34. Macauley, E. "Physical activity and psychosocial outcomes" in *Physical activity, fitness and health: international proceedings and consensus statement* eds. Bouchard, C. and *et al* Champagne, Illinois, 1994.
35. Thomas, J. R. and *et al.* "Exercise and cognitive function" in *Physical activity, fitness and health: international proceedings and consensus statement* eds. Bouchard, C. and *et al* Champagne, Illinois, 1994.
36. Berkman, L. F. and Breslow, L. *Health and ways of living: the Alameda County study*. New York, Oxford University Press. 1983.
37. Michie, C. and de Rozarieux, D. The health impacts of green spaces: a rapid review to support the Mayor of London's Biodiversity Strategy. 2001. London, Ealing Hospital NHS Trust.
38. Hillman, M., Adams, J. *et al.* One false move: a study of children's independent mobility. London, Policy Studies Institute. 1990.
39. Valentine, G. and McKendrick, J. Children's outdoor play: exploring parental concerns about children's safety and the changing nature of childhood. *Geoforum*, 28 pp.219-235, 1997.
40. Green Games Watch. Olympic Social Impacts. 2000. available at <http://www.nccnsw.org.au>
41. Andranovich, G., Burbank, M. *et al.* Olympic cities: lessons learned from mega-event politics. *Journal of Urban Affairs*, 23 (2) pp.113-131, 2001
42. Neulinger, J. Leisure lack and the quality of Life: the broadening the scope of leisure provision. *Leisure Studies*, 1 pp.53-63, 1982.
43. Marmot, M. Alcohol and coronary heart disease. *International Journal of Epidemiology*, 30 (724) pp.729, 2001.
44. Deehan, A. Alcohol and crime: taking stock. ed. Webb, B. Crime Reduction Research Series Paper 3. 1999. Home Office, Policing and Reducing Crime Unit, Research, Development and Statistics Directorate.
45. Bovet, P. and Paccaud, F. Alcohol, coronary heart disease and public health: which evidence-based policy? *International Journal of Epidemiology*, 30 pp.734-737, 2001.
46. Joyce, R. and King, A. The right approach: quality standards in drug education. 1999. London, Drugscope and the Drug and Alcohol Prevention Team.
47. Measham, F., Parker, H. *et al.* Starting, switching, slowing and stopping: report for the Drugs Prevention Initiative Integrated Programme. 1998. Manchester, SPARC, Department of Social Policy and Social Work, University of Manchester. Report prepared for the Home Office.
48. Matarasso, F. Use or ornament? The social impact of participation in the arts. Stroud, Glos, Comedia. 1997.
49. Acheson, D., Barker, D. *et al.* Independent inquiry into inequalities in health: report. pp.1-164. 1998. London, The Stationery Office.
50. Policy Action Team 10. 2001. London, Department for Culture, Media and Sport. available at <http://www.culture.gov.uk/sport/pat10.html>
51. Cave, B. and Curtis, S. Health impact assessment for regeneration projects. Volume I: A practical guide. 2001. London, East London and the City Health Action Zone and Queen Mary, University of London. available at <http://www.geog.qmul.ac.uk/health/guide.html>

About the London Health Commission

The London Health Commission works to reduce inequalities in health within the capital and to improve the health and well being of all Londoners.

The Commission recognises that this requires co-ordinated action to improve the determinants of health across London. It promotes this action by:

- Building partnerships across sectors and organisations
- Influencing key stakeholders and policy makers
- Providing practical support for local activities.

To find out more about the work of the London Health Commission, see our website: www.londonhealth.gov.uk

or contact:

London Health Commission,
City Hall, The Queen's Walk,
London SE1 2AA

Tel: 020 7983 4120

Email: gus.wilson@london.gov.uk

Health Impact Assessment (HIA)

HIA is an approach to ensure that decision making at all levels considers potential impacts on health and health inequalities, and identifies actions that can enhance positive effects and reduce or eliminate negative effects.

Although HIA is a new and developing approach, it is increasingly being recognised nationally and internationally.

Developing and promoting the use of HIA is one of the supporting priorities of the London Health Commission.

A number of resources are now available to support those considering or conducting health impact assessments. Please see our website at: www.londonhealth.gov.uk/hia.htm

I can do poster



If you have ideas (painting, music, arts, theatre, social activities, etc...) for the community or a specific target group, based on your creative skills, that you would like to be implemented in DARI Recreation and Counseling Center for Families-Balbeck. Let's collaborate to make it happen.



Conditions of Participation:

- 1-Write down your detailed idea or activity on a printed A4 paper with all the details.
- 2-Write down the materials on a printed A4 paper you need to accomplish your project.

Activity proposals are to be sent to DARI Recreation and Counseling Center for Families or IOM at the following numbers: 01-752108 or 06-370456.
First day to send in proposals January 17 2008
Second day to send in proposals February 20 2008

"Dye mon, gen mon". Social theatre, Community Mobilisation and Participation after Disasters: The International Organization for Migration Experience in Haiti, after January 2010's earthquake

This is the original manuscript for the article 'Dye mon, gen mon' ('Beyond the mountains, more mountains'). Social Theatre, Community Mobilisation and Participation After Disasters: The International Organization for Migration Experience in Haiti, after January 2010's Earthquake. It was written by Guglielmo Schininà, Justin Voltaire, Amal Ataya and Marie-Adele Salem; published in *Research in Drama Education: The Journal of Applied Theatre and Performance*, 16:1, pp. 47-54. The use in the manual has been kindly authorized by the publisher due to the humanitarian scope of the publication. The published article can be found at: <https://www.tandfonline.com/doi/full/10.1080/13569783.2011.541607>

The earthquake that thumped the Haitian coast in January 2010, wiping off entire suburbs of Port au Prince and other cities, left 222,570 casualties with an estimated 80,000 corpses still missing. One and a half million people were displaced and the majority is still living in 1000 improvised camps, in tents or self-made shelters. The national and international relief effort has been hampered by logistical, co-ordination and leadership challenges. Six months after the event, reports suggest occasional distribution of food and poor water and sanitation facilities in many sites. The resettlement and reconstruction plan has been slowed down by disputes about land and property allocations. Security is very weak and the resettlement, the cyclone clouds, political unrest, and the continued exacerbation of economic divisions are the mountains beyond the mountain of the experience of the earthquake itself. And these have grown up in the shadow of the mountain range of decades of underdevelopment, political unrest, and corruption (The New York Times 2010).

In January 2010, the International Organization for Migration (IOM) was asked to lead the cluster co-ordinating humanitarian agencies involved in the management of the camps and to provide various forms of assistance, including psychosocial, to the populations living in them. The IOM psychosocial response plan has since focused on community mobilisation and participation, and has used the arts and social theatre widely as tools.

Psychosocial interventions, community participation and theatre: a rationale for Haiti
According to Vanessa Pupavac (2001), in western countries democratic participation has been increasingly substituted by the delegation of responsibility to a ruling cast. Politicians are no longer facilitators of democratic processes, but become super social workers, tasked with assessing, prioritising, and responding to risks with a therapeuticlike governance that transforms citizens from political subjects into clients-patients. For Pupavac, humanitarian and especially psychosocial programmes in emergencies may represent the internationalisation of the therapeutic governance of societies. In psychosocial paradigms, wars and disasters are often misread through the lenses of the alleged pathological effects that they can have on the population, rather than through the consideration of their root-causes. Programmes end up focusing on curing individuals, often by means of international models and expertise alien to local cultures, rather than on promoting local critical participation in the devising of responses. This process may be anti-democratic and smack of cultural and medical colonialism. By including community participation and mobilisation in the design of IOM's psychosocial programme, Pupavac's concerns were

considered alongside the unwelcoming attitude of most Haitians towards the international humanitarian presence. This critical attitude however coexists with a strong aid-culture. The resulting contradiction should not underplay the fact that both tendencies are bi-products of the same history of disastrous international interferences in Haitian internal matters (Caribbean Country Management Unit 2006), fed by the patent faults of the current humanitarian intervention (Schininà et al. 2010).

Theatre was deemed as an appropriate tool to promote active participation of the camp inhabitants and to build bridges between the communities and the service providers. Art and theatre are already a popular rather than an elite form of communication in Haiti, permeating social events, rituals, and healing practices (Gray 2008) due to their capacity to link ‘the visible and the invisible’ (Brook 1994). Haitian culture is in fact cosmos-centric rather than anthropocentric. Wellbeing results from the harmony that an individual is able to create with his/her context and the natural world, which includes spirits, ancestors, and materialisations of the so-called ‘invisible’ (McGill University, Division of Social and Transcultural Psychiatry 2010). Dance, rhythms and theatrical performances are associated with the different *lwas* (the voodoo spirits) and characterise a variety of specific ceremonies (Dash 2001). They facilitate relaxation and expression, and take place in group circles, thus reinforcing group ties. They have codified forms that connect the group to cosmological forces, giving containment to the sense of loss.

Activities

In the immediate aftermath of the earthquake, the Chaka Dance animation group, and the Planche theatre company were asked to create performances and dance animation sessions with the population in 19 priority camps. They gathered and entertained the camps’ residents, while informing them of the various animation, relaxation, participatory, artistic, and individual and group support activities that were going to be offered by Haitian professionals. Chaka Dance has for 20 years used traditional dance and music to educate children and adolescents from the slums, who are then involved as peer-animators. Planche is a community troupe of very young artists whose productions encompass staged performances, educational theatre pieces and workshops for youth.

Rituals were organised to strengthen community ties and mark important moments in camp life, such as relocations and calendar feasts. All rituals included a creative component bridging the needs and desires of the camp inhabitants with service provision. For instance, the spring and women’s day festivities resulted respectively in the creation of a camp tree with recycled material, and of an anthropomorphic installation called ‘Mama’ on whose branches-limbs the population can attach small messages highlighting problems, possible solutions and positive thoughts. These messages are regularly collected and discussed between camp inhabitants and the camp management team.

More importantly, interactive performance has been used to mobilise the community in the identification, prioritisation of and response to problems they are facing. These performances have been created in collaboration with Nif Company, a troupe of young graduates of the National School of Arts, which had been active in educational programmes in Haiti before the earthquake. Any time IOM psychosocial teams identify a simmering issue in one camp, they propose a set of

activities to the community to be discussed in a participatory fashion, including through the use of interactive theatre. If an interest is identified, Nif is called in to explain the purpose and approach of the theatre process to the community. If enough people agree to commit, a workshop between one and three weeks in length takes place. The workshop, organised in two-hour sessions a few times per week, initially focuses on physical training, work on rhythm and voice, and improvisations, including image-theatre sequences on different subjects. A group discussion about the problems identified follows, in order to prioritise them and select one. The following sessions focus on image theatre exercises and improvisations on the selected problem and lead to the creation of a collective dramaturgy, which is completed by training work on the characters. The performances are usually based on rhythms, songs, proverbs, and ironic scenes, compatible with the Haitian theatrical tradition. They are open-ended and include an interactive component in which the audience can discuss the issue, and suggest possible solutions. The rationale of Augusto Boal's Forum Theatre, in which unresolved problematic scenes are presented and the audience is asked to substitute the protagonist to pursue solutions, has been adapted by the groups to meet Haitian traditional participatory performative models and to complement the technical expertise of the Haitian facilitators. The public can therefore engage in the process, completing songs, mimicking dances, completing poems, or using the traditional form of the Krik Krak storytelling, which allows different people to make a given plot evolve in different directions. The solutions are then discussed, prioritised and developed by the community or they are shared with the camp management for their consideration.

The problems staged so far have included insecurity, overcrowding and water management, the difficulties in accessing education, genderbased violence, food distribution, the request to receive cash instead of food for work and issues surrounding relocation. The open-air performances are usually attended by small crowds of camp inhabitants, who actively participate in the creative brain-storming. In some cases the performances are one-off community events bringing to light some resolutions and requests. For example, in one camp, after an interactive theatre play on environmental health, the population decided to clean the canal on which the camp is built. They created a committee and then asked for and received funds for the necessary tools. Another example is presented in the box below. In one camp the participants in the workshops have created their own social theatre troupe in the camp, while in other camps the community has requested the theatre process to be duplicated multiple times to discuss different problems.

Apart from the small but significant positive results, an interactive theatre play on the theme of food for work and its inadequacies in responding to the emerging needs of the population led to participants requesting cash for work instead, since the value of food was decreasing in the market and other items in addition to food were needed. The agency managing the camp, however, not only did not accept the proposal, but also accused IOM of mobilising the camp inhabitants against them. On another occasion, during the most recent performance on the theme of access to education for children, a few members of the public started to protest during the performance, claiming that what they needed from IOM were practical solutions, not entertainment.

Scenes of daily life in Haiti open the performance. They are interrupted by drumming: the earthquake. Some people die; others are injured and struggle to survive. Later on, the first humanitarian help arrives in the form of a helicopter that throws enormous bags of rice, injuring some survivors and killing some of the injured.

A few days after, the survivors line up to receive the coupons for food distribution. A young man dresses as a woman to make his way to the less crowded women's line. When his turn arrives, the humanitarian worker distributing coupons sexually harasses and blackmails him (her). A fight begins and escalates.

The fight slowly transforms into a dance. The actors dance expressing with words and bodies the different related 'problems': hunger, anger and fear. The public is invited to sing adding other related 'problems'. 'Insecurity' 'lack of care', 'threatening intrusions of the national police', the 'oppression from gangs' are all added to the list.

The song now switches to the solutions, using the Krik Krak traditional method. At the end, the community makes a resolution to establish a committee, which will be in charge of a security and sanitation campaign in the camp.

In conclusion, the actors sing folkloric Haitian songs referring to the hope and the strength of the Haitian community, its fight for independence and its resilience. The audience sings and dances along.

Discussion

The last two episodes can be analysed on two levels. The first is political. They both confirm how the humanitarian approach to emergencies is often non-participatory in nature, and informed by a 'therapeutic governance of societies' tendency. Enabling populations to express, prioritise and advocate for their needs in this context can be perceived as an anti-humanitarian act by both humanitarian agencies and by the beneficiaries themselves, who are more used to a donorrecipient culture. However, this somewhat comforting analysis does not fully overcome the doubt that those participatory activities, limited as they are in scope and magnitude and included in a system that is overwhelmingly acting according to un-participatory models, instead of creating spaces of difference and change are serving as a front that just tries to make the situation look a tiny bit better. And the fact that some beneficiaries asked the humanitarian agency to provide those resources for which it was funded, and stop playing participatory theatre with them, may just be a request to stick to the real rules of the game.

The second consideration is technical in nature. Augusto Boal's Forum Theatre is a consolidated dramaturgical scheme that has largely been proved to foster participation, safe discussion, a confrontation between different points of view and a shared discovery of solutions. However, in this case, the rationale of the Theatre of the Oppressed was adapted to other dramaturgical forms that came from the Haitian background and practical experience of the theatre facilitators. These approaches fostered participation of the public in some, mostly reactive forms but were not well formulated as participatory discussion and problem-solving tools. The dramaturgy of the performance on 'food for work', for example, was largely designed as a piece of propaganda theatre and the one on access to education as a 'theatre in education' piece. They both promoted a reactive participation from the public who supported the ideas of the

conceivers (also members of the community) but it made the emergence on stage of different points of view among the audience very unlikely. Because of this the camp management and some members of the public respectively may have felt ignored as in those specific theatre presentations their perspectives, no matter if minoritarian, could not really be performed. A future technical challenge would be to try to adapt Forum Theatre's techniques to local theatre forms more systematically and specifically ones preferred by the Haitian artistic community without touching Forum's basic dramaturgical structure. Seeing if this is possible is the next stage of this work.

Conclusions

Placing the value of participation and prevention, and ultimately of democratisation over solely reactive social responses to natural disasters has been a learning experience from IOM's Haitian programme. The lesson, however, has still to be digested. Actions such as the ones described above are little, almost irrelevant steps in that direction, and sometimes they may still be un-participatory in essence. Technical and ethical challenges arise, but the importance of participation remains. A community's self-motivation and ability to identify their own problems is vital because, once the emergency passes and the international humanitarians leave, there will be only three things individuals can really count on: themselves, their community, and the knowledge that beyond this mountain there will always be another.

For all references please see bibliography.

Notes on the organization of sessions of Social Theatre¹ Guglielmo Schininà

The entire process, and each session of work, are organized according to three interacting models of drama work. Appreciation of the way these models should interact in the devising of a mid- to long-term social theatre workshop is important. The three models and their interaction can also help the organization of other psychosocial support paths, including psychological responses, psychotherapy and art-therapy.

- 1 The three applied models
 - The Drama Therapy Session Model (Jennings, 2019);
 - The Complex Circle Model (Schininà, 2004b);
 - The Embodiment Projection Role Model (Jennings, 2019).

1.1 Drama Therapy session model

This is a simple structure for the entire workshop and each single session of it. It comprises six steps:

- Contact.
- Contract.
- Warm-up.
- Main activity.
- Cool-down.
- Feedback.

All steps should be followed. The proportion of time dedicated to each of them in a session will vary according to the activity, and where the group stands in the process. For instance, in the beginning, the facilitator dedicates more time to the contact, while during later sessions the contact is much shorter. Each time the facilitators introduces a new mean or type of activity, the group should work on the warm-up more than the activity itself, but after a while the proportions will change. If an activity is particularly emotional, it will require a longer cool-down, for example. Note that representations for the others in the group or for the public are considered cool-down. For a list of games for each of the phases, see below.

1.2 Complex Circle model

This model regards the way the stimuli–games are organized in a session in relation to the interaction between the different members of the group. It is a model that respects the existing differences, and fosters coordination and collaboration rather than assimilation. It is particularly useful when working with groups of people with different abilities, of different cultural backgrounds, or when the aim is to enhance collaboration between diverse groups. It is crucial when working on problem-solving, because it lets anyone express their problems, avoiding stereotypes and augmenting the creative solutions to the problem.

The model posits that, while constructing the work group, the stimuli proposed should allow each and any participant to play in his/her own way, and gradually meet the others, without modifying the essence of his/her own way of playing the game, but just adding up to the others in a gradual and coordinated

¹ This article is an elaboration of the report of the Social Theatre training session of the course *Psychosocial Interventions in Migration, Emergency and Displacement* organized by the Scuola Sant'Anna di Studi Accademici e Perfezionamento and the IOM on a yearly basis.

manner. Only when all participants, slowly and gradually, have been involved in a linear relation on the same action, can the circle be created. The circle is not a venue where everyone does the same thing, but instead is one where each and every participant can enhance his/her diversity.

The exemplification of this model is found in all the sequences of games described below, which are based on the model: one, one plus one, one plus one plus one, one plus one plus one, and so on, until at the end the circle is formed. In the circle, each one is an actor for and spectator of the other, and each action arises from the collaboration of all participants, each with his/her specific understanding of it.

As a process, it is more difficult than one implying copy or assimilation, since it requires repetitions, trials and efforts to combine the existing, rather than doing something new together, and a certain fatigue. However, in the long run, this model proves to foster better expression, emergence of personal issues, and better and healthier group dynamics, based on collaboration. Therefore, as mentioned, this model is particularly efficacious when we work on problem-solving. One just has to be patient a bit.

Finally, this model very often helps to break the polarization of humanitarian–therapeutic interventions. These have been illustrated (Papadopoulos, 2001) in the humanitarian triangle.

Transforming the therapeutic and humanitarian relation, from the triangle in which a saviour helps a victim – and to do so also has to identify a perpetrator – to a circle in which everyone can collaborate with the others and add to a common discourse, helps in avoiding sclerotic attribution of roles, and therefore enhances participation. The solutions brought to the problem won't come from above, but will be suggested in a peer-to-peer fashion.

Technically, while the first days' sessions of work focus more on the construction of the linear relations and less on the circle, with the progression of the work, proportions will change and in later sessions the circle can be constructed very soon, after a quick replication of the linear relations.

1.3 Embodiment-Projection-Role model

The Embodiment Projection Role Model pertains to the progression of the contents of the exercises proposed in a workshop. According to Jennings (2010), the dramatic development of any human being happens in three phases. First comes the embodiment, such as playing with the body, copying the movements and facial expressions of the adults, cuddling, rolling and such. In the second phase, the small child starts projecting, bringing contents and expression out of himself/herself through objects of transition, such as drawings, models and playing with toys. Finally, the dramatic capacities of the child develop in role construction. The child starts impersonating different characters, “as if” they were someone else.

According to Sue Jennings, each session and any entire workshop path, to be efficacious, should follow the same progression, and start always with embodiment games, move to projection games, and finally to role playing. This is valid for children as well as adults.

Also in this case, each session should comprise this progression, but the duration of each step varies with the time and nature of the stimuli proposed. Most typically, the work of the first sessions will be more focused on embodiment, with little projection and role-playing, then there will be more projection, and finally more role-playing.

Combining the three models in a flexible dynamic is challenging, but necessary in problem-solving, in order to give space for each participant to express the problem, analyse it, formalize it, and receive solutions from the others that may really enhance his/her vision of his/her own problem and distressful situations.

The three models act on different levels: one on the organization of the session, another on the nature of the interaction we create among participants, and the third on the progression of the nature/contents of the games proposed. As such, they can interact. The games sessions below illustrate this interaction.

The games and techniques proposed include

- Games (with a purpose) from various sources.
- Dramatherapy (the tree sequence).
- Image theatre, images of transition and Theatre Forum from Augusto Boal's the Theatre of the Oppressed.

2 Games

2.1 Colombian Hypnosis

- Contact (can also be used as warm-up);
- Embodiment;
- Linear relations in couples, triplets, all group.

Participants were asked to choose a partner of the same height, and, if willing, of the same sex. The partner on the right side, the leader, holds his/her hand open, the partner should follow the movement of the hand with his/her nose, keeping a maximum distance of 5 cm. The leader can move in the space, and play on the different heights, speeds and difficulties of movements. The only constraints are: (a) the movements of the hand should be realistically possible to follow for the partner; and (b) they have to be safe, not putting the partner at risk. Roles are exchanged.

In the second phase, a third person is added to the group and the one in the middle leads the other two, each with a different hand. Roles are exchanged.

In the third phase, a cue is created. One leads, the other follows. Each one in the group follows the last one of the cue with his/her nose, not further than 5 cm from a point in the body of the person in front.

People sit down and introduce themselves with names, backgrounds and such.

Note: Contact is created following the Complex Circle Model, with intensity but without physical contact.

Age: 8 and up.

2.2 Basket of wishes

- Contact (framed brainstorming);
- In the circle.

Step 1: Each participant writes on two different small pieces of papers (or Post-its) something he/she would like to gain from the training, and something he/she would not like to gain from the training.

Step 2: Each participant sticks the papers on two respective baskets, the "want" and "do-not-want" baskets. The baskets can be drawn on flipcharts on the wall, or created with carton boxes, for example.

Step 3: All participants can read the other's definitions, and select one and only one that they agree with (not their original one). They signal it with a colour spot, a cross with a pen, or a sticker, according to the available materials.

Step 4: The most chosen “wants” and “do-not-wants” are selected and transferred to a flipchart, and a discussion is held with the group, to create contact based on the identified expectations.

Note: This game is optimal with adolescents and adults, especially when working with bigger groups. However, children from 8 years of age and up can also do it, and if we use drawings instead of definitions, can be done with smaller children as well.

2.3 Walk, faster, run, stop

- Warm-up;
- Individual in the group;
- Embodiment.

Step 1: Keeping silent and concentrated, walk in the space.

Step 2: Fill each gap that is created on the floor, without going in circles, and trying not to bump into/touch the others.

Step 3: Walk with different speeds indicated by the trainer: slow, very slow, fast, faster, run, stop. At the stops, participants should freeze, keeping the energy.

Age: 8 and up.

2.4 The body drives

- Warm-up;
- Individual;
- Embodiment.

Step 1: Walk in the space, as per the exercise above.

Step 2: A part of the body, indicated by the trainer, leads and drives the movement. It can be the nose, the right or left shoulder or the chest, for example.

Note: The facilitator asks the participants to analyse how the movement and the body posture change with the different drives.

Age: 8 and up.

2.5 Glances

- Warm-up–relation–concentration;
- One plus one;
- Embodiment.

Step 1: Walk in the space as per the exercises above.

Step 2: While walking, look at the others.

Step 3: Look at the others in their eyes.

Step 4: Keep any single look as long as your movement consents. Do not stop the movement to look at a certain person.

Step 5: Participants may laugh, but should not talk.

Step 6: Participants are now allowed to keep individual glances for longer and modify their movement accordingly.

Step 7: When one feels particularly comfortable in looking at someone else, the two start looking at each other.

Age: 14 and up.

2.6 Elastic band

- Warm-up–relation–concentration;
- One plus one;
- Embodiment.

Step 1: Divide the group into couples.

Step 2: Couples stay one looking at the other.

Step 3: Imagine that an elastic band connects the foreheads of the two individuals in the couple.

Step 4: The band gets shorter, longer, more or less elastic by indication of the trainer. Each couple tests the resistance of the elastic.

Step 5: The same moving in the space.

Age: 10 and up.

2.7 Glue walk

- Warm-up–relation;
- One plus one plus one, and so on;
- Embodiment.

Step 1: Walk as in the Walk, Faster, Run, Stop exercise (section 2.3 above), but this time glued to another person. You walk as a unit.

Note: This can be attached to the end of the previous exercise (the elastic gets shorter and shorter).

Age: 10 and up.

2.8 The blind

- Relation–trust;
- One plus one;
- Embodiment.

Step 1: Divide into couples.

Step 2: Each one close their eyes and try to remember the space.

Step 3: One in the couple (the one on the right or the left) opens his/her eyes, and drives the other around the space.

Step 4: The pace and speed of the movement around the space has to be found in relation between the two, so that the one with closed eyes should feel comfortable in the movement.

Step 5: Stop, open the eyes.

Step 6: The same, exchanging roles.

Age: 14 and above.

2.9 Flying greetings

- Relation–group building;
- One plus one plus one, and so on;
- Embodiment.

Step 1: Walk in the space, glance at the others, leave the first glance only when you find a second.

Step 2: When each participant feels so inclined, he/she can go towards the person, say the name, shake hands and continue.

Step 3: Continue doing it just shaking hands.

Step 4: Each one should always have a hand free and a hand busy shaking another hand.

Step 5: Do it faster, faster, faster, stop.

Age: 8 and up.

2.10 Breathe the vowel

- Group building, voice warm-up;
- In the circle;
- Embodiment.

Step 1: Sit with crossed legs, or lie down.

Step 2: Inhale and exhale, concentrating on the various steps of this automatic movement, forcing it in a regular pace. Repeat a few times.

Step 3: While inhaling, try to pass the air from the lungs to the stomach, and back. Repeat a few times.

Step 4: Repeat the exercise, emitting a vowel sound while exhaling. Start with A, continue with E, I, O, U. Repeat a few times each.

Step 5: To facilitate, participants are asked to imagine that the emission of the sound pushes the movement of a very little man from the mouth further. For A, the man is pushed straight, for E obliquely, for I up, for O straight down, for U obliquely down.

Step 6: All together, each one choosing his/her own vowel.

Step 7: The same, with no indications from the facilitator.

Step 8: Same as step 6, but modifying the pitch following a scheme (or similar).

Step 9: The same for frequency.

2.11 Body sounds

- Group building, rhythm preparation;
- In the circle;
- Embodiment.

Step 1: Each one, individually and sitting on the floor, explores the sounds that can be produced by the contact of two parts of the body. Explore different possibilities, not only the most obvious ones, for five minutes or more.

Step 2: Choose the sound you liked most.

Step 3: A few volunteers show how to produce their favourite sound to the group. The group repeats it all together.

Age: 13 and up.

2.12 Walk the vowel

- Group building, rhythm creation;
- In the circle;
- Embodiment.

Step 1: Walk as in Walk, Faster, Run, Stop exercise (section 2.3 above), emitting a vowel of choice. Stop when you need to inhale.

Step 2: At this point, the work focuses on pitch, which is the acoustic version of speed in space (by walking). The faster you walk, the more acute is the sound, and vice versa.

Step 3: Frequency corresponds to the pace and stop–walk relation.

Step 4: Add the body sound.

Step 5: Interact with the others. The interaction does not come from copying the others, but from adding your own rhythm to one of the others.

Step 6: Walk together with the person that you feel as more compatible, with each one in the couple keeping his/her own rhythm, but combining them.

Note: Keep in mind that it is not the volume that goes down but the pitch. It is important to take time, not to rush. Ask participants to calibrate the pitch according to what they are listening to.

Avoid imitating the other, but try to keep listening to them. Ask them to calibrate the frequency according to the length of their breath.

Age: 14 and up.

2.13 Japanese greetings

- Group building, rhythm creation;
- In the circle;
- Embodiment.

Step 1: Everyone in a circle.

Step 2: Each one in the group shows his/her own rhythm and sound to the others. The others repeat it all together.

2.14 Maestro!

- Group building;
- In the circle;
- Embodiment.

Step 1: Participants are divided into groups of four.

Step 2: Each group is like a small orchestra of rhythms.

Step 3: The orchestra is led by each member of the group, one at a time, for three to five minutes each. The director leads the others in terms of activation – stop, pitch, frequency, volume – with movements of the hands.

Step 4: Each group chooses the best director by consensus.

Step 5: All groups in a circle. The first group starts. The director brings his/her orchestra to the maximum and to the end. At the end, the following group starts.

Step 6: The same in a closer circle. When the director thinks his/her group is ready, s/he leaves the lead and joins the group with its own rhythm. In the circle, the orchestras mingle their respective rhythms up to a common polyphonic one, until by consensus, and gradually, they arrive to an end.

Note: The facilitator gives only basic indications, but the real direction is left to the directors first, and to the group at a later stage.

Age: 13 and up.

2.15 Walk in the elements

- Warm-up on metaphor and imagination/contact;
- One by one;
- Embodiment.

Step 1: Like in Walk, Faster, Run, Stop exercise (section 2.3 above).

Step 2: The same but walking through different elements: sand (hot and cool), asphalt (boiling and normal), snow and ice, pointy rocks, seashore, deep sea. Dedicate two to four minutes to each element.

Age: 8 and up.

2.16 Shark

- Contact using imagination;
- One plus one, plus one, and so on;
- Embodiment/projection.

Step 1: Participants are “swimming in the sea”. It is cool, sunny and pleasant. If participants can’t swim in real life, they can imagine walking fully covered by water, except for their heads .

Step 2: The facilitator disseminates on the floor carton sheets, or papers of different sizes (A4, A3, flipchart size).

Step 3: The facilitator calls from time to time for a shark. When a shark is called, participants should reach the closest rock (pieces of carton or paper) to be rescued. They should be with both feet on the paper, or anyhow not touching any portion of floor out of the paper with any portion of their bodies.

Step 4: Between shark’s calls, the participants “swim” freely. During those breaks, the facilitator progressively reduces the number of sheets on the floor.

Step 5: At the last call, only two sheets are left, forcing participants to cooperate or fight to be rescued.

Step 6: Comments.

Note: Better to link the shark game to the Walks in the Elements game (section 2.15).

Age: 14 and up.

2.17 Walk with closed eyes

- Warm-up; preparation for closed eyes exercises;
- One by one;
- Embodiment.

Step 1: Like in the Walk, Faster, Run, Stop exercise (section 2.3 above), but segmenting the movement. Walk, stop, take another direction, walk, stop, take another direction, and so on.

Step 2: Do the same movement. Walk, stop, take another direction, walk, stop, take another direction, with both feet on the paper, or anyhow not touching any portion of walk, and so on.

Step 3: The same, but closing eyes when reaching to the chosen point.

Note: People may want to put their hands in their pockets, if for religious reasons they can’t touch people of a different gender.

Age: 10 and up.

Step 8: While participants were with eyes closed, the facilitator had put an A3 paper and a set of colours close to each participant. (Better to use dry colours.)

Step 9: when all participants open their eyes, the facilitator asks them to draw the tree they were, in the season they preferred. The drawing can be descriptive or abstract. It is important to reflect the tree “you were”.

Step 10: After the drawings are completed (10 minutes), participants are asked to name the tree and to assign it an age (both written on the paper).

Step 11: On a separate sheet of paper write down the history of your tree beginning with ree and tn a time there was a tree (its name)...”

Step 12: Split in groups of six. For three minutes, you are given the possibility to tell the story of your tree. At the end, for another three minutes, others can raise a question (in relation to the tree and its history) and the person has the right not to answer.

Step 13: Each group creates a theatre image of its own forest, encompassing all individual trees.

Step 14: In the circle, each group represents its forest for the others by sequences/snapshot of images.

Age: 12 and up.

2.20 Path of the islands

- Imagination, expression, sharing personal feelings and stories through metaphor, autobiography;
- One by one, one plus one, in small groups, in the circle;
- Embodiment/projection/role-playing.

Step 1: Walk in the space as different means of transportation (bicycle, train, airplane, and so on).

Step 2: Walk in the space as if you were heading to different activities (a funeral, a date).

Step 3: Walk to a place you really like from your past or present.

Step 4: Stop. Close your eyes. Sit down or lie down.

Step 5: Imagine you are in the place. Segment the portion of this location closest to you and imagine it is like a very small island surrounded by the sea, and you are in it.

Step 6: The facilitator helps, asking to recall colours, shapes, temperature, sounds, surface under the feet, body, people you were with. He/she does it several times.

Step 7: The facilitator asks the same questions. This time he/she touches someone on the shoulder, and the person replies loudly.

Step 8: All participants are asked to reproduce the sounds in their respective islands, all together, like in a choir.

Step 9. Stop. Open your eyes.

Step 10: You have 15 minutes to construct your island with any available material (carton boxes, coloured papers, paint and brushes, staplers, glue, cellophane tapes of different sizes and textiles of different colours are made available). The island is constructed in a way that you can sit in it or relate to it.

Step 11: While sitting in your island, create a treasure map. Use an A3 paper. Draw your island, small, giving it a shape, a colour and a name.

Step 12: Draw all the islands that come before and after the one above, in the treasure map of your life. Give them shape, colour and names.

Step 13: Finally, mark the location of the treasure if any, and the path to reach it.

Step 14: Stand up and go around, observing the others' islands. While visiting the other islands, you may have seen something that relates to yours.

Step 15: Groups of three persons are formed based on the above.

Step 16: The groups present their treasure map (only what they want to share) to the others in the group. Others can ask questions, but the teller is not obliged to give an answer.

Step 17: Merge three islands in order to perform a theatrical action resulting from the discussion. The theatrical action is presented to the other groups.

Age: 15 and up.

3 Body images

The main focus is on body images and how to express and discuss images and how to express and discuss issues and solve problems through body images. Images of the body bring to embodiment (by default), projection (since you use your own body to express a feeling or a concept), and role.

3.1 House in the wind

- Warm-up, intro to images;
- One plus one plus one;
- Embodiment (and little projection and role-playing).

Step 1: Divide the participants in groups of three. Two on the sides shape a house with their arms as the roof, while the third person stays inside it. One person should be by himself/herself.

Step 2: The facilitator calls for a bad meteorological or catastrophic event which destroys the house (rain, snow, storm, tsunami and earthquake). For each of these events, the house breaks up, and subsequently the trio is dissolved and they move in the space as if in the rain, snow or other event.

Step 3: The facilitator says stop. Participants have to recreate houses and inhabit them as soon as possible. The person who manages to take refuge in the created shelters has to illustrate the condition s/he escaped from through a body image. The one who is left out should call for the next disaster.

Age: 6 and up.

3.2 Surprise image

- Warm-up, intro to images;
- One plus one;
- Embodiment and projection.

Step 1: In pairs, one person stands still, then breaks his/her posture, assuming a casual body image in which he/she freezes.

Step 2: The other completes the image of the first, attributing it meaning.

Step 3: Repeat the same a few times.

Note: Ask the participants to exaggerate the image and make it as explicit as possible.

Age: 12 and up.

3.3 Walking images

- Warm-up, intro to images;
- One plus one;
- Embodiment and projection.

Step 1: Walk in the space.

Step 2: The trainer suggests feelings.

Step 3: Stop. Participants should freeze in a body image of the feeling.

Step 4: Exaggerate the image.

Step 5: Look at the other images while keeping yours.

Step 6: Do it a few times.

Age: 13 and up.

3.4 Image by image

- Warm-up, intro to images;
- One plus one plus one, and so on;
- Embodiment and projection.

Step 1: All participants are in a circle.

Step 2: One person goes to the centre with an image.

Step 3: Another participant volunteer completes the given image.

Step 4: The first image leaves, the second stays.

Step 5: Same as step 3, a few times.

Step 6: The same, but this time the first image does not leave, and images sum up the previous ones, until all the group creates a common image.

Step 7: Each participant adds a sound, or a word and a small movement to the image. Participants perform it all together, activating the group image.

Note: The meaning of the first image is not told at first, but can be told in later repetitions.

Age: 14 and up.

3.5 Images in a circle

- Expression and discussion through images, solidarity, pluralization of problems;
- In the circle;
- Embodiment/projection/role-playing.

Step 1: All standing in a circle, with backs turned to the inner part of the circle, half a metre away from the neighbours.

Step 2: The trainer calls a word (such as “love” or “family”) and counts to three. At three, each one should turn facing the centre of the circle, with a boy’s image illustrating the feelings and thoughts that first came to mind when hearing the word.

Step 3: Exaggerate the image.

Step 4: Look at each other.

Step 5: Repeat a few times, with different words. At a certain point, participants can suggest the words.

Step 6: After a while, people are asked to go towards images that are similar, connected or in a cause-effect relationship with theirs.

Step 7: They create a common image.

Step 8: They create a common moving image.

Step 9: They create short performances, starting from the images.

Step 10: Alternatively, discussions on the differences between common images can be initiated.

Age: 14 and up.

3.6 Segmented dance

- Warm-up, introducing sculpturing;
- One by one;
- Embodiment.

Step 1: Walk, segmenting your movement according to body parts.

Step 2: Control every single movement of a part of your body: neck, head, shoulders, arms, hands, legs and feet (one by one).

Step 3: Explore the variety of movements you may do with it.

Step 4: Be still. Move only the part of the body called by the facilitator.

Step 5: You can do it following music. The body stays rigid apart from that part.

Step 6: The facilitator calls more than one part. The participants move/dance only with those.

Age: 12 and up.

3.7 The puppet

- Warm-up, introducing sculpturing;
- One by one;
- Embodiment.

Step 1: In pairs, one stands, the other lies on the ground.

Step 2: The one lying down is like a puppet. The one standing moves the puppet.

Step 3: The puppet has imaginary ropes attached to any junction and other parts of the body (toes, ankles, knees, hips, shoulders, neck, head, elbows, wrists, hands).

Step 4: The one standing moves the puppet with the ropes, until the puppet can sit, stand or even walk.

Step 5: Reverse roles.

Age: 14 and up.

3.8 Balloons

- Warm-up, introducing sculpturing;
- One plus one plus one, and so on;
- Embodiment.

Step 1: Still in couples, one behind the other.

Step 2: The one in the front is a deflated balloon.

Step 3: The person who stays behind blows up the balloon, blowing on the shoulder of the person in front. The person in front mimics the blowing up with the entire body.

Step 4: When the balloon is fully inflated, the person behind punctures it as if with a needle and the one in front mimics the rapid deflation of the balloon.

Step 5: The same in groups of four. One blows up and three mimic the balloon.

Age: 8 and up.

3.9 Mirror

- Warm-up, introducing sculpturing;
- One plus one plus one, and so on;
- Embodiment.

Step 1: Divide participants into groups of five, one facing four in a line.

Step 2: The one does a very precise, segmented sequence of movements, the other four mirror it.

Step 3: The one in front is replaced by one of the other four after two or three movements, until everyone is mirrored.

Age: 10 and up.

3.10 Sculptures

- Expression of contents in the group, discussion, solidarity;
- One plus one plus one, and so on;
- Projection/role-playing.

Step 1: Divide into groups of six.

Step 2: Each person creates an image on a subject sculpturing the others' bodies.

Step 3: Each group memorizes the six images.

Step 4: Each group puts them in a sequence.

Step 5: Each group presents the sequence of images to the others.

Step 6: Each spectator should consider whether each image belongs to her/him and, if yes, what would be his/her individual image within that image, and where does he/she locate himself/herself in relation to it?

Step 7: Consider together if images repeat themselves across groups, different categories of images, and so on.

Step 8: Images are repeated and voted on. Three are chosen.

Step 9: The three images are presented again. The public can intervene, adding their own image to the given one.

Step 10: Discussion follows.

Age: 14 and up.

3.11 Images of Transition

- Problem-solving;
- In the circle;
- Projection/role-playing.

Step 1: Everyone in the circle, or sitting in front of an empty space (stage).

Step 2: A volunteer creates an image of discomfort related to his/her daily situation of oppression. The volunteer can do it by himself/herself or sculpturing a maximum of two other participants, still taking the role of the oppressed himself/herself.

Step 3: Someone else substitutes the protagonist in the image, mirroring him/her. The Image of Oppression is created.

Step 4: The protagonist creates, with the same process, the ideal image, representing how the protagonist would like the situation to be instead.

Step 5: The protagonist sits among the audience with the facilitator, while the images stay onstage.

Step 6: Each one from the audience can come onstage and do the image of transition, the image of how the real image can be brought to the ideal one.

Step 7: Each time one brings an image of transition onstage, the facilitator asks the protagonist if she/he accepts it or not. If yes, the image stays in the background.

Step 8: At the end, all selected images are shown, one by one, the public votes the most suitable one, and the protagonist selects the most suitable one for himself/herself.

Step 9: Discussion can follow.

Age: 15 and up.

4 Role

4.1 Character-building

- Creative expression;
- In the circle;
- Projection/role-playing.

Step 1: As in Walk, Faster, Run, Stop exercise (section 2.3 above).

Step 2: As above, stretching.

Step 3: As in “the body guides”.

Step 4: As in segmented dances.

Step 5: Stop, close your eyes and think about a funny person that you met recently on your way. You do not know him, you just saw her/him once or a few times. Try to remember her/him, and then open your eyes.

Step 6: Walk trying to impersonate the funny person. While walking think about his sight, his mouth, the head movement, the neck, shoulders, arms and hands, pelvis, spine, legs, feet, and so on.

Step 7: The same adding a rhythm, a sound or a word.

Step 8: Exaggerate the most characteristic elements.

Step 9: Explore the dominant feeling of the funny person and enact it.

Step 10: Explore the opposite of that feeling and explore how much of this feeling can be expressed by your character, and enact it.

Step 11: Everyone stops.

Step 12: Stop. The person whose shoulder is touched enacts the character, exaggerates it to the maximum and walks it around until he reaches another person of his/her choice, who does the same.

Step 13: The same until everyone is done.

Age: 12 and up.

4.2 Character building variant

- Re-elaboration, creative distancing;
- In the circle;
- Projection/role-playing.

As above, but enacting an oppressor from your past or present experiences.

Note: in the variant, it is important to perform and enact the funny elements of your character and transform them into a mask that contains a ridiculous element, and walk around the space with it.

Those who drop out of the scene, because they cannot find a funny element in the character, or because they are tired, may go back to stage without the funny element, or act while being seated. If uncomfortable, they can withdraw. Those who found the ridiculous element remain on stage and emphasize it.

To close the variant, one uses two games:

- You shower out the character, with individuals and the collective acting like showers.
- In a circle, each one expresses a snapshot of the way he/she feels through an image. Create a collective image and dynamize it through sound and movement, and make a sound loudly in order to get rid of the feeling.

Ask people who still feel uncomfortable to speak up.

4.3 Forums

- Problem-solving;
- In the circle;
- Projection/role-playing.

Step 1: In the circle, persons who are facing an everyday oppression are asked to discuss it.

Step 2: If the group feels inclined to work on one of the presented oppressions, it votes for it. In this case, since the Variant of the character-building game had left two participants still uneasy about their oppression, this passage was disregarded and the oppressive situations treated were those of the above-mentioned participants by default. This should always be the case.

Step 3: The protagonists are asked to build and direct a short performance. In the performance, no longer than eight minutes, the oppression should be presented clearly and unsolved. The scene should contain the oppressed (the protagonist), the oppressor, and eventual third figures, who could act on the situation

(colleagues, family, friends, etc.). The roles have to be clear, almost stereotyped. The protagonist can choose a few other participants to build the scene, and does it in a separate space.

Step 4: The performances are presented on stage. The first time, the audience is asked to look at it carefully and (a) analyse if the scene relates to him/her, and (b) analyse how the person can overcome the oppressive situation.

Step 5: The scene is presented a second time. This time, the audience can stop the scene at any given time to (a) substitute the protagonist, (b) substitute the oppressor but only to make it worse, or (c) substitute one of the third figures for realistic solidarity actions.

Step 6: Once on scene, the new protagonist should try to solve the problem. At the end, the original protagonist accepts or not the proposed solution, and the audience does as well.

4.4 Forum. A variant

If the oppression is more an internalized feeling than a socioeconomic or sociocultural one than in step 4, the audience analyses if the scene relates to him or her, but also which feeling/attitude is provoking the weakness of the protagonist.

Step 6: The audience members who feel so inclined transform the identified weak point in an image, which is brought on stage.

Step 7: The scene is repeated. The weak point images are on the side.

Step 8: Whenever the protagonist is falling in the weak point identified by the audience, the participant who made the respective image advances on stage to make it visible to the protagonist. The protagonist will therefore try to overcome the weakness. If the “image” thinks this is happening successfully, it goes back, ready to come back visible if the problem occurs again.

At the end, the protagonist speaks out his/her feelings and whether changing attitudes and winning certain identified weak points may help her in life, based on what happened on the stage.

This work is particularly suitable for adolescents, as they tend to feel stuck, as if the situation can't be defined by them. This is even truer for migrant and refugee adolescents, who are not used to be given a choice. Once the problems are identified, it is not the facilitator who should tell them the solutions, but the peers, according to their own personal experiences.

5 Feedback

Feedback can take different forms:

- A diary can be created at the beginning of the workshop. Each participant creates his/her own, by folding four A4 papers in half and drawing the cover page. The diary is absolutely personal, and at no point will the participants be requested to read it to others, unless they feel like doing so. At the end of each session of work, the facilitator gives 2 to 10 minutes to the participants to express their feelings, uneasiness, doubts and such in the diary. Moreover, the facilitator poses some questions to direct the reflection on particular games.

- In the circle, each one could give a personal and professional feedback on the work session. The modality may change according to the activity of the day, so that feedback could be given with one word, one sentence, a body image, and the like.

For all references please see bibliography.

Further Reading:

Psychodrama:

Moreno, J.L. (1987)
1987 *The Essential Moreno*

British Psychodrama Association (BPA) (2019)

American Society of Group Psychotherapy and Psychodrama (ASGPP) (2019)
(not recommended in emergencies due to timing, necessary skills, settings and quality of the traumatic experiences)

Dramatherapy:

Jennings, S. (1994)
Tools: Sue Jennings series for Speechmark, including manuals on Creative Drama, Creative Storytelling, Creative Puppetry, Creative Mask for children and adolescents, and adults.

Social Theatre:

Schininà (2004c)

Practices and Examples:
The Drama Review 48 (3)

For practices and examples on the differential use of dramatherapy and social theatre:

Jennings, S. (2009b)

For practices and examples of the use of social theatre in refugee settings:

Balfour, M. (2013)

Playback theatre:

Dennis, R.
2004 *Public performance, personal story: a study of playback theatre*. Griffith University, Brisbane.

London Playback Theatre
2019 Available from <http://londonplayback.co.uk/> (accessed 21 May 2019).

Play Therapy:

O'Connor, K. and L. Braverman
1996 *Play Therapy Theory and Practice: A comparative presentation*. Wiley, New York.

Theatre of the oppressed:

Boal, A.

2008 *Rainbow of Desire*. Routledge, London.

2010 *Games for Actors and Non Actors*. Routledge, London.

2010 *Theatre of the Oppressed*. Routledge, London.

Games:

Pitruzzella. S. (2006)

Terre des Hommes Manuals (2007, 2012)

Here We Are - Social Theatre and Some Open Questions about Its Developments

This is the original manuscript for the article 'Here We Are - Social Theatre and Some Open Questions about Its Developments'. It was written by Guglielmo Schininà; published in the *Drama Review*, 48:3, (T183), Fall 2004, pp.17-31.

The published article can be found at:

https://www.jstor.org/stable/4488568?seq=11#metadata_info_tab_contents

Origins

Anthropologists and historians do not agree on the origins of ritual and theatre. According to René Girard (1972), Jacques Heers (1983), and Claudio Bernardi (2000), just to mention a few, at one time there was only religious ritual. However, others maintain that ritual has always been social and has regulated the social functioning of not only human groups, but also groups of animals from the prehuman era (Bonino 1987; Eibl-Eibesfeld 1989; Schechner 1993). Among those who believe the latter view are those scholars who think that the origin of ritual is biological. Victor Turner's research, for instance, tended to stress the biological identity of human beings and a rigid division of the functions that regulate the instincts, emotions, and rituals according to the different cerebral regions (Turner 1990). Paul Ekman, with his comparative analysis of the facial expressions of emotions in the human face stresses the bio-neurological origin of these expressions and claims that these are not determined by cultural, historical, environmental, and social specificities (1982).

Those were the theoretical tendencies of the theatre at the beginning of my theatre experience. Today I work with theatre in places affected by war and other crises usually provoked by ethnic and cultural differences and economic disparities (see Schininà 2001, 2002a, 2002b). During my fieldwork, I arrived at the conclusion that the value of theatre does not lie in its capacity to emphasize what unifies human beings, but rather in its potential to emphasize their differences and to create bridges between them. I believe the theatre should work at the limits and the borders—and not at the center—of what is defined as "humanity."

The research mentioned above was scientifically motivated but paved the way and gave theoretical justification to the search for a universal means of communication that was to be found in the unifying factor of the body. This search led to the political and then artistic failure of the new theatre. Its focus was indeed centered on something apparent but not substantial. Even if there are elements human beings have in common, there are, at any level even the biological one—big differences. Even in everyday life, as Boal writes, the job one does or one's social class "mechanizes" one's body (1974). If we concentrate on the unifying factors, we create elites who do not act in history; we position them as somehow existing "above" or removed from the social and relational dynamics of identity formation. If we work on the differences among and within all people, we might be able to turn conflicts into peaceful contrasts and exchanges—into ways of relating.

Evolution

What theatre scholars do agree on is that at a certain point, either following its development, or recuperating its original characteristics, social ritual became independent from religion. This process helped the theatre become, after many centuries, an autonomous form of human action. According to Turner, industrialization prompted the disintegration of the former integrity of the well-organized and all-encompassing religious gestalt that was the ritual of liminal societies. As societies modernized a space opened for a number of performance arts such as theatre, ballet, opera, cinema, the novel, poetry, music carnivals, processions, popular theatre, sporting events, and many others that Turner dubbed "liminoid" (1982). Thus, there was a transition from a collective and compulsory ritual that was a self-representation of communities and an enforcement of shared and common values through the symbolic inclusion of dissent and marginality in the system, as in Greek tragedy, to the theatre as part of the set of individual, optional activities operating in spare time and by means of the entertainment and arts industries. The economic revolution of industrialization led to a professionalization of the theatre and the specialization of the theatre artists, who could only be admired by those able to buy tickets. The primary socioeconomic "draw" to attend the theatre varied from century to century, from the actor to the playwright, and then to the director and then back again.

I am Sicilian. I grew up in an environment where the main community and social events were, and in many cases still are, processions of statues of the saint protectors of the different towns and villages (usually a female saint: Agata, Rosalia, Lucia, the Mediterranean mother *Addolorata*, the fishermen's Lady of Portosalvo) as well as the community-based rituals and performances of Holy Week. They were and are organized by the different social "confraternities or professional associations. The Catholic Church often considers them to be pagan, even when it is deeply involved in the process. Therefore, I know from experience that the divisions between religious and social ritual, between symbol and representation, and the strict evolution of ritual into commercial theatre do not necessarily apply to all the cultures and communities in the Western world. I have traveled enough to understand that these divisions do not apply to other cultures and continents, certainly not to most of the African cultures. What we are describing here is only the mainstream of what has been "globally" defined as theatre in the last century in the Western academic and cultural environments.

Revolution

Regarding this mainstream: in the 1950s, following Artaud's fascination with the Balinese dancers he saw at a colonial exposition in Paris in the 1930s, the search for a new "ritualization" of society began within the "liminoid" sphere of entertainment. This search would give back to the theatre its fundamental role and heritage of political intervention, peaceful redefinition of the rules of the society, cultural discussion, and social therapy. The starting points of this new transition were the experiences of Julian Beck and Judith Malina, and then, also in the USA, Richard Schechner's Performance Group, Luiz Valdez's Teatro Campesino, Peter Schumann's Bread and Puppet Theatre; Augusto Boal and Vianna Filho in Brazil, and many more groups in South America; and Jerzy Grotowski, Peter Brook, and Eugenio Barba in Europe. In the meantime, anthropologists such as Erving Goffman (1959) began to study the importance of representation, with its ritual and performative aspects, in everyday life. On the other hand, the traditional playwright and innovative movie director Pier Paolo Pasolini, in his "Manifesto per

un nuovo teatro, wrote that the theatre is 'anyhow, in any case, always and everywhere a rite' (1968)¹. Numerous other experiences seemed to corroborate those of the founders of this new theatre movement.

In the 1970s, the search for new forms of social and political participation found in this transitional theatre one of the strongest means of communication and symbolic self-representation, as well as a powerful cultural arm. Therefore, from a theatre perceived as part of show business, a widely disseminated theatricality evolved and infused schools, institutions, political groups, marginal communities, suburbs, and cities, while new models of dramaturgy emerged, such as collective (ensemble) work and the workshop-theatre. The first trend took the name "community-based theatre" in the States (see Schechner 1998); and in Italy, France, and neighboring countries, a similar trend was known as "theatre animation" (Rostagno 1980). This latter definition includes all decentralized, educational, recreational, and community-based social activities using theatricality and performance. The second trend took the "new theatre" (De Marinis 1987). These two trends have much in common, since they both refer to what Peter Brook calls the "third culture" (1987). As Bernardi pointed out (1996), according to Brook three cultures exist: the collective, the individual, and the culture of the relationship. The latter is for him the proper culture of theatre because of the theatre's ability to create bridges between what is usually divided within and among individuals and communities, between the micro- and the macrocosmos, and finally between the visible and the invisible (Brook 1987).

Inclusion

The relationship between the visible and the invisible in the 20th century has been culturally defined by the relation between the visible and the repressed. The long-standing link between theatre and madness is an example and symbol of the relationship between theatre, diversity, and marginality in general. Madness, perceived as tragic awareness that displays the truths present in the repressed part of the human being (desire, violence, and death), is the focus of the history of written dramaturgy: from Oedipus to Hamlet and Othello, to the abnormal psychology of the characters of 1950s American dramaturgy (Tennessee Williams, for example), to the theatre of the absurd. Moreover, over the centuries, the religious and social rituals of many communities have used madness as a justification for an explosion of the repressed in the social field. This included openly criticizing power and rules and performing their symbolic destruction on specific ritual days when everyone was allowed to be "fou" crazy (Heers 1983).

In the second half of the 20th century, and especially during and after the 1970s, the relationship between theatre and mental health evolved and took on new forms. The first such form is the use of theatre as therapy. The most well known methodologies are Jacob Moreno's psychodrama (Moreno 1947), dramatherapy (Jennings 1997), and most recently the "second phase" of the Theatre of the Oppressed (Boal 1990). The underlying idea is that the characteristics of psychosis or psychological uneasiness are the complete or partial loss of one's sense of one's own proper limits and the inability to relate to others or communicate with reality. Theatre, on the other hand, is a relational and symbolic form of communication that structures personal experience in relation to a particular context and the world (Bertoni 2000). The second form is more closely linked with the experiences of theatre animation and

community-based theatre that were perceived in the 1970s as valid instruments to facilitate the community work of a "third-psychiatry" aimed at the deinstitutionalization of psychiatric patients and the perception of psychiatric illness as a social, rather than a medical, phenomenon (Basaglia 2000). Theatre animation/ community-based theatre, with its ability to create relationships, to include marginal groups, and to work on a group's creative self-representation for the purpose of social communication, was perceived as a useful instrument for empowering psychiatric patients and helping to erase the stigma that marked them.

Recession

With the defeat of the ideals of the political movements of the 1960s to 1970s, theatre animation and community-based theatre faced a crisis in the 1980s. At least this was the case in Italy, where the demand for new forms of participation declined, leaving space for a new individualism. Drama therapy and psychodrama, which had become popular, were largely used and sometime misused in therapeutic private practices. Ensembles of the new theatre faced a crisis in the same period because of their obsession with a universal language to be found in the transcultural value of the body.

Reasons for this obsession differed. Artistically, the body was perceived as an element of theatre that was neglected by the dramaturgy of official theatre from the 18th century onward. Culturally, the new theatre was born in the years and within the cultural context of "naturism," "free sex," and an intellectual rediscovery of the instincts. But mainly for bio-anthropological reasons, the body was perceived as the element common to all humankind, conclusion drawn from the research of Ekman, Bonino, and others previously mentioned. As a consequence, in the search for universal theatrical relationships, there was an underestimation of the importance of nonphysical languages and of the relevance that social and cultural contexts, symbolic elements, and individual memory have in the formation of both the individual body and the social perception of bodies.

The actors in new theatre groups achieved outstanding physical technique and collective dramaturgical skills, but this resulted in new stereotypical mannerisms. In certain commercial theatre settings, tickets were bought to view the new professionals, which these "ensembles" had become. From a political point of view, these groups were confined in the cloisters of the theatre world—from Holstebro to Pontedera—unable to communicate any longer with their respective societies.

The new theatre, as well as community-based theatre and theatre animation, while initially willing to be radically liminal and to play an active role in the symbolic and political redefinition of communities, ended up being part of the liminoid spheres of show business and of spare time. Ironically, these theatres were merely a minority phenomenon within these spheres, as Patrice Pavis has stressed (1988). Thus, they changed neither society nor the entertainment industry.

I went through different forms of theatre training at the beginning of the 1990s when the transcultural tendency of theatre still dominated the cultural environment but was already in serious crisis. I was not interested in becoming an actor but wanted a better understanding of the experience of acting in order to use theatre in the social field. In all of my training, which included mime, new theatre, Peter Brook's CICT (Centre Internationale de Creation Théâtrale)

methods, Barba's techniques, and many more, I used the body, sometimes the voice and, in some exercises, the words of famous dramaturgical texts. I greatly improved my physical skills and the expression and control of my body; but very often, I felt intellectually frustrated. I often spoke with the trainers after the workshops. The usual answer given to my questions was that theatre was not an intellectual activity. But why was this? They were intellectuals and they intellectually explained to me the "non-intellectualness" of their theatre work. We were living our "everyday" lives, making representations and intellectual analyses just like other people, but within the codified spaces of the theatre workshops, we were forbidden to do so.

Contradictions like this made me feel that the theatre would not take me where I wanted to go. Using today's terminology, I would argue that it was totally unclear to me why it was good to create islands where a limited number of people (usually wealthy intellectuals) were able to develop their global unintellectual communication skills and simultaneously lose their ability to interact with their local contexts. Although I felt comfortable in these "theatre islands," I missed the bridges connecting me to the wider society.

I was about to give up on the theatre when I met Boal. With his work I used my body and was able to voice my thoughts in new and extraordinary ways. Finally, through Boal's different kind of theatre workshop, I was able to build bridges from the workshop to the reality outside. This convinced me to continue with the theatre. Meanwhile, many other people shared my experience and frustration.

Definition

At the beginning of the 1990s, a new form of theatre—taking inspiration and methodologies from theatre animation and community-based theatre, new theatre, and theatre therapy—found its way into direct interaction with the problems of individuals and groups in specific areas. It was a theatre based upon the body and relationships, but distanced from purely therapeutic approaches and without solely aesthetic and artistic goals. It was, in fact, less self-centered and was ready to become an instrument of social action through laboratories, workshops, and performances with a goal of healing and of heightening the quality of social interactions (see Schininà 1998). It was a theatre that linked the experience within the group to the sociocultural, economic, and historical context the group emerged from and remained a part of. This was and is called social theatre.

As Bernardi stresses, social theatre is part of the current involvement of anthropology in society and facilitates:

the social construction of the individual; the dynamization of interpersonal relations and inter-subjective comprehension; the structuring of the entire community and of the smaller social institutions of which the community is comprised, such as schools, hospitals, villages. (2000: 31)

Three things differentiate social theatre from theatre animation and community-based theatre:

1. The care social theatre exhibits for the role of the individual within the group and, therefore, its focus on the empowerment of differences rather than on a collective experience or

transpersonal/ transcultural unity;

2. The importance given in social theatre to the training of individuals and groups rather than community and community-based dramaturgy or

3. The role of the social theatre trainers: the new trainers are or should be skilled professionals able to consider in depth all the social, psychological, relational, and theatrical implications of their interactions with the group and the context.

What differentiates social theatre from the new theatre, commercial theatre, and the avantgarde are the following four points:

1. The aim of social theatre is not the aesthetic result, but the process of building relationships through creative communication. To this end, the aesthetic result can be a means, but is certainly not the primary goal;

2. Social theatre is not included in the socioeconomic structure of the mainstream, commercial theatre;

3. Social theatre perceives the theatre as an activity, which can involve everyone within its purview, and is not the prerogative of only the most talented and/or committed, who build up their technical capacities in the cloisters of the theatre.

4. The focus of social theatre is on the chorus. The professional of the social theatre is the choragus, the one who is able to build the choir in the group s/he is interacting with. S/he can be an actor, playwright, a social worker, etc., but s/he always uses her or his own particular profession to better serve the construction of the choir. The chorus in the social theatre is always a polyphonic one: a group made up of differences.

The main difference between social theatre and the majority of theatrical therapeutic techniques is that social theatre does not seek catharsis but metaxis (pluralization). Its ultimate goal is to empower differences and create solidarity, not to purify and to "normalize" them. In social theatre, the objective is to question society, with the living presence of its differences, rather than to be purified and brought back to a "normal" value system or social code.

In 1993, Richard Schechner wrote that the future of performance was developing in four directions: entertainment, therapy, training, and ritual (1993 : 20—21). These domains cannot be strictly fenced off from each other because performance is the practice of communicating and relationship building, which involves politics, medicine, religion, traditional, and popular cultures, and the everyday interactions between individuals, groups, and communities. Social theatre became the theatre "aware" of all of this, committed and ready to use its power for social aims and the well-being of communities.

In 1993, I was called on to work with theatre in the biggest psychiatric institution in Milan. My companions during that two-year workshop were the long-standing patients of the institution. The psychiatric law in Italy wanted this and other institutions to be closed and substituted with community-based services. The theatre project was an attempt to make this process possible. The value of this plan is not what I want to discuss here. Rather I wish to pose another question. At the time, I was a 21-year-old, inexperienced student of theatre and social communication.

Personally, working in the psychiatric institution was a terrific opportunity and experience, which improved my life and my skills greatly. But was hiring me the best thing for the patients? Was I the best person to bring theatre to such circumstances?

Certainly I was not aware of all the medical, psychological, social, and even political implications of what I was doing. I tried to travel around Italy to study what others were doing with theatre, not only in psychiatry but also more generally in the treatment of social diseases. I met many motivated and amazing professionals and artists. But sadly, the majority of people that I met were: students with no experience (like me); teachers compelled to run theatre workshops by these new ministerial programs without having any idea how to do so; frustrated professional actors and directors who, with no other way to earn a living, were haphazardly applying some Actor's Studio techniques to poor groups of handicapped children; trainers, who wrote dramas at home and personally selected the best "actors" to perform them, regardless of whether they were working with groups of elderly people or raped women and indifferent to the expectations of the members of these groups; theatre directors of dubious artistic skill, making a career as social theatre operators in prisons, with the real goal of producing an artistic show with professional actors the following commercial theatre season.

Social theatre was sometimes the worst of community theatre applied to social problems; sometimes it seemed to be social security for not particularly good actors; at other times, it seemed to be a scene which simply let the trainers express their frustrations. Sometimes it was funny, at other times, it was unethical and did more damage to the lives of individuals who certainly did not need any more difficulties or stress. However, there were some cases in which it was an experience that truly changed the lives of the group members for the better, altering their perceptions of particular problems and their social functioning in certain areas.

There was a widespread need for a stronger way of building relationships and for social therapy; the theatre became a means to achieve these goals. In the beginning the boundary between "pioneerism" and amateurism was very tenuous but after some years a level of ethical standards and ground rules for good conduct was put forward. Through these exchanges, the operators of social theatre bettered one another, increased their skills, and renewed the function of the theatre. Eventually we all agreed on a basic rule: We remain at the service of the groups we work with and we do not use them for artistic, solely aesthetic, purposes.

Institution

Nowadays social theatre is actually one of the newest tendencies of theatre in many countries. Let us analyze it according to the subdivisions Schechner formulated in 1993.

1. In **POLITICS**: The UN and different NGOs use social theatre in many crisis and post-crisis situations: for emergency relief, in rebuilding community capacities, and for democratization. Many formal and informal groups, belonging to minority communities, have been able to raise their voices, be heard, and be politically included thanks to the power of performance (for example: ACT UP, the Rwanda Human Rights associations, and many others).
2. In **MEDICINE**: With the revival of traditional, performative ways of healing and with the experiences of Patch Adams (Adams 1998) who brought together several similar projects from across the world, theatre, music, and visual arts workshops are taking place in many psychiatric

care services and health houses.

3. In TRADITIONAL CULTURES: Significant funding (from foundations such as Ford, Rockefeller, and others) has gone to revive, or to keep alive, ancient or renewed community-based, traditional performances and rituals all around the world, even as so-called "world music" has conquered the international market.

4. In EVERYDAY SOCIAL INTERACTIONS: Social theatre workshops are currently taking place in schools, institutions (social, penal, etc.), and health facilities. There are many performance interventions in difficult environments such as war zones, refugee settlements, displaced persons camps, and violent slums.

5. In EDUCATION: Training facilitators in social theatre is very popular. A growing number of universities and social work schools offer specific training/majors in social theatre. Applied theatre is a subject studied in many theatre departments and schools. More generally, theatre is used as a methodology to educate people in a wide range of subjects. This is a method originating in "theatre for development" projects but now more generally applied.

6. In ENTERTAINMENT : In the sphere of leisure time, the use of theatre workshops is popular within trade unions' recreational sectors, social centers, and "squatters communities" (Dragone 2000). In addition, commercial and new theatre were challenged by social theatre to find ways to overcome their creative crisis by turning to social theatre initiatives. The most prestigious Italian theatre awards, the UBU and the Hystrio, were in recent years often presented to socially oriented projects, such as a theatre group of prisoners or groups comprised of both professional actors and people with physical and emotional impairments.

In the last few years, I have worked as a choragus in various places in the world marred by social divides, war, and injustice. In 2003, I was engaged in a broad range of social theatre activities. I worked with youth volunteers in Moldova, with mixed ethnic groups in Kosovo, with Roma youth living under siege in the Balkans, with women Victims of Trafficking in Human Beings in Macedonia. In all this work, I used what I learned directly or indirectly from Augusto Boal, Roberto Mazzini, Sue Jennings, Mamadou Dioume, Bano Ferrari, and Duccio Demetrio—just to mention those whose methods I found most effective. Likewise, I greatly benefited from the theories of Claudio Bernardi, Richard Schechner, Sisto dalla Palma, and Claudio Meldolesi. I work with theatre, or perhaps it is better to say that I work with the logic of communication and relationship-building inspired by the games of theatre and performance. This has little to do with the theatre as an aesthetic activity, per se.

I believe that this logic is highly effective in working on the reconstruction of individual, group, and community roles. Playing with theatre in dangerous situations among threatened or oppressed people, makes it possible to initiate ethical processes and changes that begin with the individual, move to the group level, and ultimately enable the group to introduce the content of these processes to an institutional domain—thus, increasingly widening the ritual circle of theatrical communication and, often, political and social change. The individuals, groups, institutions, and organizations I have worked with have found the logic of social theatre both powerful and useful.

Disillusion

While the institutionalization of social theatre can be viewed as a success, it also is a means of

hiding a crisis, or at least, some incoherence. I find this troubling on a personal level. When I speak with my colleagues, I often find them in agreement with me. We find ourselves facing questions that need to be addressed immediately and collectively. Some of the latest developments of social theatre endanger or threaten its original, positive characteristics. Below I will highlight what I find to be the most pressing concerns.

Socioeconomic and Political Aspects

One of the main characteristics of social theatre is its departure from the mainstream socioeconomic structure of the theatre. We rejected that structure of working in a separated aesthetic and sociopolitical space, in order to facilitate the better functioning of society. This led to freedom, research, a strong involvement with communities, a greater value placed on experience than on professionalism (as theatre artists), and the conquest of new physical, personal, and community spaces.

However, in an ironic turn of events, during the last few years social theatre has adapted perfectly to other socioeconomic structures such as the healthcare and social welfare systems, various government ministries and departments, charities, cultural foundations, international organizations, and universities. Many of us work for entities that are complicit or at least connected/ related to the exclusions of the very same marginalized groups for which and with which social theatre operates. Sometimes we do our work directly for one of these compromised institutions; more often we work through nongovernmental organizations (NGOs). Nevertheless, these NGOs are financed by the same sources, so our feelings might differ but the substance does not change. Was this our aim? Did we leave the socioeconomic structure of theatre only to find ourselves operating in other, even more restrictive, structures—structures whose sources of funding are even more directly connected to the powers/institutions we want to question, that we need to question?

In my work in crisis situations, regardless of whether I am working for the United Nations or the smallest, most obscure NGO, too often I have had the feeling that my projects only get funding when they are deemed useful or functional for achieving or fitting into some larger, general strategy with which the groups I am working must not interfere. Sometimes I assume I am being sent to work on institutional limitations in order to raise awareness and include marginalized people in a democratic dialogue, but once I am in the field, I discover that I was actually sent only to "calm these people down." To what extent should functionality be our goal? How are we able to know that our work is serving to change things, and not merely being exploited for its strategic "usefulness"?

Employment and Professional Profile

New funding sources have made possible the dissemination of social theatre into many different socio-economic structures. And these new employment opportunities compel many artists without jobs to work in social theatre. Very often these professionals apply acting methods and aesthetic criteria in their social work with unethical and ineffective results. Other times, social workers or other professionals without any theatre experience run theatre workshops because their institutions demand it of them. But how can we differentiate a good"

from an "incompetent" social theatre operator? In deprofessionalizing the theatre, viewing it not as a specific, learned skill but as an innate human activity that everyone can do, we ended up creating a new profession, the choragus. However, since this was not our goal, we did not establish criteria or definitions for the profession of choragus. This has created a space for the misuse and the unethical abuse of our practices. We made two mistakes in one and I find it difficult to see a happy resolution. If we specify the requirements for a 'good' choragus, we give up on the deprofessionalization of the work; whereas if we continue not to specify the optimal parameters of the work, we endanger the practice as a whole.

The Artistic Sphere

Traditional and research theatre are in the midst of very deep creative, artistic, and economic crises. Currently, it is widely understood that a social theatre project has a much greater chance of being funded than any other purely artistic production. This has prompted many theatre companies and ensembles in need of financial support to present artistic productions as social theatre. These theatres involve marginalized groups with the sole purpose of securing funding and earning money, taking advantage of their differences or abnormalities for financial gain. I disagree completely with this attitude because it tries to give an ethical value and significance to experiences that are more akin to a Barnum and Bailey Circus.

On an even more serious level, this creative crisis, combined with the surprising and sometimes unplanned and unexpected aesthetic results of some social theatre experiences, has brought various artists and theatre ensembles operating in both traditional and new theatre to develop projects of exchange and interaction with marginalized groups or individuals. For example, in Italy during the past few years, handicapped persons, people with anorexia, prisoners, people who are HIV positive, drug addicts, the homeless, people with psychiatric disorders, terminally ill patients, economic migrants, the elderly, street children, prostitutes, and "freaks" participated together with professional actors in commercial theatre shows (Dragone 2000). These shows are not without merit, but they are not social theatre because they are rooted in the socioeconomic structure of theatre. This difference manifests extremely important, contrasting results:

First, social theatre denies both the concept and the practice of repetition and finished performances—the run, the production "open for critical review" (Schechner 1985 : 120). In social theatre, the performance IS no longer something that has to be reproduced but is instead a single experience of growth for the group, enabling it to communicate with other groups and the reality outside the group. But the commercial/ artistic productions described above reject this concept because they are shows that open, run, and tour.

Second, the idea of a nonprofessional theatre as an activity in which everyone can participate, which is fundamental to social theatre, underlies the previously described commercial/ artistic productions but with a very different end result. As Bernardi wrote:

[O]nly the best (of the nonprofessional marginalized actors) go onstage. The others are left home. The success and the progress of the ones who were so lucky and so good to become real artists are exalted while all the others who live in similar conditions are forgotten. But they are as able as or even more able than the others who reached the stage to do what they do and

to be what they are. Why should the joys, the emotions, the successes touch only some of the marginalized of the world? (Bernardi 2001)

My concern is that in our attempt to champion differences and to work on metaxis through theatre, we have also, inadvertently, paved the way for some traditional and research theatre ensembles and individual artists to solve their artistic and economic crises through the creation of a new professional, who the audiences pay to see and who receives prestigious awards for being the "different" one who can act "normal" or "better than normal. "

Conclusions

And here we are, proud of the achievements of a theatre that is able to facilitate communication, relationships, true exchange, democracy, and development; creates groups, celebrates diversity, spots problems, and raises public awareness; creates circles of barter and encounters, Astonishing in any context, but particularly in the situations I have witnessed.

But here we also are facing several powerful contradictions of a theatre that wanted to reject institutions yet has become institutionalized; a theatre that denied professionalism but has created a new profession; a theatre that preferred conciliatory questioning and challenge to revolution but has become all too often useful for and close to the powers it wanted to question; and finally a theatre that wanted above all to be ethical yet leaves space for unethical practices or brings ethical practices into wider unethical political strategies and processes involving aesthetic exploitation.

As operators of social theatre, we work as the choragus. We know by experience that social theatre is powerful and effective in doing this. We should also be aware that from a political perspective sometimes the choragus is used to make persons copy rather than "re-act" —for example, to "act normal," even when the conditions/ situation they are living in are absolutely abnormal and unjust. From an artistic perspective, a tendency now exists to create theatre actors out of a select few of the marginalized, rather than working on the root causes of the marginalization of their entire group.

There is a word we all use when speaking about our job, and this is the word "limit. " Working at the limits, at the borders, with the aim of creating bridges is always difficult, and it can easily create, or indicate, contradictions. If one works at the ultimate limits of society and wants to create bridges between these limits and the institutional center—and this is what social theatre is mainly about—being trapped in contradictions and functionality are the greatest risks. To avoid these tendencies we must always remember, and not be scared to remind our colleagues, that no matter what our individual background and precise expertise, our goal should be to serve the groups with whom we work. For these reason we:

1. Do not exploit them for our own artistic purposes. Our objective is the well-being of the people involved. The aesthetic must always be a means to an end, not the aim of our work.
2. Do not initiate creative processes of empowerment for groups when the background conditions for change do not exist and it is impossible to create them. We should keep a close eye on where the money for our projects comes from and what the ultimate goal of our donors and employers is— and not only be taken in by what we may accomplish in the short term.

We must not compromise and "go to work" if these points are not clear. If we work without clarity, then the institutionalization of social theatre is a failure that may ultimately do more harm than good to the individuals and groups It seeks to empower. This is a concern I personally grapple with, since I am writing this article in the office of a major international organization where I work as a Social Theatre Expert. From time to time, anti-globalization groups demonstrate in front of the organization's office windows. How do I resolve the paradox of working inside while many with whom I am in profound sympathy are demonstrating out there? Every day I need to perceive the edge of my office door as a creative limit and my work as a bridge; to make certain that I am bridging and not compromising.

For all references please see bibliography.

Like Ham in a Temperance Hotel - Healing, Participation and Education in Social Theatre

This is the original manuscript for the article 'Like ham in a temperance hotel - Healing, participation and education in social theatre'. It was written by Guglielmo Schininà; published in Jennings. S. (ed.), (2009), *Dramatherapy and Social Theatre – Necessary Dialogues*. London: Routledge.

The published article can be found at:

<https://www.routledge.com/Dramatherapy-and-Social-Theatre-Necessary-Dialogues-1st-Edition/Jennings/p/book/9780203876367>

Introduction

Social theatre is a theatre for change. It is a theatre that facilitates individuals, groups and communities in finding their own ways to meet their own needs, improve their social functioning, and eventually overcome unhappy situations.

Social theatre is therefore a variety or an 'arsenal', to use Boal's definition (Boal 1995), of creative tools, communication techniques, and artistic ethics, derived from performance studies and the history of theatre (Bernardi 2004; Schinina 2004a). These used in combination can bring people to express themselves freely, communicate better than before, redefine safely their own roles, discuss peacefully possible changes, and enact socially these personal and collective changes.

Over the last few years, however, social theatre has been mainly identified with theatre for healing and cure and prevention, rather than with theatre for participation. For the most part, social theatre has become an important - and sometimes indispensable - component of what is known as psychosocial intervention, and has therefore been affected by the same set of contradictions and limitations pertaining to this particular activity.

Throughout this chapter I argue that healing, participation and education cannot be understood as separate concerns in social theatre interventions. When they are, the risk of partiality, elitism, lack of ethics, exploitation of the beneficiary, subservience to dominant political discourses becomes extremely high. I substantiate my argument by discussing a number of observations, mostly drawn from my experience as a psychosocial manager and trainer in war-torn situations, in particular during the Kosovo, Iraqi and Lebanon crises.

Social theatre, psychosocial interventions, and war

Theatre in general, and social theatre in particular, is about working on limits and borders. Any theatre activity results from an urgency of some kind. For the human species, war probably represents the uppermost confrontation with its individual and collective limits, and the ultimate emergency. In tackling the issue of social theatre and healing, I have therefore decided to refer mainly to the use of theatre for psychosocial interventions in war-torn situations. The ethical, social, political implications become indeed more obvious in these contexts. However, the insights developed here could apply, to a varying extent, to any social theatre project in the mental health and psychosocial fields anywhere.¹

The psychosocial theory, and theatre in psychosocial interventions: Participation and healing

A basic definition of 'psychosocial' can be found in the *Oxford English dictionary* (OED 2019), where it reads as 'pertaining to the influence of social factors on an individual's mind and behaviour, and to the inter- relation of behavioural and social factors; also and more widely pertaining to the interrelation between mind and society' (OED 1997).

The psychosocial perspective highlights the interrelation between psychological and social factors. It cannot be limited to either a psychological understanding of social factors, or a social understanding of psychiatric and psychological needs and healing, as is still common among mental health professionals worldwide. In my view, the scope of psychosocial work is much wider and much less fragmented, and its ultimate meaning lies precisely in the fundamental interconnectedness of the individual and the collective dimensions. Psychosocial programmes should aim at readjusting the role of individuals, groups and communities inside a given society.

The key word in psychosocial theory is 'role', a notion that situates itself at the intersection between individual construction and collective perception, psychological beliefs and social norms and habits. For this reason, the psychosocial approach proves especially useful in situations where individual, group and community roles are questioned, annihilated, in need of reconstruction and/or readjustment, as is the case with social settings affected by war, disasters, displacement or social disruptions. In all these contexts the four domains (individual-collective- social- psychological) cannot be compartmentalized, nor can one be given prominence over the others.

The readjustment and rehearsal of personal and collective roles, relationship and communication, limits, creative responses to unexpected situations, the self/context relation, and the process of ritualization are central topics in psychosocial work, especially when operating in war-affected situations. It would therefore seem all too natural that there should be a role for theatre, and especially for social theatre, in psychosocial interventions, given that drama addresses exactly the same issues and can boast a time-honoured record of responses across a wide range of cultures and circumstances. And yet, during my practice in psychosocial and social theatre in war-torn situations, I have been confronted with a number of problems and contradictions.

The psychosocial practice, and theatre in psychosocial interventions: Healing vs. participation

The dominant psychosocial discourse in war-torn situations has been medical, pathological, individualistic and based on pre-packaged research and response frameworks that are not necessarily tailored to local realities, cultures and understandings. Psychosocial work often becomes a therapeutic branch of humanitarian interventions that, from Kosovo onwards, have been a key component of international military interventions that were labelled 'humanitarian' (Kosovo) and 'preventive' (Iraq). A sort of transitive relation has been established between humanitarian war and humanitarian intervention, which however raises a number of ethical dilemmas.

Is it appropriate for the international forces to bring war to a country or region, and simultaneously the therapeutic tools to investigate and eventually cure its effects? Is it ethical? And what can be the role of social theatre within this context? Can social theatre afford to be critical of the dominant political paradigm, or would it just be used to maintain the *status quo*, entertaining, distracting, appeasing, and relieving the suffering of the people? Should not social theatre instead foster the participation of beneficiary communities in the humanitarian project, and thereby empower them to react?

I do not have definitive answers to these questions, but I can try to pinpoint what I feel to be the most urgent issues according to my experience in the field and to the international literature on the subject.

Mass trauma in conflict: The Kosovo case

In many recent international psychosocial programmes, mass trauma in conflict was taken for granted. During the Kosovo crisis, it was at a certain stage assumed that 75 per cent of the population had been severely traumatized by the war - a notion that several closer assessments later failed to support. As Vanessa Pupavac highlights, 'the appearance of clinical conditions in war remains particular, not universal', and 'appearance of clinical trauma rendering people unable to function is relatively rare' (Pupavac 2004: 7). These early estimates, however, had the effect of bringing psycho-social response and mental health issues to centre stage. 'Trauma' readily became a 'buzzword' among fund raisers within many organizations. And, sadly, a lot of theatre projects were graced with the additional label of 'Trauma Response projects'.

PTSD and other western models: Kosovo and others

Most interventions were based on the notion of Post-Traumatic Stress Disorder (PTSD) syndrome. This was certainly the case in Kosovo, Sri Lanka and Iraq, where the unchallenged western presumption that there is a universal response to highly stressful events, and that this response can be categorized as a diagnosable form of mental disorder, resulted in cultural insensitivity. PTSD was conceptualized while dealing with Vietnam war veterans; it therefore refers to a very specific geographical, cultural, historical and social environment (Summerfield 2001) and cannot be applied per se to all war-related distress. While it is true that the PTSD approach was often criticized by many scholars and practitioners in the field, this was usually done in order to promote the use of alternative models - conversational versus medical-biological, psychotherapeutic versus cognitive-behavioural, and others (Losi, 2002) - and not to endorse the empowerment of the beneficiaries and their active participation in identifying, prioritizing, and devising a response to their psychosocial (and not merely psychological) needs.

And what was the role of social theatre within these projects? On the whole, it provided entertainment, an alternative therapeutic tool, and the opportunity to involve people in high visibility events. Very often, social theatre was employed to get people to relate their life stories through autobiography, storytelling, metaphors, according to the western practice of counselling or talk therapy, rather than inviting them to create new stories or a new history. This was just another case of unquestioned reliance on foreign explanatory models that failed to

acknowledge cultural specificity. In some societies, for instance, silence and avoidance are preferable to remembrance. In the case of Kosovo, this particular use of social theatre resulted in the validation of collective political narratives of suffering and war, which tended to disregard individual specificity and promote violent discourse. Was it indeed feasible to work on people's roles in the context of a military and humanitarian intervention that took for granted their role as victims or perpetrators and inevitably cast foreign experts as their saviours? Should not these fixed roles have been targeted and readjusted by theatre interventions in the first place?

Normal reactions to abnormal situations: Iraq

By disregarding individual and collective coping and resilience mechanisms, many international programmes risked 'pathologizing' entire communities. As Derek Summerfield puts it, 'features of post traumatic stress disorder are often epiphenomena! and not what survivors are attending to or consider important: Most of them remain active and effective in the face of continuing hardship and threat' (Summerfield 2001: 123). Moreover, certain psychological reactions are just normal reactions to abnormal situations, and as such they should not be cast as mental pathologies. Quite to the contrary, they are a healthy sign of people's capacity to assess their situation. People living in Iraq today and suffering from fears, anger, and nightmares are simply showing an awareness of their predicament. Considering them ill would be unethical and would only corroborate the mistakes of the international intervention.

What is the current use of social theatre in Iraq? It serves to divert people, especially children. It creates safe spaces. That is all that can be allowed in the present security circumstances. But is it ethical to create fictional safe spaces in what has become one of the unsafest places on earth? Is this not liable to harm, rather than help, the populations involved? And does it not amount to a paradox, considering that it comes along with and from the very same cultures that occasioned those security circumstances?

Training as propagation of ideas: Anywhere

Education and training have played a rather prominent role in most psychosocial programmes in emergency and war-affected contexts, mainly because of the need to ensure the sustainability of the programmes themselves. Training local people means, first, the possibility of relying on local staff who would be fully knowledgeable of the project during its implementation; second, having someone to hand over the project to when budgets become too low to fund an international presence; and third, the chance for organizations and aid workers to leave a lasting mark of their presence in the field, thereby laying the foundations for long-term professional international networks. Training, however, is grounded in foreign models and expertise, while the relevance of local experience, training and knowledge is usually downplayed. It is also generally based on priorities identified by agencies that are often more concerned with the implementation of their projects than with the local population's actual needs.

One could argue that training programmes are often successful, attract large numbers of participants, and are evaluated positively by those who attend. It should be kept in mind,

however, that international interventions create a labour market with which the local one cannot compete in terms of opportunities and salaries. Job offers and training tend to come from the same sources. In this sense, it results obviously that education comes across as a field where the boundary between capacity building and cultural colonialism tends to become blurred. And what is the role of theatre in these circumstances? It is used instrumentally, as an effective method to transmit and validate through experience new concepts and tools over a short period of time. It is more and more common to see social theatre become a subject matter to be learned. But social theatre is an experience more than a technique, and aims at participation. How can it fit in ready-made training modules that aim at remodelling local expertise to suit pre-planned projects, rather than facilitating the creation of new scenarios?

The internationalization of ethics: Iraq

In 2005 I conducted on the behalf of the International Organization for Migration (IOM) an assessment of the psychosocial situation of displaced communities in Iraq (Schinina 2005). I was particularly worried and impressed by some coincidental results. First, it emerged clearly that the Iraqis were reporting their psychological (or better, spiritual) concerns to traditional - mostly spiritual - healers and not to local professionals. Second, all the people interviewed were noticing an unexpected deterioration (orchestrated from above, according to them) of the relations between different religious groups: Sunni, Sh'ia, Catholics, and so on. Third, societies were being religionized, because religious leaders had also suddenly turned into political authority figures. Moreover, assuming religion-based values and habits offered people an effective way of becoming accepted into a wider community. Finally, many people felt that they were in need of spiritual help, such as the one provided by psychosocial counselling, especially to cope with the consequences of the Operation 'Iraqi Freedom'. And yet what can one do in a situation where people have pressing psychosocial needs, but the only response they are prepared to accept is a religious one, in a context where the therapeutic, social, religious and political responses alike are all concentrated in the same hands?

In a broader perspective, I started to wonder whether my concerns did not smack of arrogance, and whether the same crooked logic was not at work behind all international interventions. Any international psychosocial intervention attached to humanitarian relief operations risks turning into the therapeutic side of a single political, cultural, and sometimes ideological and military discourse. The 'Iraqi Freedom' intervention was justified and informed by a distorted or even perverted concept of democracy, on which the ethics and practice of the military, political, informational intervention were based. My assessment, too, was grounded in a democratic understanding of psychosocial needs, and its validity was therefore undermined by the same paradoxes and contradictions.

The risk management approach

Finally, psychosocial programmes can be seen as an internationalization of the risk management approach, defined by Pupavac (2004) as the non-participative preventive actions that inform the social policies and activities of many western governments. Over the past few decades, the risk management approach has progressively reduced the value of politics and

participation, promoting instead the therapeutic governance of societies. People have been turned from political subjects into the recipients of administrative actions, and as a result they have increasingly renounced active participation by delegating decision-making to politicians. The most glaring example of this process and of its consequences was seen in the United States in the (mis)management of the armed intervention in Iraq and in the failure of the preventive and rescue operations during the Katrina flood. In both cases, risks were not properly assessed, priorities were arguably determined, and the responses claimed more human lives than all the terrorist attacks ever suffered by America. In both cases, the US

government manifestly failed to deal responsibly with national and international crises, and this caused the current administration's popularity to drop dramatically. What seems to have proved particularly bewildering for Americans was their leaders' incapability to perform a correct risk analysis, as a result of sheer incompetence or of the misleading influence of ideological beliefs and vested interests. And yet, the risk management approach to politics, according to which societies hand over to a ruling elite the task of setting security priorities and social agendas, still goes unquestioned.

So far, the theatre has been unable to change the general perception on these issues.

A step forward? The Lebanon crisis

The Lebanon crisis of 2006 produced a drastic and positive change in the psychosocial approach to conflict and war. While the war was still being fought, an Inter-Agency Technical Committee on Mental Health and Psychosocial, comprising 12 of the more active international agencies in the respective fields (among them, WHO, UNICEF, the IOM and many others), issued technical advice for the emergency (2006).

The document stated that while wars produce a number of distressing factors, only in a small percentage of the population is the distress so severe that it limits the basic functioning of individuals. The committee therefore discouraged the medicalization of communities and advocated the promotion of a safe and supportive environment, through the access to basic rights such as health and education, water and sanitation, shelter and livelihood, and the preservation of family unity to avoid displacement. It was also emphasized that the key programming principles should focus on human rights, participation, resiliency, normalization of daily life, a community-based approach, capacity building and integrated multidisciplinary support. Interventions should comply with the rule of 'DO NOT HARM' - that is, avoid culturally inappropriate tools, or inappropriate explorations of distressing events - and perform two necessary and concomitant actions:

- 1 They should provide social and protective activities for the entire population, including: access to services and to psychosocially aware humanitarian assistance; help to communities in re-establishing their normal activities and rituals, including grieving rituals; psychosocial training for community members; information; promotion of recreational, sporting, artistic and cultural activities, group discussions and support groups; reduction of children's exposure to the representation of violence; life skills and vocational training; psychosocial care for humanitarian workers and avoidance of widespread and short-term trauma counselling.

- 2 Psychological treatment for people in acute distress and people with pre-existing mental disorders, including: psychological first aid; psychotropic help in exceptional cases only and always in combination with non-medical forms of support; avoidance of programming focusing on a single diagnosis (e.g. PTSD), and support for programming considering the wider range of urgent neuropsychiatric needs.

Finally, the document recommended avoiding the terms 'trauma' and 'therapy', which were deemed inappropriate in the Middle Eastern context, and using instead 'distress', 'stress', and 'structured activities'. Drama was mentioned as a necessary psychosocial tool.

The Inter Agency Technical Advice is undoubtedly a step forward from the theoretical point of view.

In practice, though, it has to be noted that the document was written by international organizations and only endorsed by local authorities. The issue of participation was at last addressed in theory, but the process was initially non-participatory. Ironically, the Lebanon crisis found the local professionals and political movements highly prepared. While hostilities were still ongoing, the Khyain Rehabilitation Centre for Victims of Torture had already issued its Ten Commandments for Mental Health, instructing people to respond to the crisis by resorting to notions of heroism, God and martyrdom.

Education and healing

So far I have investigated the dangers involved in a therapeutic use of social theatre that disregards the importance of participation, or in contexts that hinder participation. By contrast, when it comes to social theatre and education the healing value that training experiences have or might have on the participants can hardly be overestimated. To illustrate my argument, I turn to an episode that occurred during a training programme in social theatre that was held in south-eastern Sicily in 2005.

The programme consisted of six modules of 20 hours each. The group of participants included 27 theatre practitioners, social workers, activists, psychologists, teachers and educators, as well as actors aged between 19 and 64. The modules covered the full range of social theatre practices, following a progression from individual empowerment and expression in the group (dramatherapy), to group building (social theatre, complex circle), to self-identification of problems and resources in the group (complex circle) or identification by the group of problems and resources within society (theatre for the oppressed; TdO), to direct social action, including dramaturgical actions (TdO, dramaturgy of the group). The training emphasized the value of participation (Nemoprofeta 2006).

Given the professionally oriented curriculum, and the background and expertise of most participants, I had expected the technical component to come to prominence. This was not the case. For instance: at the end of the 'Theatre of the Oppressed' module, participants were asked to divide into subgroups, identify an oppressing situation, and present it in a forum theatre. The topic had to be chosen according to specific guidelines designed to ensure that the dramatized story would focus on social rather than personal issues.

One group presented the episode of a car crash: a man driving his car, another man crossing the road on a bicycle; the rider gets run over by the car and dies, the driver bursts into frantic

crying; a policeman intervenes, and two symbolic figures, one representing guilt. the other a positive attitude, comment on the scene and interact with the driver. In selecting this particular story, the group had ignored all the instructions they had received. The performance counted more as the first scene of a psychodrama session, the one where the problematic scene is presented, than as anything resembling a theatre forum. Needless to say, it dramatized an event that had actually occurred to one of the participants a few weeks earlier. It was obvious to all that the participant's need to share this story and his feelings about it in order to obtain help from the group was extremely pressing, and prevailed over any technical consideration or direction. The other group members, perceiving his urgency to emotionally ventilate the experience, initially chose not to interfere. After a while, however, I asked the group to modify the scene so that the forum could eventually take place. The setting then changed to the oppressive situation brought into being by the accident within the driver's family.

This episode left me deeply perplexed and raised the following dilemmas:

- (1) Is it possible to actually train people in social theatre, given that the experience of social theatre involves first and foremost working on the self?
- (2) Can a training programme in social theatre concentrate on participation only, ignoring the psychological needs of the participants?
- (3) If the answer is no, then is there any difference between a group in training and an informal group? Is there any difference between a trainer and a facilitator?
- (4) Is it possible, within a social theatre learning context, to use pre- packaged training material, or can this material only come from the specific experience of each group? Was it appropriate in this particular case to ask the group to change the story to make it fit in with the technical description of the module (theatre forum)? Or would it rather have been more effective, in educational terms, to keep the scene as it was and work on it using a psychodrama approach, thereby meeting the obvious need of the group member from which it had originated? After all, the aim of social theatre is allegedly that of serving real, self-identified needs, not abstract techniques. I still have not found a definitive answer to these questions.

Conclusion

This essay offers doubts rather than certainties, dilemmas rather than conclusions, but it does take a clear-cut stance on the importance of understanding the interconnectedness of the therapeutic, participatory and educational facets of social theatre. Even in extreme situations, as in war- torn societies, social theatre should aim at social empowerment and participation; otherwise there is a real danger of corroborating questionable therapeutic and political approaches, and of becoming instrumental to the internationalization of the therapeutic governance of societies. Conversely, even in a protected educational environment, any social theatre experience inevitably comes to include personal involvement and the venting of intimate feelings and stories. Here, concentrating on participation while downplaying the therapeutic dimension of social theatre could amount to placing technique and ideology above the needs of the individual. Healing, participation and education should be one single, indivisible realm of action within social theatre practices.

For all references please see bibliography.

USING CREATIVE MEDIATION IN THE PSYCHOSOCIAL INTERVENTION.



BY: ROLA SOUHEIL
PSYCHOSOCIAL SPECIALIST
2017

Overview



The three days' experimental workshop started on the 16th until the 19th of November and took place at Pinnacle Hotel in Maiduguri.

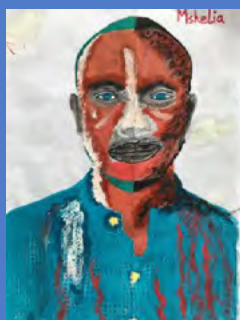
The workshop aimed to train the psychosocial team on the impact of arts on the individual's wellbeing and health, especially in the psychosocial intervention, and to introduce exercises and methods of art therapy that can support the team applying art mediation sessions. In addition to that, the workshop introduced some relaxation exercises and drama games that can help in assisting these mediation sessions.

Also this workshop paved the way to discover the relation between emotions and expression, and it offered a space to learn techniques to facilitate this expression in support groups.

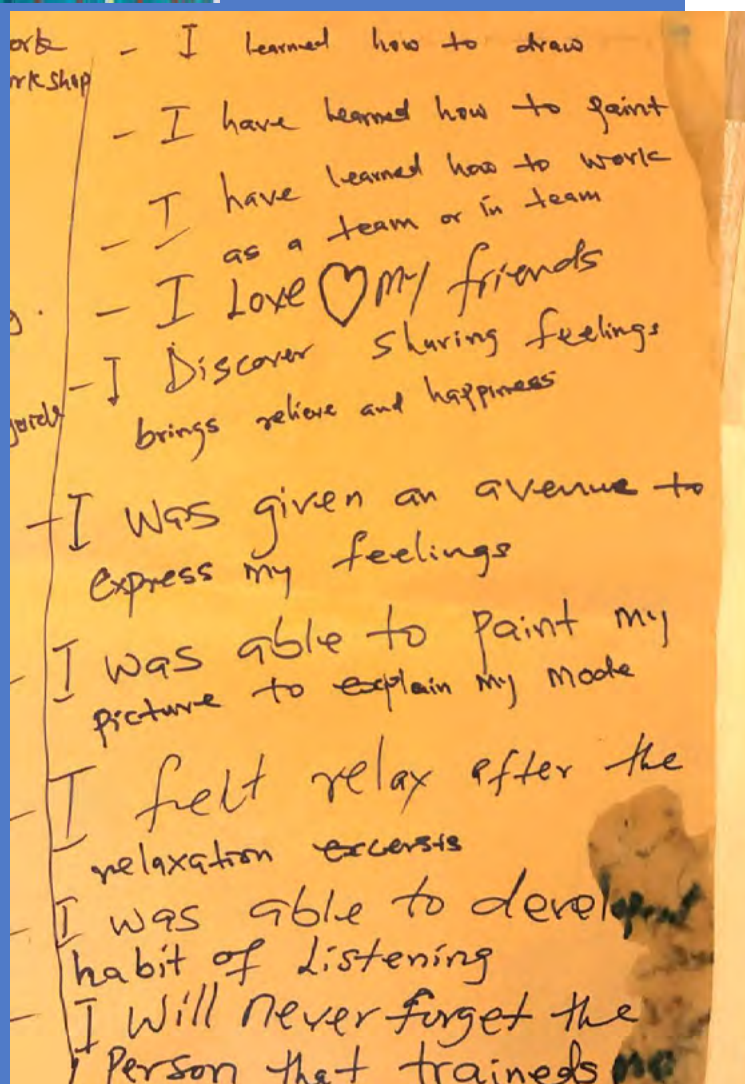
The approach is based on arts and drama therapy methods, drama games, breathing and relaxation exercises. The combination of these exercises and approaches led to empower the participants by developing the art mediator trainer's knowledge, skills and attitude. At the same time, the workshop fostered their personal and social skills.

The workshop focuses on using art in particular as a medium and as a mediator for wellbeing, and on creating a safe space in order to connect with the self and the other. This connection happened through the process of experimenting creativity and imagination to acknowledge their impact on healing. This was done through projecting on the painting, colors and forms, and practicing modeling, drawing and painting.

- I would to change from being shy to bold and outspoken.



WHAT ARE THE OBJECTIVES OF THE WORKSHOP?



The objective of this workshop is to introduce knowledge, skills, and attitude for an expressive art trainer.

The workshop builds basic art knowledge related to art techniques and materials. Besides, it introduces the importance of painting related to feelings and emotions. This creative expressive workshop strengthens the individual's flexibility and resilience.

The exercises with the discussions develop various basic skills needed to lead an expressive art workshop such as, listing, creating, communicating skills ...etc. the workshop introduce as well the attitudes needed to facilitate an expressive art workshop such as being tolerant ,knowledgeable, curious, and engaged listener...etc In addition to the above this workshop introduces painting and modeling with the support of art therapy approach to create an art mediation session that should directly enable expression and discovery of the self-resilient capacity to help the individual make a certain change concerning the challenge he/she is facing.

→ OBJECTIVES



Attitude
 Steps in art and creativity in ps
 express
 Attitude
 Relaxation exercise
 clock exercise
 Using of colours to express your feel
 what's in your heart
 Relaxation cause concentration

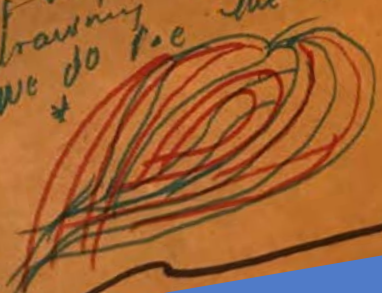
* some thing I discover during this training
 through art and create you can express how
 you feels..

* some thing I felt during this training, I feel
 relief and happy in the whole three days because
 I have some thing in my mind that is worried
 not but during this training I get relief.
 and I am so happy with it.

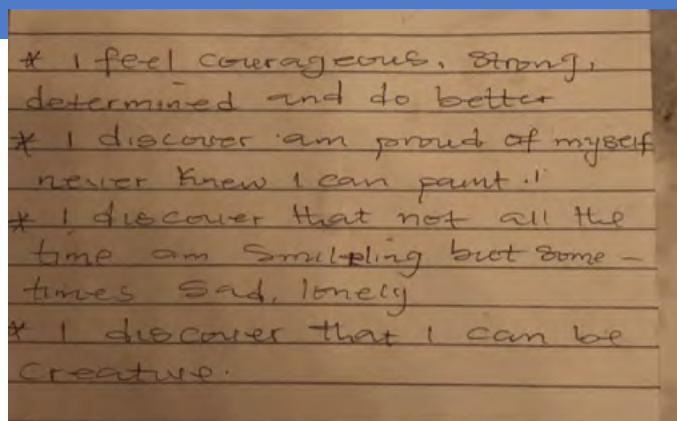
* some thing I will change in my life is
 that if some offend me I will tell that
 person immediately and speak at that
 time.

* I will always remember is the art and creative
 that I do with my own hand most especially the pain
 of my picture. check in using five fingers and
 drawing of heart - some of the exercise that
 we do for the killer exercise.

* some thing I won't forget,
 - The dead of my mother
 - The day I was separate with
 the one I love.
 - my wedding day.



WHAT WERE THE METHODS APPLIED ?



The method applied is a combination of diverse approaches and techniques. The method is based mainly on the concept of learning, productivity, projection, transformation, creative therapies approaches of art and drama therapy.

Learning:

"Learning isn't a way of reaching one's potential but rather a way of developing it."

Anders Ericsson.

Learning is an empowering process that reduces the feeling of vulnerability and unleashes potential. Learning puts the person in a status of discovery of its capacities and capabilities.

Also, the learning process provides the feeling of starting new knowledge, which can put the participant in a posture of debuting a new phase; when the person's mind is stretched by a new idea, it never regains its original dimensions.

In addition to that, to learn something can help with explaining and understanding the resilience effort and power, or in other words it can be a metaphor of the path that a person in a resilient phase should act for it.

Sometimes, change leads to disappointment if it is not sustained, but Transformation sustained change, and it is achieved through practice. And this practice is symbolically represented by the learning process.

"I Can do anything "; "I can do it "; "if I could do this painting I can do a lot of things", these expressions were often repeated where the participants discovered that if they work for something, they can reach it. What I have added: This can be true; however what is definitely true is that if we Don't work for a change, it will definitely never happen.

Learning is the process that leads you to change something in you that you can reflect on it tangibly with the product at the end. You listen, you learn, you know what you want, and you work on your painting.

"The only person who is educated is the one who has learned how to learn and change."

— Carl Rogers

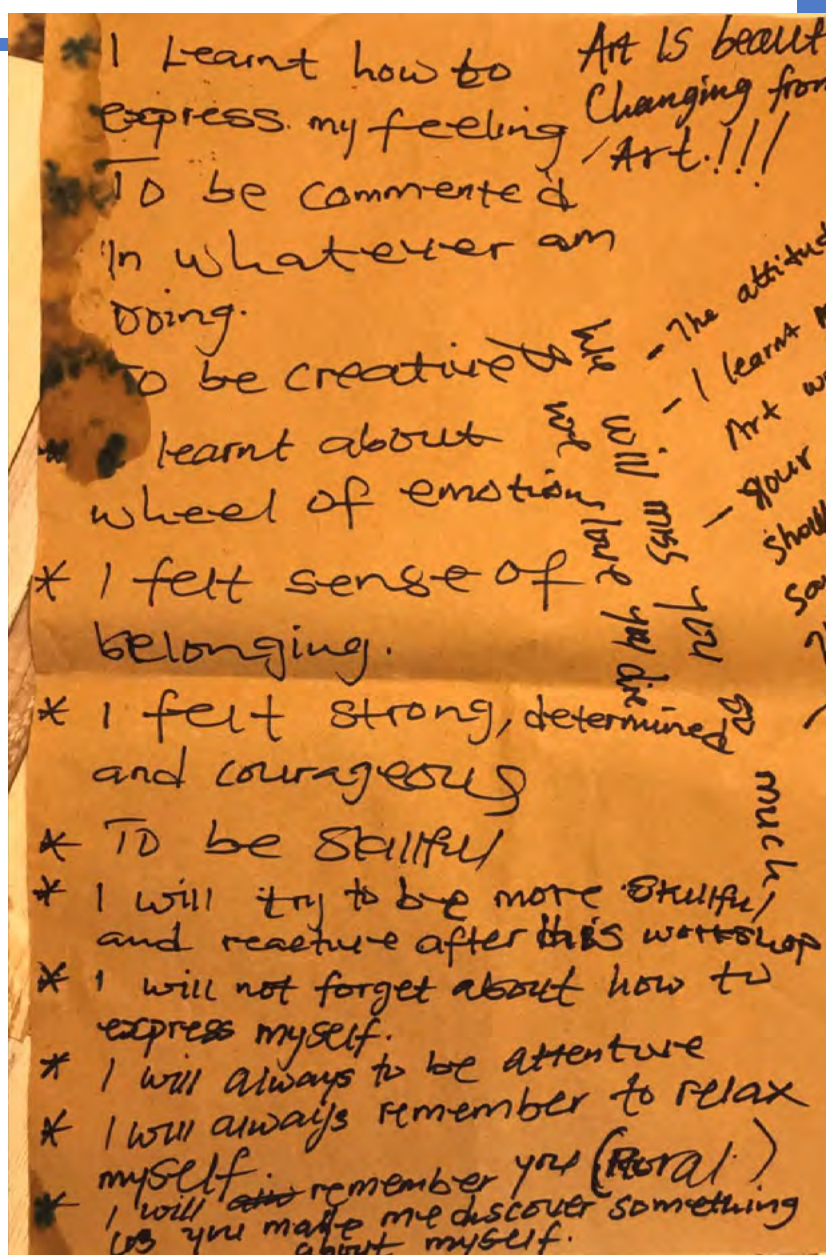
PRODUCTIVITY



This workshop provided a constructive learning in order to assure a satisfying product that gives participants a sense of possibility. The trainer plays the role of a facilitator who gathers and distribute material and knowledge to the participant to build their own recapitulation of it. this recapitulation is represented in the painting at the end, THE PRODUCT”.

The product brings proud and satisfaction to the participant. the participant will experiment the feeling of accomplishment and project it on his life. the fact that producing a beautiful painting use to be something impossible to reach, wiput the participant in a status of reflection on his attitude concerning everything that he thought that he was incapable regarding it, therefore the process followed to produce the painting, of learning, giving the best to attempt the final product open the space for him or her to experiment “: INITIATIVE”.

The product represents “the Proof “for the participants, that life is about surprises, is about believing, is about trying, is about working hard. this product wakes up hope in the participant mind. This painting experience drive the participants to think and reflect about his daily routine and sometimes changing one tiny thing in the daily routine can change much in return.

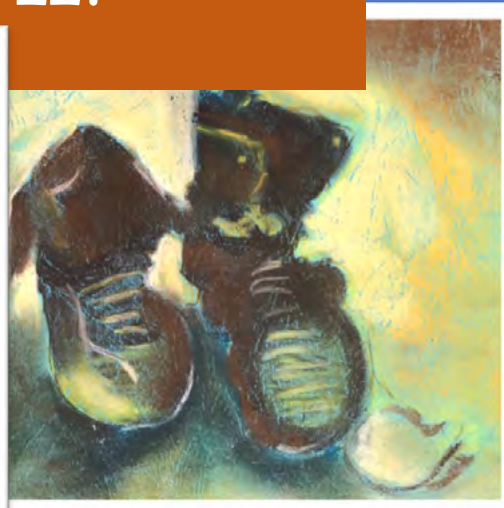
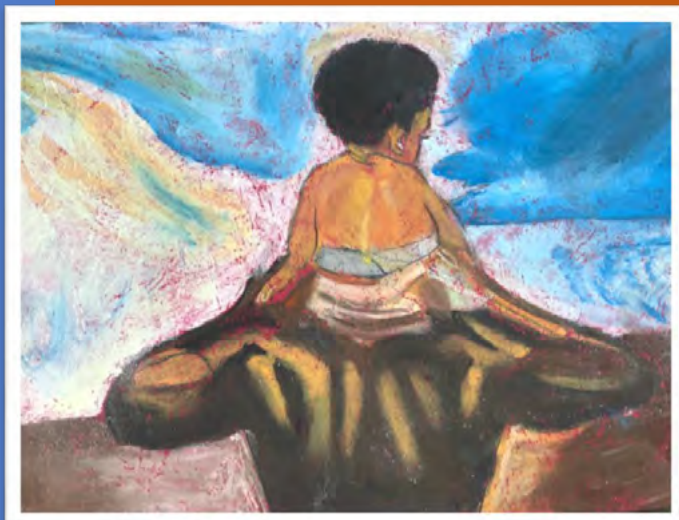


WHAT IS THE TRANSFORMATIONAL PROCESS?

“Transforming pain into beauty”, means transforming negative emotions into positive emotions, the participant tests many transformational exercises and this done through learning something new and to master a new skill.

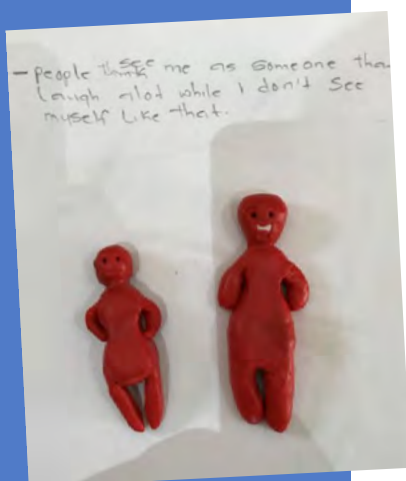


WHY USING MODERN ART PAINTINGS AS A MEDIUM IS IMPORTANT IN WORKING WITH DISPLACED AND MIGRANT PEOPLE?



The use of paintings for famous artists has an impact on the participants especially displaced people and people with trauma because it's a tool that can mirror different kinds of interpersonal conflicts. The paintings positions (drawings) with the coloring treatment facilitate the projection of the participant, as it enables the expression through a tangible product.

HOW TO BENEFIT FROM ART AND DRAMA THERAPY APPROACHES IN THE PSYCHOSOCIAL CONTEXT?



The workshop introduced basic art therapy exercise such as: “Draw what is in your heart?”, “Draw a person that means something special to you”, “Paint what is in your mind”, “Make a statue of the person you want to become after two years “... etc. In addition to a number of drama games in order to add fun and to create a positive energy of a group. Also, drama games play a role in developing the social skills of the individual and encourage him to remodel his body expression within the group.

The approach always tends to create a safe space by developing listening and cooperative skills which make the person acknowledge acceptance. The feeling of acceptance enables the person to freely express.



HOW THE PROCEDURE WORKS?



The approach begins with a check which is a creative exercise to express how we feel at the moment, like : “Do a statue, or pick a color, or pick a photo, or do a gesture to express how you feel at the moment....

After sharing how we feel today, we go to the main art exercise like for example print your finger hands and pick 5 strengths you can specify in yourself and five others that you would like to change.

A discussion takes place after each exercise to share what came to the participants’ minds during the art work process. After the discussion, the participants shared what they had in mind and the trainer asked questions such as:

who discovered anything?

who would change anything?

How do you think this change can be happening?

why do want to make this change?

Another discussion was open after these questions, and the participants chose something they want to change and shared it through the discussion after every art exercise.

The psychosocial team applied a number of drama games which comes usually after the art exercise and the sharing in specific. In addition, the team practiced relaxation and breathing exercises to make the concentration more accessible.

WHAT KIND OF FEELINGS SHARED?



ABDURRAHMAN
 I cry out my sorrows but no one to hear
 I have my grief & pain but ~~no~~ one to share
 In the dark I cry coz no one too dear
 my mum was but not hear to bear.
 I discovered ~~man~~ weak inside, but belly
 to be strong too near.

Sky blue is my best colour, I used
 it for background and sometimes here
 is darkness and fear so I used black for
 the drawing it's divided into two parts
 the lighter part and my
 my cold that is the darker part.
 warm part that is the darker part.
 I discovered that I will be every
 good artist in no time.

The team exchanged and mentioned that they would work on their anger issues, their sadness, their lack of expression, their low self-confidence, their dialogue and communication skills. Many participants mentioned loss of a person in their lives and they discovered that they can be sad but they can also move on and open their heart for daily happiness.

SECOND WORKSHOP OVERVIEW

The workshop received 26 displaced Nigerian participants, women and men who experiment a creative arts therapy workshop.

The workshop focused on the use of art especially painting using acrylic, chalk and oil pastel. In addition to that, the participants experienced modelling exercises with newsletters and clay.

To add fun and to develop concentration, social skills and connection among the participants, a bunch of drama exercises took place.

Method used:

The method used was the same as the one used with the team.

The exercises applied was based mainly on doing reproduction for famous paintings and to do auto portraits reflects something which the participant wants to say or something that is hidden for long time.



→ SECOND WORKSHOP/ PAINTINGS REPRODUCTION



① why i took this picture is its remind me of my girl friend, wich i love her so much.

② i think of marry her - i think of seeing her close to me everytime i open my eyes just to see he close to me.

③ i felt happy, glad, joy excited

④ i felt happy while doing this i dont think i could be able to do it as good as this one and make me to understand that i can do better than this.

⑤ i discover that i can do more than this drawing next time

title
 1 my love
 2 the love of my life

Using Modern art paintings especially the expressive paintings as a medium is important to inspire and to aid the participants to understand the concept of Art language.

Modern art is rich in expression that displays social and individual life challenges, hence the use of this medium and introducing the stories behind them and the challenges that faced the artists, gives the participants an idea that pain, sadness, war, displacement, migration, death, happiness, helplessness, failing is global and not personal.

→ SECOND WORKSHOP/ PAINTINGS REPRODUCTION

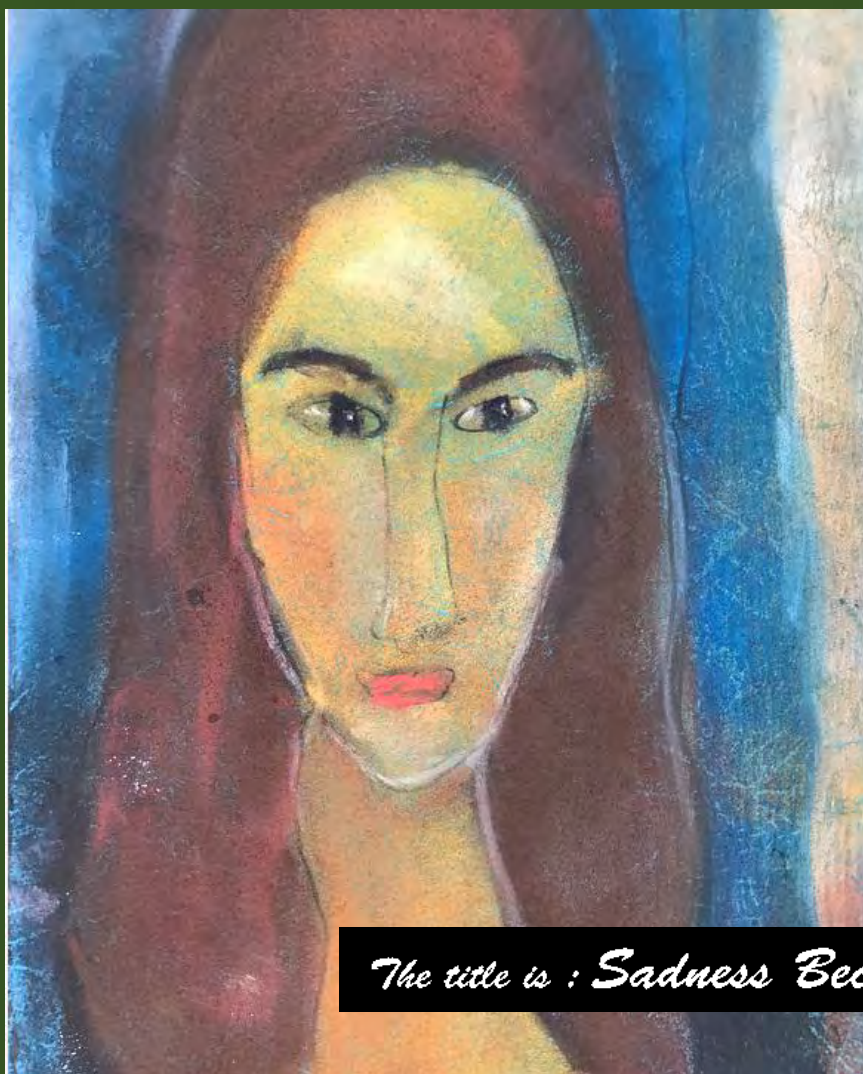


"When I draw this pic, I remembered my dear friend whom we used to work together. My friend had an accident and was sick, the last time I saw him, he was laying on the bed sick so he later died the picture I took remind him of that moment.

I was relieved after painting his pain on the paper."

By Mado

→ SECOND WORKSHOP/ PAINTINGS REPRODUCTION



The title is : Sadness Became Joy.

"I choose the picture because it reminds me of my husband whom while we were running from our place, we were not in good terms because people came between us, and we got divorced. But when we became displaced, met met in Maiduguri and we settled and now I am happy together which makes me happy as this picture."

By Sana

WHAT WERE THE EXERCISES APPLIED?

Techniques used:

The participants did 3 auto portraits using printing as a technique and acrylic, chalk and oil pastel as a medium. The trainer introduced a number of modern art paintings to the participants in order to connect to one or two of them.



Procedure:

The participant chose one or two paintings that reflect his feelings or can draw his feelings through. After choosing the paintings, the trainer introduced basic color theories and explained the importance of relating feelings to coloring and giving examples on famous painter's styles and coloring ways.

1- The participants started with a copy of the famous paintings but each painting should talk about something in his mind that he will share later. The participants showed high appreciation for the paintings and for their reproductions they were very impressed by the outcome and they shared a lot of sadness, guilt feelings, trauma, depression, anger, anxiety, sleeping problems, and incapability.

→ EXERCISES APPLIED



- 1) The reason why I took this picture is because I love the hair style => And also that reminds me of my younger sister because of the color to hair style
- 2) When I was painting I was thinking about my home and my kid sis that loves playing.
- 3) I felt happy
- 4) I felt happy because at first I don't think never thought I can do it but at last I made it so am happy.
- 5) I discover that I can do more than the tomorrow.

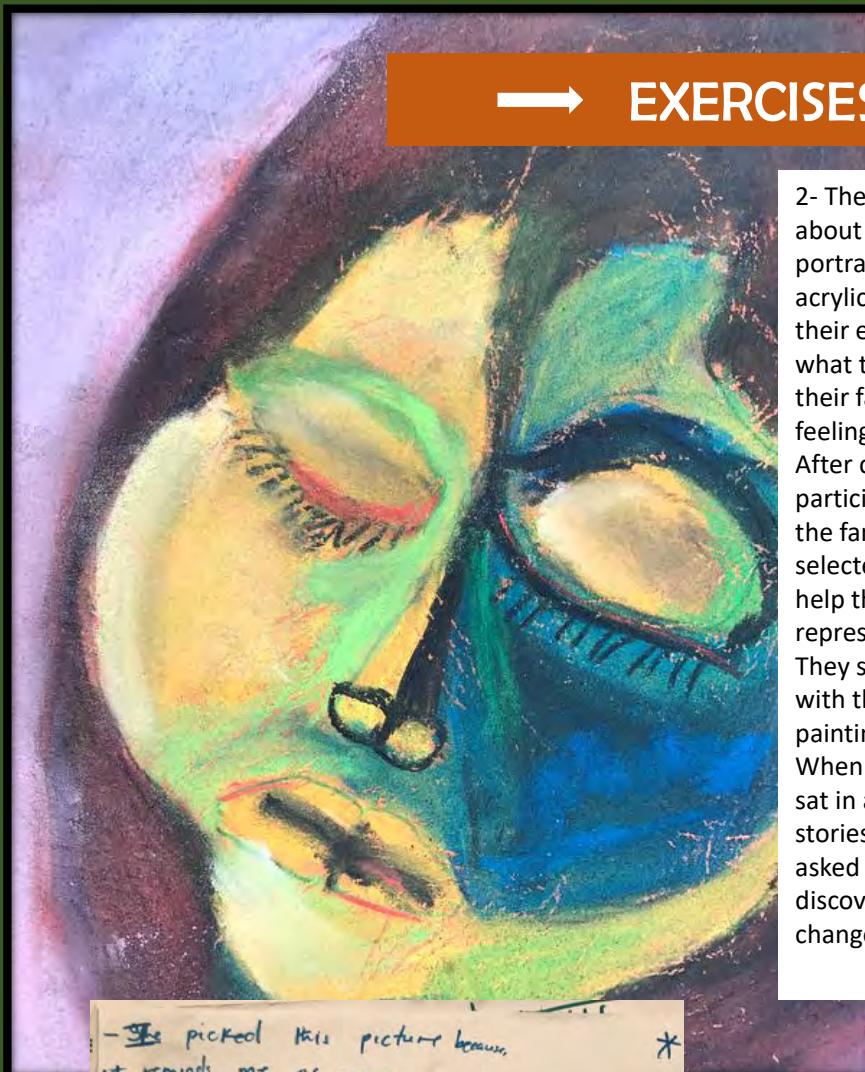
Fashion Babe

- 1) The reason why I took this picture is that I remember my lovely sister, who was known in the hands of (H.B). She likes reading so much, so anytime when I see someone was reading on I use to remember her.
- 2) The time when I was painting this drawing, I was imagining them as if we are together with her. And I'm just seeing her sitting in front of me.
- 3) I'm very happy. Because I never think, in my life that a day may come, when it's a wonderful day, a day that can take away painful & sadness. I'm happy
- 4) I was very surprised, because I never of myself, because is a wonderful hand work that I alone think I can able to do it but I put my effort to see that I try best, and with the drawing given by you (RDL) I do.

TITLE: YOU TAKE MY SADNESS AWAY



→ EXERCISES APPLIED



2- The second exercise was about printing their own portrait and coloring it using acrylic. The participants closed their eyes for a minute to know what they want to show on their faces, which story, which feeling, which conflict ... After choosing the content, the participants walked between the famous paintings, and selected paintings that could help them in their representation on their faces. They sat and started painting with the help of the other paintings. When everybody was done, we sat in a circle and shared the stories. The questions were asked again: What did you discover? What can you change?

- I picked this picture because it reminds me of my missing daughter Hauwon is her name. *

- The picture also speaks about me thinking of my house that was destroyed hoping I will get it someday. *

- It also says a clear information about my life and all I have lost, hoping to find work to do.

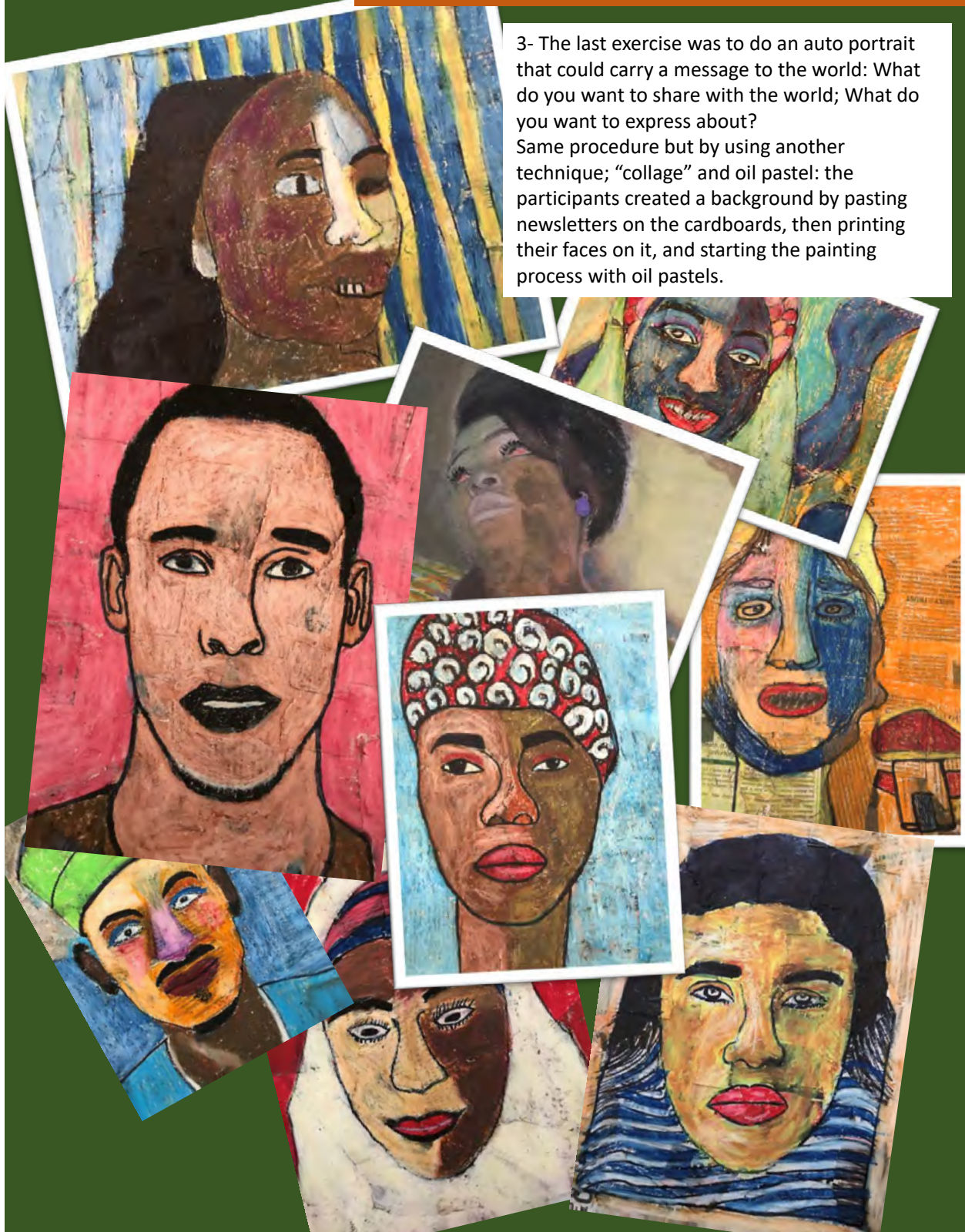
2) The thought that came to my mind is, if I had gone to school, I would have learnt and have knowledge of a lot of things. to help people and myself too.

3) While painting the fingers, our feet, soul, the color then made me feel better then after the painting I became happy

→ EXERCISES APPLIED

3- The last exercise was to do an auto portrait that could carry a message to the world: What do you want to share with the world; What do you want to express about?

Same procedure but by using another technique; "collage" and oil pastel: the participants created a background by pasting newsletters on the cardboards, then printing their faces on it, and starting the painting process with oil pastels.



RECOMMENDATION

This workshop represents an introduction to use art therapy in the psychosocial context. The team was very committed and active exhibiting high level of interest and willingness to learn about this approach. Accordingly, I would recommend the following:

1- workshops on basic art techniques (coloring / painting/ modeling/ drawing/ collage/ ...) (supported with a guide book)

2- workshops about art exercise (supported with a guide book activity/manual in the psychosocial context).
workshops about Art and craft (supported with a guide book/manual)

3- creation and manipulation of puppets (supported with a guide book/manual)
creative workshops about conflict resolution (supported with a guide book/manual with art and drama specific exercises)

4- workshops about drama games and exercises/ breathing and relaxation) (supported with a guide book/manual)

5- On the psychosocial side, the team needs more training on handling a structured intervention



Conflict transformation and mediation

Tatsushi Arai

Glossary

- **Conflict:** A contradiction, or a set of contradictions, between two or more parties, each pursuing their own goals. A party may be an individual or a group that is autonomous enough to be able to formulate a collective goal and take concerted action. Conflict is a system of relationships in which one party's goal-seeking behaviour stands in the way of the other party's goal-seeking behaviour. The conflict parties may or may not be able to accurately and explicitly describe the goals they consciously or subconsciously seek. For this reason, disagreement, a state of relationships in which two or more parties do not see eye to eye with each other, is but one manifestation of conflict. The distinction between conflict and disagreement is important because conflict parties – for example, men and women in a patriarchal society – may neither recognize their goals nor accept the existence of the conflict. It requires educated consciousness to recognize the formation and presence of conflict.
- **Violence:** A harm inflicted on the human body, mind, and/or spirit, as well as on nature. While direct, physical violence is the most visible form of harming effect, violence can also take a less visible and more indirect form. Structural violence, for example, is a form of indirect violence caused by an institutionalized denial of access to opportunities (such as education and employment) and resources (such as water and land). Cultural violence, on the other hand, is a cultural influence that justifies psychical and/or structural violence. Cultural violence makes a sustained presence of violence look and feel normal.
- **Conflict analysis:** An in-depth, systematic and multi-angled analysis of the sources and evolution of conflict. Conflict analysis requires identifying conflict parties, their goals and their relationships. It also requires empathy, an ability to put oneself in the shoes of others. Empathy is important for conflict analysis because it helps identify the goals of each of the parties involved.
- **Conflict transformation:** A self-reflective process of collective learning in which conflict parties come to develop a systematic, multi-angled understanding of their conflict and use the understanding to generate a mutually acceptable solution, as well as a common platform for continuous problem-solving and relationship-building.
- **Conflict resolution:** A social process through which the sources and contexts of a given conflict are systematically examined and effective means developed to remove the destructive aspects of the underlying problems that gave rise to the conflict.
- **Conflict management:** A social process through which destructive manifestations of a conflict are controlled and made less destructive. Proponents of conflict management support applying either violent or non-violent means by which to cope with the manifestations of social conflict.
- **Dialogue:** An interactive exchange of words and gestures between two or more individuals or groups in which they can freely, openly and respectfully express their

opinions and feelings, while at the same time listening to and learning from the opinions and feelings of the other side. Dialogue is contrasted with debate, an interactive exchange of words and gestures between two or more individuals or groups in which they present their predetermined positions to convince each other.

- **Conflict mediation (or simply, mediation):** A dialogue process in which a mutually acceptable third party, who has no authority to make binding decisions, facilitates communication between conflict parties, helps them build relationships and mutual understanding, and enables them to generate mutually acceptable solutions and/or procedures to generate solutions to contentious issues. The term “mediation” can be used to mean a larger scope of less structured, more open-ended activities in which one or more intermediaries, with varying degrees of closeness and impartiality to one side or the other, devise means by which to elicit the conflict parties’ goals, bring them together, and help them find mutually acceptable ways of resolving their conflicts peacefully. An integrated use of one-on-one meetings and a community ceremony for self-reflection and dialogue, for example, is an example of less-structured mediation practice that falls under this broader definition of mediation.

Essential skills and knowledge in conflict transformation and mediation

Tatsushi Arai

Essential knowledge and skills in conflict transformation and mediation that MHPSS workers need to develop include:

- (a) The nature and effects of social conflict, which are important because MHPSS challenges often take place in conflict-affected societies.
- (b) Violence, which is important because it generates psychosocial problems MHPSS workers need to tackle.
- (c) Conflict transformation, as well as resolution and management (see glossary), which are important because of the inseparable link between conflict and MHPSS interventions in conflict-affected societies.
- (d) Conflict analysis, which is important because a systematic understanding of conflict parties, their goals and their relationships is essential, not only for conflict transformation, but also for conflict-sensitive MHPSS practice.
- (e) Creative problem-solving, which is important because conflict analysis alone does not generate a concrete, practical solution to the underlying causes and conditions of the conflict.
- (f) Methods of applied practice in conflict transformation, which is important because applied practice can translate theory into action. Types of conflict transformation practice useful for MHPSS workers include:
 - (i) Mediation (through individual consultations and group discussions);
 - (ii) Dialogue facilitation (less structured and more open-ended than mediation);
 - (iii) Advocacy (with an emphasis on awareness-building to highlight general principles and issues to which all sides should pay greater attention);
 - (iv) Community-based practices of relationship-building, such as religious ceremonies, traditional rituals, livelihood development activities, sports and the use of artistic, creative expressions. (See the main text for more information on community-based practices.)

Case study 1

Tatsushi Arai

Conflict analysis 1: Scenario of a two-party conflict

Conflict analysis refers to a range of analytic processes designed to identify the sources and nature of conflict. Any systematic process developed and applied purposefully to analyse conflict serves as an example of conflict analysis.

Understanding of basic human needs, defined as essential conditions of life, without which human beings cannot survive physiologically and/or mentally, contributes to conflict analysis, especially when identifying conflict parties' goals. A social theory used widely in MHPSS practice, basic human needs theory, recognizes the fulfilment of both tangible, material needs (such as food, water, shelter and clean air) and social, psychological needs (such as safety, identity and self-actualization) as indispensable for human survival and wellness. This working assumption about basic human needs leads to three implications for conflict analysis:

- (a) There are irreducible essentials of life human beings are naturally inclined to meet. These irreducible essentials are so basic that conflict parties consider them non-negotiable.
- (b) Human beings become frustrated and even aggressive when their essential needs remain unfulfilled. Generally, the greater the level of frustration caused by people's inability to meet their basic human needs is, the greater the level of their aggression becomes.
- (c) To meet basic human needs, find adequate satisfiers. To prevent and overcome aggressive behaviour and destructive conflict, find satisfiers that enable conflict parties to satisfy their frustrated needs.

As demonstrated shortly, conflict transformation requires searching for creative ways in which all conflict parties can find mutually acceptable satisfiers to fulfil their basic human needs.

The case study that will be examined below focuses on a real-world conflict between two members of a women's tailoring group in a humanitarian emergency. The women's group was established by an international humanitarian agency at an internally displaced people's camp. The displacement occurred a few years earlier as a result of religiously and ethnically-motivated fighting with long-standing socioeconomic, political and historical roots.

The two women in conflict, Ms Very Productive (VP) and Ms Less Productive (LP), come from different religious, ethnic, socioeconomic and regional backgrounds. LP is a severely traumatized farmer in her late 30s from a low-income background. She has generated the equivalent of one United States dollar through her tailoring work during the past two months. LP struggles to raise her eight children without much support from her husband, whose own history of trauma and limited livelihood skills outside farming can barely support their large and growing family of 10. Although LP recently started tailoring to secure a means of livelihood for her family, she has neither prior experience nor self-confidence in tailoring. Her group's leader VP, on the other hand, has 10 years of professional experience in tailoring in her home community. With her husband's strong support for her work and with her own good educational, socioeconomic background, VP is self-confident, articulate and committed to her task. VP leads her tailoring group by registering the equivalent of USD 40 on her team's account over the past two months. A mother of two children, VP seems to be managing her life-work balance well, despite many difficulties she faces in the camp.

The two women's incomes and lives are inseparably linked. They are linked because they and the rest of the tailoring group members share only one sewing machine. The five women who belong to the same tailoring group take turns using the same sewing machine. Each group member is allocated several hours weekly to use the machine and earn as much as possible within the given time frame. While individual group members earn incomes according to their individual skills and productivity, one group member's conspicuously low productivity can, over time, adversely affect the morale and productivity of the entire group.

It is against this backdrop that a bitter argument broke out between VP and LP. VP recently expressed her discomfort toward LP for the latter's low productivity as well as for her attitude of resignation, which began to affect the morale of the other group members. While VP is sympathetic to LP's plight as a fellow IDP woman, she feels frustrated when LP hints at her envy of VP's competence and good fortune. VP, on her part, believes that she has earned her advanced tailoring skills and her livelihood through her hard work and her strong faith.

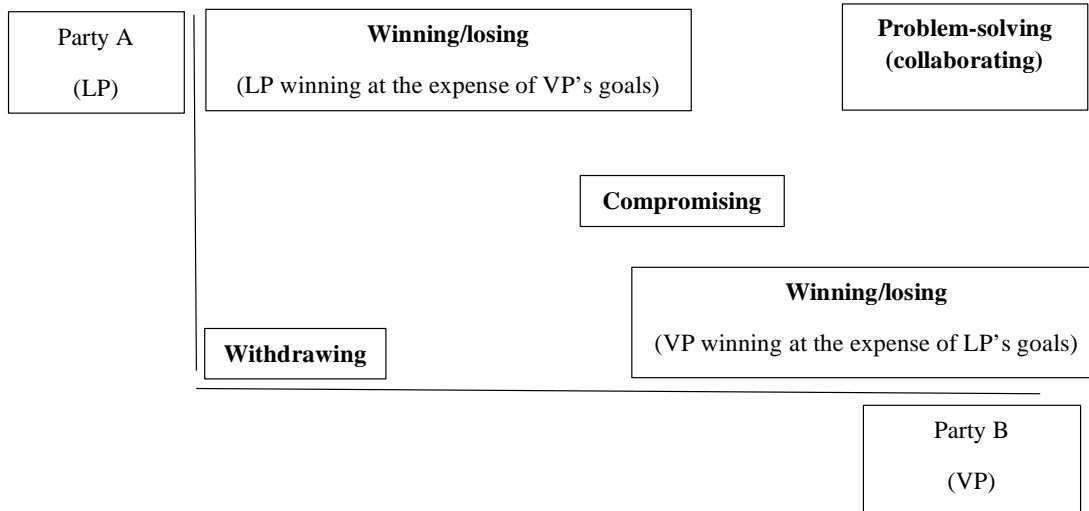
An important starting point for working on conflict scenarios of this nature is to perform a feasibility analysis for intervention. Questions for feasibility analysis include:

- Is this scenario subject to mediation and/or other forms of conflict transformation practice?
- Is there a political, legal, institutional and security environment that either inhibits or justifies the use of mediation as a means to transform the conflict?
- Has the conflict resulted in a state of violent confrontation, thereby calling for law enforcement authorities' intervention at this point?
- Who should play a leading role in approaching the conflict parties and helping them reflect on and transform the conflict?
- Is the MHPSS worker on site the right person to take a leading role, or should somebody else take the lead?
- Does the person taking the lead have adequate skills, credibility, time, resources and awareness of potential risks involved?

The MHPSS worker must answer these and other questions for feasibility analysis and self-diagnosis before taking action. International practitioners may find it useful to answer the questions with the help of informed local advisers.

Assuming that the MHPSS worker, whose home agency set up the women's tailoring group in this particular context, has both the responsibility and preparedness to lead or co-lead mediation, a first step the MHPSS worker must take is to conduct a conflict analysis. One of the accessible methods of conflict analysis applicable to this scenario is a dual-concern model, a two-dimensional Cartesian space (the X and Y axes) describing a two-party conflict over a relatively small number of issues.

Annex Figure 10.1: Dual-concern model – The case of a conflict over livelihood development



The figure places Party A (LP in the conflict scenario) on the Y axis and Party B (VP) on the X axis as if the two parties' attempts to seek their respective goals were standing in the way of each other. In response to the mediator's opening question – "Would you mind telling me what is happening between you and the other person?" – which the mediator may choose to ask in either a separate one-on-one conversation with each party or in a three-person meeting, the mediator may hear responses such as:

LP: VP is judging me because I cannot work as efficiently as she can. She is trying to reduce the time I can spend on the sewing machine. She is also trying to eventually remove me from the tailoring group. She does not understand how hard I am trying. She is dominating and threatening my life and my family's life.

VP: LP is not putting much effort into her work. She is spending so much time on the group's sewing machine and producing so little. She cannot see the negative effect of her problematic work habit on the morale of the women's group. What makes the matter worse is that she is envious of my productivity. She has no appreciation for how hard I have worked over the years to develop my sewing skills.

One of the presenting issues in this dispute is about whether LP should spend less time on the sewing machine. However, the mediator must probe deeper into the underlying motives of each party and help them identify their unarticulated basic human needs at stake. After careful probing and listening, the mediator may discover each party's more fundamental needs as follows:

Needs of LP:

- A sufficient, reliable means of livelihood;
- Respect from VP and the community at large for her life and her identity;
- Empathy from others for her ongoing struggle to recover from psychosocial distress.

VP:

- Maintain access to the means of livelihood she has successfully established;
- Maintain respect from LP and the community at large for the capacity and social standing she has earned through many years of hard work
- Fulfil her responsibility as a group leader for fellow group members whose livelihoods depend on the productivity of the whole group.

In the above diagram, “winning” in favour of VP (which means LP “losing” by implication) could mean, for example, VP successfully convincing LP to reduce LP’s hours of work at the sewing machine and to eventually make LP leave the group. Through such a move, VP can prevent LP from accusing and disrespecting VP. VP can also prevent herself and her group as a whole from failing in terms of their effort to sustain productivity and livelihood. Conversely, LP can “win” at the expense of VP’s needs fulfilment. LP could, for example, mobilize other community members holding grudges against VP. Through such a collective action, LP could threaten VP’s position as a group leader, her social standing, and even her livelihood. Either way, the binary assumption about winning/losing presupposes zero-sum thinking. It means one side’s gain resulting in the other side’s loss.

Compromising, on the other hand, means conflict parties meeting their demands halfway. A compromise requires each party to give up on part of their demands in order to secure the rest of their demands. In the conflict scenario on women’s livelihood, a compromise between LP and VP can be achieved by VP promising not to threaten LP’s right to retain her existing hours of tailoring time in exchange for LP promising not to speak ill of VP. In this arrangement, LP retains the existing means of livelihood yet loses her right to stand up against her group’ leader; VP, meanwhile, can contain LP’s disrespectful behaviour yet will continuously struggle with the unchanging reality of LP’s low productivity. Compromising, therefore, is a form of zero-sum thinking that distributes amounts of needs satisfaction and dissatisfaction between conflict parties in a balanced way.

Withdrawing, another option presented in the dual-concern model, means neither party taking action on their conflict. In a state of withdrawal, conflict parties neither attempt to resolve their conflict nor escalate it. They postpone responding to their conflict. In the conflict scenario on women’s livelihood development, withdrawal could mean both VP and LP avoiding communication about their concerns. It could also mean the two women having little to no contact for fear of conflict escalation. The problem of withdrawal, however, is that the unfulfilled needs and mounting frustrations of both parties will remain intact. A sustained period of withdrawal may therefore lead to a larger, more complex conflict later.

Finally, problem-solving (or collaborating) refers to a joint effort between the conflict parties to find a mutually satisfactory solution. It requires identifying the basic human needs of both parties and devising a creative means by which to fulfil their needs in a mutually supportive manner. When successful, problem-solving enables the conflict parties to achieve better outcomes than what each party can single-handedly achieve. In the present conflict scenario, LP and VP may explore a number of problem-solving options if they so wish. Focusing first on procedural steps for relationship-building between LP and VP, the two women can:

- Accept mediation under the leadership of a trusted impartial intermediary they are both willing to work with.
- Enter facilitated dialogues, art-based methods of self-reflection and experiential learning, and other constructive means by which to build mutual understanding and reconciliation.

- Join an informal tea time conversation between the two of them and their teen children, especially if their children are good friends with each other. The goal of this conversation is to create a circle of humanizing relationships in which the two women can reaffirm their shared commitment to livelihood development and community-building, which in turn can benefit their children's present and future needs.

Focusing on substantive outcomes of problem-solving, the two women can:

- Explore if LP's skills can be better utilized to iron finished products and/or cut cloths instead of keeping her current role in tailoring.
- Invite LP to a different tailoring group so that she can have a fresh start and maintain her access to a livelihood development opportunity.
- Ask if LP is willing and able to move from the tailoring group to a knitting group, assuming that LP is more skilled in knitting.
- Help LP learn sewing skills to increase her productivity. If VP can help LP learn sewing skills, such a collaborative effort between them can facilitate reconciliation and boost the team's morale.

These options for problem-solving are illustrative only. Their usefulness depends on the conflict parties' willingness and ability to implement the options.

As a general guideline for capacity-building, conflict parties and intermediaries should familiarize themselves with all these styles of handling conflict, because their familiarity can enhance their general self-awareness of conflict. They should, however, all strive to learn how to practice problem-solving as the most ideal path. A compromise and withdrawal can be used as steps toward problem-solving. A strategy of winning/losing, which implies accepting a deprivation of basic human needs on the part of the "losing" party (or parties), is not recommended. Yet, a thought experiment with conflict parties about what would happen if one side were to win at the expense of the other side's needs fulfilment can help all sides think through the possible long-term consequences of zero-sum thinking and untransformed conflict.

Case study 2

Tatsushi Arai

Conflict analysis 2: Scenario of a multiparty conflict

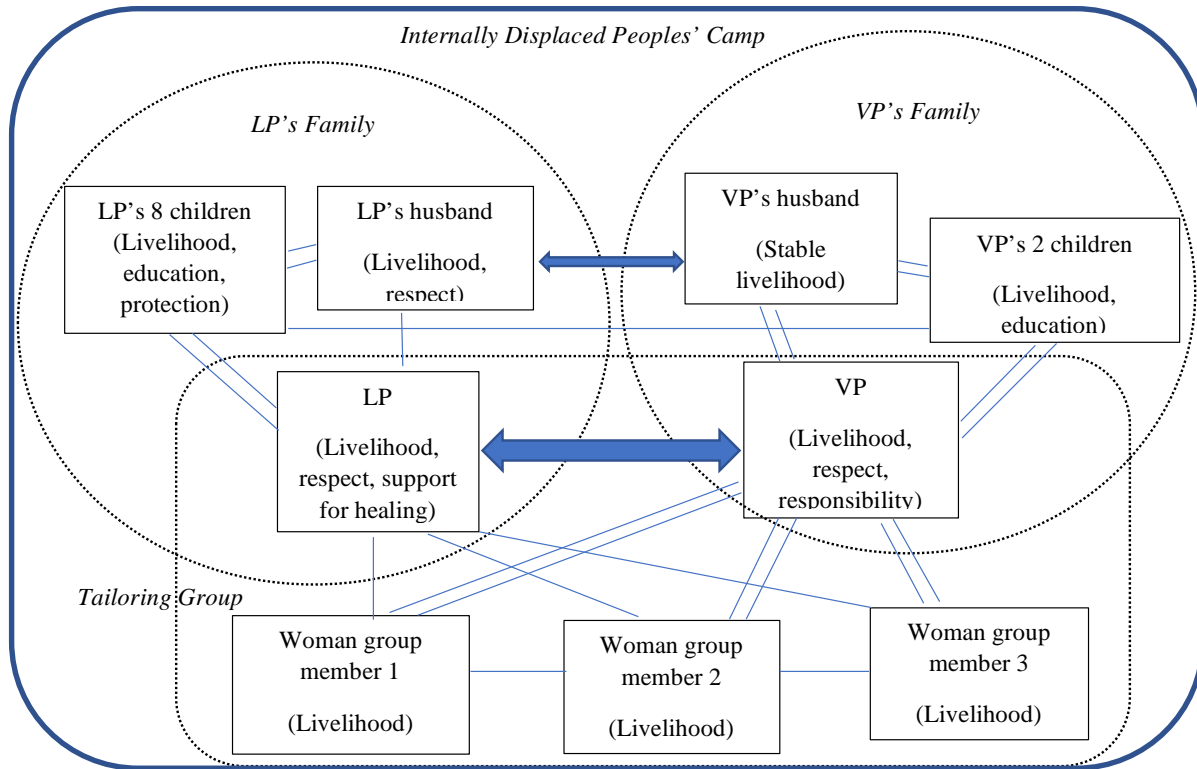
Conflicts in humanitarian emergencies involve many parties and issues. They are typically more complex than the simple two-party conflict between LP and VP discussed earlier. A useful technique for analysing a more complex multiparty conflict is conflict mapping, a visual representation of parties, goals and relationships. To illustrate conflict mapping, the following actors and needs are added to the scenario:

- Other women in the tailoring group need a stable means of livelihood.
- LP's husband, traumatized and unsupportive of LP's tailoring work, needs a secure means of livelihood. He also needs respect from his wife, his eight children and his community at large.
- VP's eight children need a means of livelihood, education and protection.
- VP's husband, supportive of VP's tailoring work and productive in his own livelihood development activities inside and outside the camp, needs stability in his livelihood and his wife's.
- VP's two children need sustained support for their livelihood and education.

VP's husband is a leader of a men's livelihood development group. LP's husband, with limited vocational skills, hopes to join the men's livelihood group to generate income. However, LP's husband suspects that VP's husband as the leader of the group will reject him. Neither of the two men has a favourable view of the other, because of the conflict between their wives.

The following diagram presents one way of applying the technique of conflict mapping to the expanded version of the conflict scenario. Each party's needs are inserted in brackets. Arrows pointed in two opposite directions represent conflicts. Double lines indicate mutually-supportive relationships and alliances. Single lines indicate relatively weak but functional relationships, which may be either adversarial or supportive.

Annex Figure 10.2: Scenario of a multiparty conflict



The goal of conflict mapping is to develop a visual image of the system of relationships in which conflicts are embedded. Conflict mapping enables parties and intermediaries to see the system, step outside the system, and talk about it objectively. It also helps them identify problems and vulnerabilities in the system as well as opportunities for relationship-building and problem-solving.

Conflict mapping establishes a basis for planning actions to transform conflict. One of the simplest ways of utilizing conflict mapping to this end is to identify conflicts (illustrated by bidirectional arrows) and explore means to transform them. There are two general approaches to the exploration of such means: synchronous and diachronic approaches.

A synchronous approach addresses multiple conflicts in the system simultaneously. It draws on the working assumption that the roots of seemingly separate conflicts can be interwoven. It suggests that interconnected conflicts can be transformed when their roots are addressed simultaneously and systematically. A synchronous approach is analogous to a medical treatment designed to cure multiple illnesses simultaneously by treating their causes systematically.

In the multiparty conflict under study, the conflicts between the wives and husbands are inseparably linked. A synchronous approach to the conflict involves bringing the two couples together and talking together about their needs and concerns systematically. A range of conflict styles from withdrawing to problem-solving that the dual-concern model presents are all applicable to different stages and aspects of the multiparty dialogue. However, an application of the dual-concern model must become more multidimensional, systemic and holistic in this case because it must somehow fulfil the needs of all the four parties. One concrete way of applying the model is to establish a joint effort between the two couples

to expand their means of livelihood development, while maintaining their respective roles in the gender-specific livelihood development groups. Mutual understanding between the two families about their characters and identities can grow as a result of creating interactive space for the children of both couples to play and work together.

A diachronic approach, on the contrary, builds on sequential thinking. It tackles one conflict at a time. While a diachronic approach, like a synchronous approach, views a conflict system as an interconnected whole, it takes the complexity of the system as a central issue to consider when building action plans. A diachronic approach is used when an integrated way of handling multiple conflicts is likely to become excessively complex and unwieldy. Unwieldiness in this context stems from an overwhelming number of parties and issues, unhealthy power dynamics caused by having too many different parties (as illustrated by a likely scenario of the husbands' dominant status that prevents their wives from speaking up on their livelihood and identity needs), and heightened emotions aroused by a direct encounter with adversaries.

There are at least two ways of practicing a diachronic approach. One way is to tackle the primary conflict in the system first and secondary ones later. In the scenario described above, the conflict between LP and VP is the primary conflict affecting their husbands' relationships; the LP–VP conflict is the centre of the conflict system of which their husbands' conflict is more of a peripheral issue. Therefore, the first way of practicing a diachronic approach is a “centre-first” approach to the centre-periphery relations embedded in the integrated conflict system. Concretely, this means using options generated by an application of the dual concern model in such a skilful way as to create enabling conditions for the husbands of the two women to transform their conflict on their own.

The second way of practicing a diachronic approach is a “periphery-first” approach, which involves tackling a relatively minor, secondary conflict first to build confidence. In the present conflict scenario, a periphery-first approach requires taking steps to build relationships and mutual understanding between the two husbands first, and then encouraging them to support their wives' dialogue and problem-solving. Concretely, an application of a periphery-first approach would mean the two husbands building an agreement to distinguish their partnership in men's livelihood development from the difficulty their wives are facing in the women's group; this agreement presupposes the two men's consent not to judge each other's character without first-hand knowledge of each other. Such a partnership between the two husbands may bring more income to their families, lessen the pressure the two women may be feeling about their respective needs to earn more income through tailoring, and create conditions in which the two women can feel more optimistic about their capacity and prospect of problem-solving.

Having described synchronous and diachronic approaches to the transformation of complex multiparty conflicts, it is important to emphasize that what is common to the two approaches is the need to tackle all the essential conflicts in the system sooner or later. This need must be taken seriously, because the conflicts in a close-knit community are interconnected, as illustrated by the IDP camp in this conflict scenario, and it is therefore neither possible nor useful to isolate one conflict from another.

One-on-one dialogues

Tatsushi Arai

Johan Galtung, a pioneer in contemporary peace and conflict studies and the author of the ABC triangle, developed a method of mediation that consists of a series of one-on-one dialogues with conflict parties. The rationale of this method is that, in deep-rooted conflict, parties are often unwilling and unable to meet and talk in person, and even if they meet, they tend to use their meeting as an opportunity to fight and defeat the other side. In order to help the parties self-reflect and think freely and creatively, Galtung recommends that a trained mediator meet with each of the parties separately, listen carefully for their underlying goals and needs, invite them to explore possible solutions, and bridge different parties' constructive goals and visions of a desirable future through one or more iterations of one-on-one dialogues. To carry out these steps, the dialogue facilitator will need to have a systematic method in mind to keep track of each party's goals, as well as the ways in which the different parties' goals seem to contradict or complement one another. (To design the method, consult the examples of conflict mapping and explore the applicability of the selected techniques of counselling.)

To summarize the steps required to carry out the suggested method of dialogue:

- (a) A dialogue facilitator identifies conflict parties and visits or invites each of them separately.
- (b) The facilitator asks each party simple open-ended questions (what, why, how, and so on) to probe into the deep-seated reasons and goals of the party's action related to the conflict. The facilitator needs to suspend judgment and exercise deep empathy with each party, especially when the party's action appears to be directly responsible for causing harms to others.
- (c) If and when the conflict party is ready, the facilitator may invite the party to explore and envision concrete ways in which the party's legitimate (life-affirming) goals, on the one hand, and his or her opponents' goals, on the other, can be met simultaneously. This part of the exercise often requires the conflict parties to gradually and voluntarily redefine what their conflict is about, enabling them to discover a deeper and more holistic understanding of the sources, effects and meanings of the conflict.
- (d) With the permission of each of the parties, the facilitator may start sharing emerging visions of possible solutions to the conflict through another iteration of one-on-one dialogues. These visions will need to be framed as questions for further inquiry rather than as definitive statements at this point. In this process of sharing, the facilitator can check with each party the feasibility and desirability of the proposed solutions, and assess the extent to which the parties are ready to meet and discuss these issues in person. (Experiences in carrying out dialogues in conflict-affected societies suggest that conflict parties tend to become more open and less assertive when they see concrete solutions and a promising way out of their conflict.)
- (e) The steps described above may be taken with a collaborative effort between two or more dialogue facilitators dividing tasks and integrating lessons from the respective parties.
- (f) When the parties are ready and willing to meet face to face, the dialogue facilitator can convene a mediation session, or a series of mediation sessions. The facilitator can build on the results of the preceding one-on-one dialogues to frame the conflict as the parties' shared challenge, facilitate confidence-building, explore concrete solutions, and encourage them to identify practical ways to implement the solutions. (Suggested steps to carry out mediation will be useful.)
- (g) If possible and desirable to the parties, the facilitator can meet with the parties sometime after the dialogue to see how they are doing in the implementation of the agreed-upon plans, and offer them support to overcome challenges.

Mediation between two or more parties

Tatsushi Arai

The following overview of suggested steps for mediation is a revised version of a model presented in Carolyn Schrock–Schenk’s *Mediation and Facilitation Training Manual* (2002). These steps illustrate a Western model of mediation facilitated by neutral third parties, and they are subject to cultural adaptation. Still, MHPSS workers across cultural contexts may find them useful as a starting point of inquiry.

Introduction:

- Convey greetings, recognize the positive commitment of the parties to coming to the mediation session, and take care of seating and logistical arrangements as needed.
- Create space for opening prayers and/or ceremonious gestures as appropriate.
- Describe the voluntary nature of the mediation process as well as the non-binding nature of its outcomes, which the parties may choose to uphold if they so desire.
- Explain the role of the mediator as an impartial facilitator, not an arbitrator, and emphasize that the mediator has no vested interest in the mediation outcomes.
- Establish ground rules, including confidentiality and the use of mutually respectful language.
- Present an overview of the suggested steps as well as the length of the session, break times, a plan to introduce a separate meeting with each of the parties, and other arrangements as needed.

Storytelling:

- Each party describes issues, concerns and needs from their viewpoint.
- The mediator summarizes each party’s perspective after they speak.
- Listen for key issues, concerns, needs, feelings, commonalities and differences.

Identifying issues:

- The mediator lists joint issues.
- Check with all parties to make sure the working list is mutually acceptable and comprehensive.
- Consider categorizing and prioritizing issues in order to establish a logical sequence in which the issues should be addressed.
- The list can include both concrete, tangible issues and less tangible relationship issues.

Problem-solving/healing:

- Choose one issue, or one set of related issues, and ask each party to describe it in more depth.
- Help parties discover underlying needs behind their stated positions. Also, help them reflect deeply on what truly matters to them.
- Encourage parties to be open to share their feelings and examine the basis of their feelings.
- Facilitate constructive communication using active listening, empathy and reframing.

- Help parties focus on the future (“How can both of you relate to each other peacefully?”) in addition to creating room for them to reflect on the past (“Who was right and wrong when the incident happened?”).
- Encourage and acknowledge moments of learning, discovery and recognition for oneself and for others.

Agreement/resolution:

- Be specific about concrete agreements, paying attention to who does what, when and where.
- Consider incorporating responses to intangible relationship issues, for example, through apologies, acknowledgement of responsibility, and affirmation of status and identity, in addition to formulating concrete agreements on tangible issues.
- Use balanced, non-judgmental language that honours the identities and characters of all the parties.
- Make sure that agreements are practical, mutually acceptable and sustainable.
- Devise steps to follow up on the implementation of agreements as well as approaches to future problems that may arise.

Two cautionary notes are in order about the use of this model. First, steps required to win the trust of conflict parties in mediation and bring them together are often no less important and challenging than the actual conduct of mediation. Some or all of the steps described in the proposed process of one-on-one dialogues may be useful for this purpose. Second, a mediation process intended to tackle a contentious issue rarely proceeds in a linear, stage-like fashion from beginning to end. A list of steps described above should therefore be regarded as a working framework, not as a fixed process. Mediators may move forward and backward between phases, return to certain phases repeatedly, and make additions and adjustments as needed.

Focused psychosocial support: Individual counselling for survivors of gender-based violence

Thomas Eliyahu Zanghellini

1 Introduction

These instructions are intended for national staff or staff with limited training or knowledge in psychosocial support who are expected to come in contact with victims/survivors of gender-based violence (GBV).

Because very often time and place of contact/intervention do not allow for long-term counselling, and referral pathways are not always established, the model that will be presented derives its methodology primarily from the Solution-Focused Brief Therapy (SFBT) model.

This document intends to outline the content for a three-day training in what kind of psychosocial support can be given to GBV survivors that is more focused than PFA and less specialized than what a clinical or psychiatric counselling in a clinical setting over a longer period of time should contain.

It is assumed that the training person has advanced knowledge in GBV protection intervention, psychosocial intervention and methodologies, and advanced knowledge in SFBT.

At best and ideally, this module will be embodied in a series of trainings which extensively cover GBV, protections, emergency intervention, MHPSS intervention and other related topics. Therefore, people who will be trained or attend this training should already be trained in the principles of protection and medical referral of survivors of rape and other GBV actions.

Added to this document are four PowerPoint presentations that include activities, an agenda for a three-day training, handouts, supporting documents, a movie and practical exercises (role plays).

This is meant to provide the basic material for the trainer or trainers, to arrange and develop further their training seasons.

2 The basics – Short recapture

The Inter-Agency Standing Committee (IASC, 2005) developed a manual called *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, as guidance to respond to GBV in emergency settings. It states that “Gender-based violence (GBV), and in particular sexual violence, is a serious, life-threatening protection issue primarily affecting women and children” (ibid.). Nonetheless, it is well documented that men can be victims of GBV as well (see, for example, the recent GBV report on the Syrian Arab Republic (Human Rights Council (2018))).

GBV is a widespread international public health and human rights issue, and adequate, appropriate and comprehensive prevention and response are not available in most countries worldwide.

According to IASC's *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery* (IASC, 2015), "Gender-based violence is especially problematic in the context of complex emergencies and natural disasters, where civilian women and children are often targeted for abuse, and are the most vulnerable to exploitation, violence, and abuse simply because of their gender, age, and status in society". Also, "Gender-based violence is among the greatest protection challenges individuals, families and communities face during humanitarian emergencies. Accounts of horrific sexual violence in conflict situations – especially against women and girls – have captured public attention in recent years. These violations and less recognized forms of gender-based violence – intimate partner violence, child marriage and female genital mutilation – are also being committed with disturbing frequency. Natural disasters and other emergencies exacerbate the violence and diminish means of protection. And gender-based violence not only violates and traumatizes its survivors, it also undermines the resilience of their societies, making it harder to recover and rebuild" (ibid.).

The Guidelines continue: "During a crisis, such as armed conflict or natural disaster, institutions and systems for physical and social protection may be weakened or destroyed. Police, legal, health, education and social services are often disrupted; many people flee, and those who remain may not have the capacity or the equipment to work. Families and communities are often separated, which results in a further breakdown of community support systems and protection mechanisms" (ibid.).

"Throughout any emergency, many forms of GBV occur. During the early stages – when communities are first disrupted, populations are moving, and systems for protection are not fully in place – most reported GBV incidents are sexual violence involving female survivors/victims and male perpetrators. Sexual violence is the most immediate and dangerous type of gender-based violence occurring in acute emergencies. Later – in a more stabilized phase and during rehabilitation and recovery – other forms of GBV occur and/or are reported with increasing frequency. These include, among others, harmful traditional practices (female genital mutilation, forced early marriage, honour killings, etc.) and domestic violence" (ibid.).

Survivors have fundamental rights:

- Right to health;
- Right to non-discrimination;
- Right to self-determination;
- Right to information;
- Right to privacy;
- Right to confidentiality;
- Right to safety.

Survivors can be affected in different ways, such as emotionally (for example, grief and anger), physically (for example, sexually transmitted diseases, pregnancies and physical harm) and socially (for example, stigmatization, loss of income). Protection intervention has the goal of minimizing the psychosocial and health effects that GBV has on its victims. A comprehensive GBV response has to include protection, community-based intervention, livelihood and safety projects, and individual and group counselling.

Often, GBV survivors experience certain stigmatization not only of being a victim, but also when branded with such words as “traumatized”, “lost person”, “destroyed soul” and the like, implying that their lives are destroyed and they will suffer from it their entire lives, without any chance to have a prosperous life again.

The approach taken here is, without minimizing the effect GBV has on its survivors, that GBV survivors can overcome their struggle, cope with what happens and have a chance to reorganize their lives, reinvent their identities and reclaim their happiness.

3 Focused psychosocial support – Solution-Focused Brief Therapy

The follow counselling model is based on the assumption that the most important protection issues have been taken care of: safety (safe place to stay), medical and health care (HIV prevention, pregnancy prevention and any other important medical treatment), legal advice, comprehensive information-sharing with the survivor and complete information-sharing on confidentiality agreements and processes.

SFBT aims to give responsibility back to the client, forming a partnership in the counselling process and through specific techniques empowering the person to manage their own lives positively. It aims to bring the client out of a mental paralysis and the perception that “I can’t deal with it” or “I can’t handle it” to an active response where the clients can specifically formulate their own goals and act on them. It’s rather short-term-orientated, but can be adapted to any context and needs. At most, three to six counselling sessions should be conducted.

SFBT for GBV survivors includes as well:

- Information-sharing; and
- Practical support.

Key messages which always should be transmitted to the survivors are:

- The survivor has done nothing wrong and is not to blame.
- Feelings of confusion, anger, guilt or numbness or any other are normal feelings to a not-normal situation.
- The survivor is not alone and will be supported.

3.1 Information-sharing

This point would include a complete protection information-sharing process. This includes the medical, safety and all other above-mentioned issues. The agreements on confidentiality and anonymity have to be made especially clear.

3.2 Practical support (case management)

Sometimes practical support is needed. GBV survivors have to deal with medical examinations, treatment and/or follow-ups. Further, if a legal case is made against the perpetrator, GBV survivors need legal assistance, have to deal with paperwork, will be interviewed and questioned by the responsible law enforcement person, and will need to visit the police station. GBV survivors may not be able to work for some time, which can create livelihood challenges.

Practical support in these cases can include the following:

- Filling out, reading and explaining medical, legal or any other documents;
- Accompanying the GBV survivors to the police, the hospital or other facilities;
- Active support in finding new accommodation if necessary;
- Connecting the GBV survivor to group counselling, livelihood projects and health-care services;
- Connecting the GBV survivor to appropriate legal counsellors;
- Connecting the GBV survivor, if necessary, to specialized mental health and psychosocial support services;
- If necessary, organizing temporary financial support, hygiene products, food and water.

Practical support always should be given with the principal that the survivors should be doing as much as possible by himself/herself to keep the survivor active and experience success. The process should involve acknowledgement for things achieved and general positive feedbacks.

3.3 Solution-Focused Brief Therapy – The philosophy

Unlike traditional and more formal forms of therapy and counselling, Solution-Focused Brief Therapy does not focus on analysing the problems, pathologies and past life events. It is not trauma therapy and it is not debriefing.

The “Why” is not the primary question to ask; instead, SFBT concentrates and focuses on finding solutions in the present time and exploring one’s hope, perspective and perception for the future to find quicker resolution of one’s problems. Questions that stimulate one’s own imagination, creativity and positive projections are used.

SFBT takes the approach that you know and have the key for what you need to do to improve your own life and, with the appropriate coaching and support, are capable of finding the best solutions. Problems are not defined as isolated interpersonal shortcomings, but a failed solution-finding strategy. The focus in the counselling process is to empower someone to find the right solution and act on it to solve the problem. SFBT can be used alone or in combination with other counselling techniques or protection intervention.

SFBT can/should incorporate the three core condition of personal centred counselling:

- Congruence: Be self-aware, genuine and congruent.
- Unconditional Positive Regard: The survivor's feelings and experiences, positive or negative, should be accepted without any conditions or judgment.
- Empathy: Empathic understanding of the survivor's experiences without getting emotionally involved.

Based on these core conditions, it is important to understand that a successful client/counsellor relationship is based on trust, honesty and transparency. To form a partnership where the counsellor can reflect and mirror developments, feelings and behaviour of the survivor is essential. Sometimes, such partnership can have a parent–child, mentor–student or friend–friend character. It needs a lot of experience to recognize such and channel/use it correctly for the benefit of the survivor.

Nonetheless, as long as the partnership is constructive and the goals are reached, it can be secondary. Attention has to be given to unintentionally recreating the relationship dynamics of abused survivors. To ensure this, and avoid issue of dependencies or exploitation, supervision should always be available and at best be mandatory.

The SFBT approach does not mean that victim and perpetrator are not clearly identified. It also does not mean that the survivor cannot talk about her/his feelings, hurts, past events, etc. Such topics should always be given room and space if the survivor so desires. But SFBT does not recreate the past events of violence by going through the instances step by step to reflect on the feelings and reaction of those events. It does not de-fragment past traumatic events.

But does SFBT work? Different studies conclude that it is:

- Effective in the reduction of aggression and criminal behaviours (Gingerich and Peterson, 2013), and has been effectively used with people with learning disabilities (Smith, 2005; Banting et al., 2017).
- An effective approach to the treatment of psychological problems, with effect sizes similar to other evidenced-based approaches, but these effects are found in fewer average sessions, and use an approach style that is more benign (Gingerich et al, 2012; Trepper and Franklin, 2012).
- An effective treatment, for a wide variety of behavioural and psychological outcomes. It seemed to be shorter, making it cheaper than alternative treatments

(www.medscape.com/viewarticle/559404_3), and has been used in counselling survivors of domestic violence (GBV).

SFBT should always be adapted to local customs and traditional ways of dealing with problems. Traditional societies have specific ways to view, talk about and deal with problems. In fact, many traditional conflict resolution strategies are inherently solution-focused and brief in nature, and very often include reframing and rituals to overcome problem-focused thinking and behaviour.

3.4 Solution-Focused Brief Therapy – How to do it

SFBT is flexible on the amount of sessions, and can/should be adapted to each case and context. If knowledge about rituals and theatre (plays, creative role plays and such) intervention is present, and competencies sufficient, it is highly encouraged to use it, as long as it is not used to recreate certain past events that would mean that the survivor will relive the event.

Following is a four-session intervention with one follow-up session. The numbers of sessions and follow-up session can be adapted at any time and place.

The sessions can be structured as follows:

- (a) Pre-session and basics:
 - (i) Appropriate setting: Places that ensure confidentiality and anonymity (health-care centres, offices, counselling centres, any safe place that keeps the survivor comfortable and ensures confidentiality and anonymity). Public spaces, such as under a tree or similar, can be sufficient and proper, and they meet the mentioned criteria.
 - (ii) Gender: Make sure that the survivor is comfortable with you as a counsellor, in case you are the opposite gender.
 - (iii) Setting: Make sure that a place that has doors is only closed if the survivors agree with it. Leave to the survivors the place that is closest to the door with a free way to reach it. Don't lock (with a key) the door at any time.
 - (iv) If in a closed room, and confidentiality and anonymity allow it, open the window a bit so that fresh air can enter constantly.
 - (v) In general, protection issues always have priority. If new violence is experienced, or safety not guaranteed anymore, the protection/GBV focal person has to be involved or referred to (with the consent of the survivor).
 - (vi) At best, there should be coordination of all levels of intervention. For example, GBV cases can involve GBV focal points, protection officers, law enforcement officers, medical staff and others. Depending on the situation, regulation and consent of the survivor, such staff should coordinate the intervention and make clear who is responsible for what. Regularly updating each other is best. The survivor has the right to know about such updates and meetings, and what has been discussed in it. If files are kept, the survivor needs to be informed about this and has the right to look at it.

The focus of the SFBT is not the protection issues, but the personal development, coping strategies and the improvement of the well-being of the survivor which, as mentioned, can include practical support. It is possible that a Protection Officer will do the most important practical support, and therefore the counsellor can focus on SFBT only.

(b) First session:

- (i) Introduce yourself, explain who you are and which organization you are from, and give your first name. Explain the service you provide, how long a session is and how many sessions you offer normally.
- (ii) Let the survivor explain and talk about whatever she/he decides to talk about. Try to understand what happened, how the survivor views what happened, which feelings are described, which physical symptoms are described, and which social and economic aspects are described. Let the survivor express any feeling he/she has, be it crying, anger, extensive head-shaking, standing and sitting, etc. Have tissues prepared and if possible water. Use enough time to understand what happened, what's going on and what the survivor expects from you.
- (iii) After you get an overview about the problem described, ask if the survivor wants to take a break. If yes, have a break from 5 to 10 minutes. Generally, if setting and time allow, breaks can be done according to the need of the survivor and the counsellor.
- (iv) Setting of goals: In the next step, it is important to be clear about the goal the survivor has in reaching out to you. The following questions, which aim to understand the goal of the survivor, can help:
 - a. What would you like to see happen in your life through this counselling?
 - b. What is the most important thing you want to change in your life now?
 - c. What is the most difficult problem you have right now and what do you want to change about it?
 - d. What would you like to see happen by the end of our session today?
 - e. What have you already tried and what has been useful?
 - f. What is already working in the right direction?
 - g. What is the least that you would like to achieve?
 - h. What would be different in your life when you have reached your goal?
 - i. How would that change make a difference for you?
 - j. How will you know that your goal has been reached? How will others know your goal has been reached?
 - k. If you had one wish and it would happen, what would you wish for right now?

- (v) Based on the answers, it is important to define agreed specific goals and actions. GBV survivors often need practical support in addition to counselling. Specific goals can often be generically formulated, such as “I want to be happy again”, “I want to feel better”, “I don’t know what to do next”, and “I need help”. Here, goals must be formulated clearly and understandably, with indicators. For example:
- a. Goal 1: My goal is to be happy again in one month. I will know that I am happy when I laugh a lot again, I meet my friends again, I sleep well and I eat again regularly.
 - b. Goal 2: I will find a job within a month, with an income that allows me to pay the school fee for my child, and have enough food for me and my child.
 - c. Close the first session by asking if there is anything else important to say that has not yet been said. Make a new appointment to meet in two to three days.
 - d. Always close the session positively with positive feedback, such as: “I am really impressed that you came to me and told me all of this – you did great”; “You have so much strength – I am really impressed by you and look forward to seeing you again”.

(c) Second session:

- (i) Welcoming and assessment: In each session, some time should be spent on welcoming the person back. Ask the survivor how she/he feels. How were the last two days?
- (ii) The focus on the second session should be more practically orientated. Changes that appeared should be worked out. Actions have to be formulated on how to achieve the goals. Specific questions should be asked to activate the survivor’s own resources and capabilities to solve her/his own problem and recognize the strength, resilience and abilities to cope. The following questions can help with this:
 - a. What is better? Of the things you did, what helped the most?
 - b. What else has helped so far?
 - c. Tell me about challenges you had in the past and how you overcame them.
 - d. What are your strengths that helped you solve your problems in the past?
 - e. What do you think you did to make that happen?
 - f. When is the problem not a problem? What were you doing differently then?
 - g. How did you manage that? And how else?
 - h. Tell me about your good qualities.
 - i. What gave you the strength to do that?
 - j. How are you managing to cope with this to the degree that you are?
 - k. How did you manage to get back on the right track?
 - l. Suppose you were to compliment yourself on your effort; what would you say?
 - m. How do you most enjoy spending your time? In what are you most interested?
 - n. What have you achieved that you are most proud of?

- o. What positive things would your parent/teacher/other say about you?
- p. On a scale from 1 to 10, where 1 is the worst and 10 is the best, where are you today?
- q. How did you manage to remain at that number?
- r. What would one step higher look like?
- s. How would you notice you have gone up one point?
- t. How would others see that you have taken a small step?

(iii) Once such questions have been asked, it is important for the counsellor to emphasize and bring into a nutshell what has been said, especially pointing out the strength the survivor has shown in coming back to the sessions, the good things that happened, and the activities that she/he is doing to feel better, among others. Encourage the survivor to do more of all the things that make him/her feel better, that improve her/his well-being, that improve her/his health, and that make her/him sleep better.

(iv) Controlling: Find out about reaching the goals. If the goal is practical, such as finding a job, ask if this has been achieved. If not, ask what has been done, what has she/he tried. Offer practical support or connect to places where practical support can be given, such as NGOs, livelihood projects, CV writing, and such (see section 12.3.2).

(v) Close the second session (see above).

(d) Third session:

- (i) While the first two sessions can be done within a few days, there should be a longer time lapse for the third session (one to two weeks). This is important to give time for protection intervention to bear fruit, and for the survivor to see changes.
- (ii) It should always be made clear that the survivor can always contact the counsellor, that the appointed times of meeting are flexible, and protection issues are always urgent and should be addressed immediately, either by the counsellor or a GBV focal point.
- (iii) Welcome the survivor and focus on what has changed, question her/him and deal with the situation if all is the same or nothing has changed.

If the responses to the questions are that nothing has changed/all is the same:

- a. How can I be helpful to you today?
- b. What would need to happen today to make this a really useful session?
- c. How would your best friend notice that this session was helpful to you?
- d. How did you manage to get out of bed and make it here today?
- e. Is this unusual, that things have not gotten worse?
- f. How have you managed to keep things from getting worse?

- g. Amplify efforts in maintaining/coping, and compliment small steps taken.
- h. Ask for more details of previous solutions or exceptions to the problem.

If the responses to the questions are that things have started to get better:

- a. Focus on details of how the client made this happen (strengths and resiliencies).
How did you make that happen?
 - b. How did you manage to take such a big step?
 - c. What did you tell yourself to help you do it that way?
 - d. Pay compliments.
 - e. What will you do to keep this going?
 - f. What additional changes would you like to see?
- (iv) Make sure that it has been emphasized what has already been achieved, what works and what else the survivor can do reach the goals. Encourage the survivor to do more of the things that help her/him. For example, sitting and chatting with friends make the survivor feel good, so encourage her/him to sit with them regularly or more often.
- (v) Referral: There are certain indicators that a survivor needs a more specialized support, such as a psychiatrist or medical support. This can sometime manifest after the first session or after some weeks from when the incident occurred. Take special care of and refer immediately if:
- a. The survivor talks about suicide.
 - b. The survivor endangers herself/himself or others.
 - c. The survivor talks about hearing voices and seeing dead people (is hallucinating).
 - d. The survivor shows constant aggressive behaviour.
 - e. The survivor shows increasing substance abuse.
 - f. There is any other behaviour that makes you feel uncomfortable and concerns you.

As a general rule, it is always good to involve a supervisor or focal point professionals if any insecurity appears on the part of the counsellor.

- (vi) Controlling: Check where the survivor stands. Make a midterm evaluation of the goals. Use the above-mentioned questions.
- (vii) Check at this point eating, sleeping and free time activity habits. If there are activity groups available – such as sewing groups, play groups or any other – give information, or connect, or accompany the survivor if wished, to such groups. Encourage activities.
- (viii) Close the third session (see above).

(e) Fourth session:

- (i) In principle, the fourth session should be a repetition of the third. The emphasis is on which changes did occur, what has been done.
- (ii) Sometimes survivors experience a setback. Explain that this is normal and all right. Let the survivor explain to you what happened, how she/he reacted to it, and what is different from last time she/he came.
- (iii) Comfort and encourage. Emphasize his/her strength in coping with the experience for so long, and that she/he has already achieved so much. The guiding principles in such situations should be understanding, listening, empathy and encouragement.
- (iv) Check also how much practical support is still needed.

(f) Follow-up session:

- (i) A follow-up session can be done with a longer time elapse, for example, one month. The focus should be on changes achieved, what is better and how this has been achieved. For this, you can refer to the questions in the third session.
- (ii) The goals have to be evaluated. If achieved, the “How” has to be in the centre. If not achieved, then the focus is on what has not been achieved. The following questions can help:
 - a. What do you think did you not achieve?
 - b. What should you try to do to achieve the goals?
 - c. What else do you think can you try?
 - d. What support can I give you to achieve your goals?
- (iii) If goals are achieved and the client is satisfied, you can explain that for now the sessions are over, but if there is any need arising she/he can contact you, you are here for support and he/she is welcome. Emphasize the courage and strength that was needed for her/him to come to this point and do so well. If necessary and thought important, a follow-up session in one or two months can be made.

4 Training in empowerment counselling

The above-mentioned counselling techniques can be learned in a feasible time. At best, the targeted audience should be MHPSS actors who already have a basic training in either GBV or MHPSS. The training should be at most five days; the emphasis should be on practical trainings in communication skills, questioning techniques, organizing counselling sessions, dealing with emotions and difficulties during counselling processes, and instructions on how and when to give practical support. It is recommended that the training is done by at least two trainers of the opposite

gender and who are experienced in the proposed techniques. General GBV protective action should be presented, as should the effect GBV can have on its survivors, an in-depth look at the different forms of sexual GBV and a look at male and female survivors.

5 Existing tools – Review

Some existing tools that have been consulted for this paper were:

- Clinical Care for Survivors of Gender-Based Violence at the International Rescue Committee (n.d.) – A prototype for International Rescue Committee health programmes.
- Mental health and gender-based violence: Helping survivors of sexual violence in conflict – a training manual for helpers.
- Clinical Management of Rape Survivors – Developing protocols for use with refugees and internally displaced persons – revised edition (WHO and UNHCR, 2004).

The above-mentioned tools try to address mental health issues from different angles. The IRC paper and the clinical Management for Rape survivors manual are focused on medical treatment and a general clinical outline to deal with GBV survivors. In both papers, a concrete adaptive psychosocial support methodology is missing. Even though counselling principles are outlined, a concrete description of principles, organization of sessions and guiding principles for counsellors are not there.

Therefore, such documents are especially helpful to consult while setting up clinical and medical care centres for GBV survivors. Such papers are more focused on specialized services, and less on “focused MHPSS services”.

The above-mentioned training manual presents a more practical counselling-orientated view, which is clearly in harmony with the intent of this paper. Nonetheless, it is essential to point out that, in the manual, a trauma-focused approach is preferred.

In general, it seems that manuals and tools dealing with GBV tend to highlight the severe consequences that GBV survivors experience. “Traumatized”, “destroyed”, “hurt soul”, “lost generation” and the like are just some of the labels with which survivors are tagged.

Such descriptions can be true, and the effect of GBV should not be minimized. Nonetheless, trauma-focused intervention has to be critically reviewed.

First, trauma-focused intervention and therapy can be done only by highly trained and qualified counsellors. Second, trauma-focused therapy is more clinical, needs more time, and can have counterproductive effects. Surely, trauma-focused therapy is a specialized service, which makes it difficult to adapt to a more field work-orientated and focused psychosocial support intervention.

But exactly such an intervention form – which is practically orientated, less clinical, and less dependent on time and place – is what is needed by psychosocial support actors who are less trained. Also, manuals should be practically-orientated. Field workers with less training are most in need of practical examples of how to respond and deal with certain situations in daily work.

This is why it is highly preferable to include trainings for psychosocial support actors that are practical and include role-playing, where such actors can exercise and try playfully the basic learned counselling techniques. Therefore, the above-mentioned documents should and can be complementary to this document, in presenting guidelines for organizing specialized clinical and focused individual services and counselling.

For all references please see bibliography.



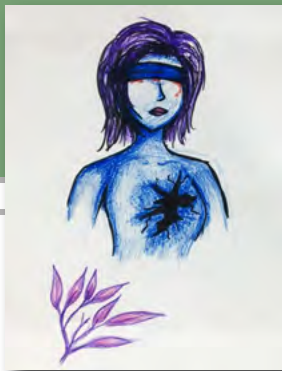
Tackling gender based violence in IRAQ

IDPs and host communities' members revealing their emotions through IOM MHPSS programme



Khanaqin (Diyala) 2018

IDPs and host communities' members revealing their emotions through IOM MHPSS programme



Najaf 2017

Gender Based Violence, particularly domestic violence, is a widespread negative trend across Iraq due to the culture of silence on the topic. According to the 2006-2007 Family Health Survey, 83.1% of married women reported at least one form of marital control, 33.4% reported at least one form of emotional violence, 21.2% experienced physical violence and nearly 14% reported violence during pregnancy. A Ministry of Planning study conducted in 2012 found that 36% of married women reported experiencing psychological abuse from their husbands, 23% verbal abuse, 6% physical violence, and 9% sexual violence.



The Iraq Women Integrated Social and Health Survey (I-WISH), conducted in July 2011, reveals the perception of men regarding violence against woman, showing a significant proportion of men considering males have the right to exercise violence against women. This includes beating their wives and daughters, preventing their wives from accessing health services alone, controlling the dress code and forcing daughters under 18 to marry.

Although only a small number of studies indicate the increasing of domestic violence following humanitarian emergencies and displacement, several factors such as increased stress, increased negative coping strategies, disruption of social networks and lack of opportunities to find alternative housing or resources can have an impact on domestic violence. According to IOM Iraq report "A Gender Perspective: Safety, Dignity and Privacy in Camp-like Settings in Iraq", issued in 2016, female IDPs face restrictions linked to preexisting gender roles, exacerbated by displacement. Women's role and freedom have been curbed in the name of protection.

Since September 2014 IOM has been in the forefront of the humanitarian response trying to address the issue on a national level through multi-layered interventions targeting a wide spectrum of the population among both displaced and host communities. Children, women, men, key stakeholders, are all engaged in a programme focused on prevention and response strategies ranging from outreach and community-based activities, focused non-specialized support to specialized interventions aiming all at identifying cases within the communities, creating awareness, reducing stigma, re-establishing hope while supporting beneficiaries to move from the victims to the survivors mindset.

Since the beginning of the programme, IOM MHPSS team has reached 103,278 people and has established 24 community centers, safe spaces where women and children can be assisted. More needs to be done to address domestic violence in a volatile context such Iraq, and IOM will keep advocating and operating across the country to tackle this issue.

This booklet, result of art-based interventions, intends to illustrate IOM MHPSS interventions through a visual journey communicating beneficiaries' feelings and emotions regarding domestic violence and gender based violence while offering a way to have their voices heard.

1. Basic services and security:

IOM MHPSS team supports IDPs and host communities providing information and linking them with services available. A common issue in IDP camps is women not being allowed to get out of their tents by male family members. The teams actively advocate to change this situation, working with the families and the whole community.



Karbala 2017



Hassan Sham (Ninewa) 2017



"Women make up half of the society and we still sit darkness"
Chamakor (Ninewa) 2017

2. Community and family support

Community and family support activities take place daily in camps and urban settings across Iraq. All activities are used as a tool to provide psychosocial support, helping beneficiaries feel safe and calm, be active members of the community, have strong social networks and regain hope in the future. Awareness raising sessions and campaigns addressing domestic violence are organized regularly for both children and adults.



Hassan Sham (Ninewa) 2017

Community and family support activities take place daily in camps and urban settings across Iraq. All activities are used as a tool to provide psychosocial support, helping beneficiaries feel safe and calm, be active members of the community, have strong social networks and regain hope in the future. Awareness raising sessions and campaigns addressing domestic violence are organized regularly for both children and adults.



"Do you think I am unable to give you a lesson?"
Qayyarah (Ninewa) 2017

Children are targeted and included in all IOM MHPSS interventions. Violence towards children in their families, in schools and gender based violence, including early marriage, are the main issues IOM is focusing on.



"We stand together to stop violence against children"
Najaf 2018

Improving children welfare is one of the objectives of IOM MHPSS programme. Each year, on the occasion of Universal Children's Day, on 20 November, children are specifically included in tailored activities aiming at promoting their wellbeing while promoting their rights.



"Child marriage is the biggest crime"
Kirkuk 2018



“The beauty of a woman can cause the loss of part of her freedom”
Chamakor (Ninewa) 2017

During several MHPSS activities, restriction of freedom as well as cultural limitations came out as one of the main issues women are currently facing. IOM is therefore also engaging men through different advocacy interventions, ranging from sessions facilitated by religious leaders to football tournaments aiming at raising awareness on the topic while re-establishing the balance of power between women and men. Occasions such as International Women Day, or the 16 days of activism against gender based violence campaigns, are also moments of reflections and togetherness on domestic violence, for the entire community.

Not only children, but also women and men are included in group activities and discussions used as tool to identify cases of beneficiaries exposed to violence in their homes. Discussion on the topic can shed the light on domestic violence, reduce its impact and help eradicating it. Different types of domestic violence are identified, along with the effects and potential remedies and solutions.



“Behind culture and tradition bars”
Chamakor (Ninewa) 2017



“This pigeon represents me, because I want to travel and fly around the world as a free woman”
Chamakor (Ninewa) 2017

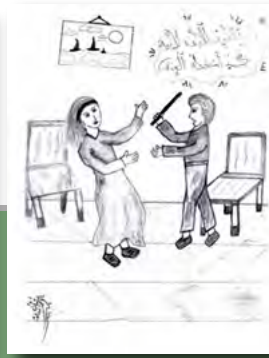
3. Focused non-specialized services

IOM MHPSS team provides psychological first aid and emotional supportive sessions after distressful events, such as episodes of domestic violence. Case management services, individual and group counseling, support groups and emotional supportive sessions targeting domestic violence are available throughout Iraq.

Domestic violence survivors receive individual support to overcome the impacts of violence and make informed decisions, recovering the control over their lives. When the survivor agrees, IOM works with the whole family to improve their communication and find alternatives to violence.



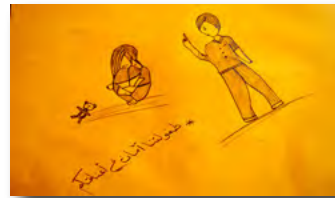
Karbala 2017



“The son takes from his father(dad) the use of violence”
Dohuk (Nasgizliyal) 2017



HajAli (Ninewa) 2017



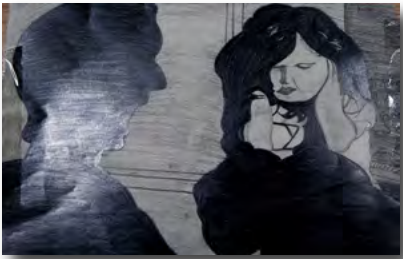
“Our childhood is your responsibility”
Najaf 2018



Najaf 2018

4.Focused specialized services

Psychological and psychiatric support are available for people suffering domestic violence as well as for those recurring to it. Survivors receive both individual support and family support if requested.



Najaf 2018



"It is not death murdering women, but ignorance, betrayal and hate instead"
Najaf 2018



"I'm a silent human being, but my words and injuries are always spoken"
Hassan Sham (Ninewa) 2017

Several success stories were achieved after engaging the aggressor in psycho-social activities and offering individual support. In addition to that, when needed, cases are referred to specialized protection actors' prior their consent, following referral pathways so as to ensure the safety of the person. IOM provides information on services available and supports people of concern making the best decision for themselves, always with respect for their choices.



Khanaqin (Diyala) 2018

This booklet is published with the contribution of the Office of US Foreign Disaster Assistance USAID/OFDA. The photos and the views expressed herein should not be taken, in any way, to reflect the official opinion of the Office of US Foreign Disaster Assistance USAID/OFDA, and the USAID commission is not responsible for any use that may be made of the information it contains.

COPYRIGHT All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the prior written permission of the publisher.

Tackling gender based violence in IRAQ

IDPs and host communities' members revealing their
emotions through IOM MHPSS programme

Relevant definitions

Jack Saul

Resilience: As defined by Panter-Brick and Leckman (2013), resilience “is the process of harnessing biological, psychosocial, structural [environmental] and cultural resources to sustain well-being”. Resilience has now emerged as a new paradigm in the fields of development and mental health (Saul, 2013). What is distinctive about a resilience-based approach is (a) an emphasis on strengths, resources and capacities rather than deficits; (b) anticipation of actions that reduce the impact of adversity; (c) attention to multiple levels of influence, ranging from the structural and cultural through to the community and the individual; and (d) mapping influences within ecologically-nested systems (Ager et al., 2010). Resilience applies not only to individuals, but also to families, communities, organizations and society as a whole.

Most models of resilience have largely focused on individual resiliency, but there is a body of literature and research on family and community resilience. For example, Froma Walsh calls for a multisystemic, resilience-oriented approach to recovery. She stresses the contextual factors in practice, by situating traumatizing events in a communal context, while attending to the relational networks and practice focused on “strengthening family and community resources for optimal recovery”. She identifies belief systems, organizational patterns and communication as the family and social processes in risk and resiliency (Walsh, 2007).

The key processes to facilitate resiliency include (a) belief systems, which make meaning of experience; (b) positive outlook, transcendence and spirituality; (c) organizational patterns, including flexibility, kin and community connectedness, and economic and institutional resources; and (d) communication/problem-solving, which includes clear, open emotional expression and collaboration. Walsh approaches resiliency as a systemic process from micro (family) to macro (communal). Researchers and theorists at a societal level explore the way in which culture both provides resources as well as shapes the meaning and indicators for resilience of a particular group (Kirmayer, Sehdev and Isaac, 2009).

Counselling: This is the provision of assistance or guidance in resolving personal, social or psychological problems and difficulties, especially by a professional (Counseling, 2018). From a community and systems approach, counselling can be seen as any interaction or conversation that promotes psychosocial well-being. This includes interactions between community members, especially those who might be identified for their wisdom and guidance, such as elders, experienced parents, professionals or paraprofessionals who are members of the community, including clergy, health and mental health professionals, teachers and others. This also includes, in the situation of emergency humanitarian response, professionals and paraprofessionals who work for NGOs or assistance organizations. Counselling may take place in formal or informal

settings, such as offices or park benches, may be scheduled or ad hoc. It may be exclusively focused on problem-solving or support, or be a component integrated into a community activity, such as recreation, arts or gardening. In many emergency settings, counselling may be an important part of an accompanying relationship: that is, community members or volunteers who help recent migrants navigate through a new environment.

Features that stand out in a contextually sensitive counselling approach include:

- (a) Mobilizing suffering persons' resilience, psychological and relational strengths and resources, in order to solve their problems. This will often include mobilizing the collective capacities for resilience that reside in family and community relationships, and that are drawn from cultural and religious traditions.
- (b) While effective counselling involves teaching important skills – such as active listening, respect and avoiding causing emotional harm – effective counselling is founded on social–emotional and relational intelligence of the practitioner and client, as well as persons who may facilitate various forms of psychosocial support and guidance, as part of the organic life of communities.
- (c) Counselling for many – particularly those who have been displaced from home, family, and community – creates a space of “protected intimacy” which may be an important capacity to prevent a sense of psychological homelessness.

For all references please see bibliography.



WORLD MENTAL HEALTH DAY 2018

10th October

World Mental Health Day is observed on 10 October every year. It is part of the global engagement with the overall objective of raising awareness of mental health issues around the world and mobilizing efforts in support of mental health. The Day provides an opportunity for all partners and stakeholders working on mental health issues to talk about their work, and what more needs to be done to make mental health care a reality for people worldwide.

This year theme of 2018: "Young People and Mental Health in a Changing World".

Adolescence and the early years of adulthood are a time of life when many changes occur. For many, its exciting times, they can also be times of stress and apprehension. In some cases, if not recognized and managed, these feelings can lead to mental distress. The expanding use of online technologies, while undoubtedly bringing many benefits, can also bring additional pressures, as connectivity to virtual networks at any time of the day and night grows. Many adolescents are also living in areas affected by humanitarian emergencies such as conflicts, natural disasters and epidemics. Young people living in situations such as these are particularly vulnerable to mental distress and illness.

Much can be done to help build mental resilience from an early age to help prevent mental distress and illness among adolescents and young adults, and to manage and recover. Prevention begins with being aware of and understanding the early warning signs and symptoms of mental distress. Psychosocial support can be provided in schools and other community settings and of course training for health workers to enable them to detect and manage mental health disorders can be put in place, improved or expanded. Investment by governments and the involvement of the social, health and education sectors in comprehensive, integrated, evidence-based programs for the mental health of young people is essential.

ADOLESCENCE

Adolescence (10–19 years) is a unique and formative time. Whilst most adolescents have good mental health, multiple physical, emotional and social changes, including exposure to poverty, abuse, or violence, can make adolescents vulnerable to mental health problems. Promoting psychological well-being and protecting adolescents from adverse experiences and risk factors which may impact their potential to thrive are not only critical for their well-being during adolescence, but also for their physical and mental health in adulthood.

MENTAL HEALTH DETERMINANTS

Adolescence is a crucial period for developing and maintaining social and emotional habits important for mental well-being. These include adopting healthy sleep patterns; taking regular exercise; developing coping, problem-solving, and interpersonal skills; and learning to manage emotions. Supportive environments in the family, at school, and in the wider community are also important.

Multiple factors determine the mental health of an adolescent at any one time. The more risk factors adolescents are exposed to, the greater the potential impact on their mental health. Factors which can contribute to stress during adolescence include a desire for greater autonomy, pressure to conform with peers, exploration of sexual identity, and increased access to and use of technology. Other important determinants for the mental health of adolescents are the quality of their home life and their relationships with their peers. Violence (including harsh parenting and bullying) and socio-economic problems are recognized risks to mental health. Children and adolescents are especially vulnerable to sexual violence, which has a clear association with detrimental mental health.



Some adolescents are at greater risk of mental health conditions due to their living conditions, stigma, discrimination or exclusion, or lack of access to quality support and services. These include adolescents living in humanitarian and fragile settings; adolescents with chronic illness, autism spectrum disorder, an intellectual disability or other neurological condition; pregnant adolescents, adolescent parents, or those in early and/or forced marriages; orphans; and adolescents from minority ethnic or sexual backgrounds or other discriminated groups.

Adolescents with mental health conditions are in turn particularly vulnerable to social exclusion, discrimination, stigma (affecting readiness to seek help), educational difficulties, risk-taking behaviours, physical ill-health and human rights violations.

MENTAL HEALTH CONDITIONS IN ADOLESCENTS

Worldwide, it is estimated that 10–20% of adolescents experience mental health conditions, yet these remain underdiagnosed and undertreated. Signs of poor mental health can be overlooked for a number of reasons, such as a lack of knowledge or awareness about mental health among health workers, or stigma preventing them from seeking help.

RISK-TAKING BEHAVIOURS

Many risk-taking behaviours for health, such as substance use or sexual-risk taking, start during adolescence. Limitations in adolescents' ability to plan and manage their emotions, normalization of the taking of risks that have an impact on health among peers and contextual factors such as poverty and exposure to violence can increase the likelihood of engaging in risk-taking behaviours. Risk-taking behaviours can be both an unhelpful strategy to cope with poor mental health and can negatively contribute to and severely impact an adolescent's mental and physical well-being.

Harmful use of substances (such as alcohol or drugs) are major concerns in most countries. Worldwide, the prevalence of heavy episodic drinking among adolescents aged 15-19 years was 13.6% in 2016, with males most at risk. Harmful substance use in adolescents increases the likelihood of further risk-taking such as unsafe sex. In turn, sexual risk-taking increases adolescents' risk of sexually-transmitted infections and early pregnancy – a leading cause of death for older adolescent girls and young women (including during childbirth and from unsafe abortion).

The use of tobacco and cannabis are additional concerns. In 2016, based on data available from 130 countries, it was estimated that 5.6% of 15–16-year old had used cannabis at least once in the preceding year. Many adult smokers have their first cigarette prior to the age of 18 years.

Perpetration of violence is a risk-taking behaviour which can increase the likelihood of low educational attainment, injury, involvement with crime, or death. Interpersonal violence was ranked the second leading cause of death of older adolescent boys in 2016.



PROMOTION AND PREVENTION

Interventions to promote adolescents' mental health aim to strengthen protective factors and enhance alternatives to risk-taking behaviours. Promotion of mental health and well-being helps adolescents in building resilience so that they can cope well in difficult situations or adversities. Promotion programmes for all adolescents and prevention programmes for adolescents at risk of mental health conditions require a multilevel approach with varied delivery platforms.

Examples of promotion and prevention activities include:

- One-to-one, group-delivered, or self-guided online psychological interventions.
- family-focused interventions such as caregiver skills training, including interventions which address caregivers' needs.
- School-based interventions, such as: organizational changes for a safe, secure and positive psychological environment; teaching on mental health and life-skills; training staff in detection and basic management of suicide risk; and school-based prevention programmes for adolescents vulnerable to mental health conditions.
- Community-based interventions such as peer leadership or mentoring programmes.
- Prevention programmes targeted at vulnerable adolescents, such as those affected by humanitarian and fragile settings, and minority or discriminated groups.
- Programmes to prevent and manage the effects of sexual violence on adolescents.
- Multisectoral suicide prevention programmes.
- Multilevel interventions to prevent alcohol and substance abuse.
- comprehensive sex education to help prevent risky sexual behaviours.
- Violence prevention programmes.

EARLY DETECTION AND TREATMENT

It is crucial to address the needs of adolescents with defined mental health conditions. Avoiding institutionalization and over-medicalization, prioritizing non-pharmacological approaches, and respecting the rights of children in line with the United Nations Convention on the Rights of the Child and other human rights instruments are key for adolescents.

Interventions for adolescents should consider:

- The importance of early detection and provision of evidence-based interventions for mental and substance use disorders. Mental health Gap Action Programme (mhGAP) provides evidence-based guidelines for non-specialists to enable them to better identify and support priority mental health conditions in lower-resourced settings.
- Transdiagnostic interventions – for example, those which target multiple mental health problems.
- Delivery by supervised staff who are trained in managing adolescents' specific needs.
- Engaging and empowering caregivers, where appropriate, and exploring adolescents' preferences.
- Face-to-face and guided self-help methods, including electronic mental health interventions. Due to stigma or the feasibility of accessing services, unguided self-help may be suitable for adolescents.
- Psychotropic medication should be used with great caution and should only be offered to adolescents with moderate-severe mental health conditions when psychosocial interventions prove ineffective and when clinically indicated and with informed consent. The treatments should be provided under the supervision of a specialist and with close clinical monitoring for potential adverse effects.



KEY MESSAGES

To promote mental health and psychological well-being of adolescents and to strengthen the awareness within the communities, several key messages have been developed by MHPSS SWG partners in North East Nigeria and extracted from Advocacy Package: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2011).

- It is common to have strong feelings after a difficult event. Such reactions include loss of interest to daily life, feeling sad, irritable or confused, having difficulty to concentrate, physical reactions or vivid memories of the event. Recognize that this is a challenging time but one that we can work to manage, with time and support we can overcome these difficulties.
- Focus on the things you did well and try to be patient with the changes in how you are feeling and reacting. Even during difficult times, try to re-establish your daily routines: talk to someone you trust about your feelings, exercise regularly, even if it is just a short walk, and have regular eating and sleeping habits.
- Taking care of yourself will help you care for others. Pay attention to seek help for yourself and do not be ashamed to ask for help. Your inner strength is important to help yourself and help others.
- Avoid or restrict alcohol intake and refrain from using illicit drugs. When you drink or use drugs, it takes longer to overcome the painful feelings and anxiety. Also, when you drink or use drugs it is difficult to protect and support your family and to help your community to overcome with difficulties. It will take longer to rebuild.
- If your distress not decrease or gets worse, it is especially important try to seek help from others who can support you. Stay connected, keep in contact with family and friends. Talk to a trusted family member, friend, or person in your community.
- Be aware of persistent negative thoughts and self-criticism and try to replace them with positive thoughts. If you feel you cannot cope or are not getting better, seek help from a professional.
- We can rebuild community together. Pay particular attention and reach out to those that are the most affected to prevent further harm: organize community and social activities such as religious ceremonies, community meetings, sports, arts, cleaning and helping others in the community.

Please find below the links to the reference and handouts that could be modified to carry out an awareness and other related activities of the World Mental Health Day 2018.

http://www.who.int/mental_health/world-mental-health-day/2018/en/

<http://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>

Acknowledgement to partners for the discussion and development of key messages:



Depression
Let's talk

Worried about the future? Preventing depression during your teens and twenties

Adolescence and young adulthood present many opportunities — for meeting new people, visiting new places and finding a direction in life. These years can also be a time of stress. If you are feeling overwhelmed rather than excited by these challenges, read on.

What you should know

- Depression is an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks.
- In addition, people with depression normally have several of the following: a loss of energy; a change in appetite; sleeping more or less; anxiety; reduced concentration; indecisiveness; restlessness; feelings of worthlessness, guilt, or hopelessness; and thoughts of self-harm or suicide.
- Much can be done to prevent and treat depression.



REMEMBER:

There is a lot that you can do to keep mentally strong. If you feel that you may be heading for depression, talk to someone you trust or seek professional help.

What you can do if you are feeling down, or think you may be depressed

- Talk to someone you trust about your feelings.
- Seek professional help. Your local health-care worker or doctor is a good place to start.
- Stay connected. Keep in contact with family and friends.
- Exercise regularly, even if it's just a short walk.
- Stick to regular eating and sleeping habits.
- Avoid or restrict alcohol intake and refrain from using illicit drugs; they can worsen depression.
- Continue doing things you have always enjoyed, even when you don't feel like it.
- Be aware of persistent negative thoughts and self-criticism and try to replace them with positive thoughts. Congratulate yourself on your achievements.

Case study: IOM MHPSS indicators study in South Sudan – Monitoring as integral to MHPSS

The term Protection of Civilian sites came into use to describe United Nations Peacekeeping bases being used as temporary shelter for IDPs fleeing the violence of South Sudan's civil war. IOM has had a strong history of providing MHPSS services in these sites. The sixth IDP site was located close to Wau Town, the second largest urban area in the country. The surrounding countryside was populated mainly by farming communities, who supplemented their incomes with hunting in the forests. The site was established when the violence of the civil war, originally confined to the two largest ethnic groups in the country, who were primarily pastoralists, suddenly spread to Wau Town. The residents of the city and farming environs fled to the United Nations Peacekeeping bases. The Protection of Civilian sites was originally an open space in which people were free to return to their businesses and fields during the day. They were united by "Local Arabic", which they had all used in trade.

The IOM Camp Management team planned activities and services carefully, setting up a representative council of leaders who could disseminate information throughout the camp. MHPSS activities were incorporated into this structure.

However, when monitoring and indicator development began for the MHPSS sector one year later, the situation had changed dramatically. Danger had increased and the residents could not leave during the day, as they were likely to be harmed. More than 21 ethnolinguistic groups were now residents of the Protection of Civilian sites. Many were women and children who had walked for many days, fleeing massacres. Many children lost mothers or grandmothers, and mothers had lost children.

When newcomers arrived, speaking so many different languages, they often had no way to get information as to what services the camp could offer, how they could access them, and which camp organization could help, with anything from plastic sheeting to protect from rain to medical care or rations for children. Rumours of favouritism began to flare up, and it seemed that the MHPSS programme was not hitting its targets.

The monitoring mission supported a participatory indicator study that would reach out to all the ethnolinguistic groups using the SEE_PET method. The objective of the study was to learn about what was required to support the well-being of young men (under 35) and conflict-affected women, two groups most affected by the violence of the conflict. The information gleaned from the study resulted in the creation of an indicator framework allowing IOM and programme participants to establish a new baseline and then regularly assess the progress of their work.

The study revealed that the Protection of Civilian sites had become a beacon for agriculturalists, people who stayed in one place, in a country largely inhabited by pastoralists. So even though languages, religion and ethnicities might be different among the residents, most shared lifestyles and values. The MHPSS team could then take the lead in creating some rapid interventions that could enhance a sense of safety and security, and activate altruism and hopefulness

- The educated young men, trapped in the camp due to violence, felt useful and important when they were invited by the MHPSS team to help camp management, by providing a weekly briefing for newcomers. This also dispelled fears of exclusion by the newly arrived groups. The young men let the new arrivals know how they might access camp services, or connect to one of the camp management committees, which could then be more effectively representative.
- The MHPSS team engaged artists and community theatre traditions to map the camp and provide illustrated versions of the information, so that those who could not read could be given non-verbal cues. Engaging people used to using theatre allowed women and men to feel in control of their lives as they helped to stabilize the camp.
- The MHPSS team facilitated the formation of small groups where women and men separately could share their traditional knowledge with one another, and engage in mourning ceremonies, adding these to planned activities.
- Staff felt empowered by finding solutions to those things in their power to control and knowing that their programme would be evaluated on the basis of realistic programmes for the changed circumstance.

With the course correction, the study yielded specific measurable and reportable indicators that could be refreshed or adjusted should the situation change again.

How to use the SEE_PET to create a MEAL frame

1 Charting beginnings – creating a monitoring frame

To create an indicator frame for a SEE_PET exercise, create a chart base on the indicators the group has operationalized. The model here is combined from those in Burundi, Uganda and Nepal. The left-hand column of the chart should contain the domains that the participants have established and agreed upon. The next column lists the ways in which each domain is operationalized in action. The PSS focal person or group leader marks the agreed-upon response on the chart next to each domain. This will form the “baseline” against which the participants will measure the success of their programme going forward. Annex Table 16.1 from this study uses examples from communities in Northern Uganda, Burundi and Nepal for illustration as these groups were created.

Annex Table 1: Charting beginnings – Creating a monitoring frame

Domain	Operational definition	Right now!	After 6 months	After 1 year
Education (PICTURE)	I have access to important information. All of my children are at school.	We feel ignorant of important information. The younger children from 5 of the families attend school.		
Access to resources (PICTURE)	I can help decide how to spend money in the household. I can get help in emergencies. I can save for things that I want.	We do not have access even to the money we earn from daily wages. The clan decides about support, sometimes they don't give. No group savings programme.		
Harmony and love in the family (PICTURE)	I feel safe in my home. My husband loves me. I am welcome to live in my home even if I am a widow.	Some of us are beaten. We have fights that cause us distress. Our family members tell us to leave.		
Friends and support outside the family (PICTURE)	When we are sad we can talk to friends. We have a place to turn when bad things happen at home.	Sometimes we feel hopeless and sad. We meet friends when we go for water or daily work.		
Voice at home community and beyond (PICTURE)	I can speak in my family and people listen. I attend community meetings.	We don't speak at home. We don't attend community meetings. We have no voice.		

2 Discovering results – Using the frame as an evaluation tool

During the coming months, the group will implement the plan made at the first meeting. Bring the chart to the midterm and final evaluation meeting, and fix it to an object so that it is easily visible. Point to the picture next to each domain and review the ways in which the group has operationalized it. Read aloud the baseline results. Ask what changes the group has made and record them on the chart. Annex Table 16.2 illustrates a filled-in progress chart that could have resulted from such a discussion at the four-month interval.

Annex Table 2: Discovering results – Using the frame as an evaluation tool

Domain	Operational definition	At inception	After 6 months	Final
Education (PICTURE)	<p>I have access to important information.</p> <p>All my children are at school.</p> <p>I learn new things all the time.</p>	<p>We feel ignorant of important information.</p> <p>The younger children from 5 of the families attend school.</p>	<p>We have a meeting once a month where someone comes to bring us new information.</p> <p>We have a common fund to pay school fees.</p>	
Access to resources (PICTURE)	<p>I can help decide how to spend money in the household.</p> <p>I can get help in emergencies.</p> <p>I can save for things that I want.</p>	<p>We do not have access even to the money we earn from daily wages.</p> <p>The clan decides about support, sometimes they don't give.</p> <p>No group savings programme.</p>	<p>We have begun a group savings programme.</p> <p>We have visited the families at home and asked that husbands allow their wives to put in a coin.</p> <p>We are discussing other ways to access resources.</p>	
Harmony and love in the family (PICTURE)	<p>I feel safe in my home.</p> <p>My husband loves me.</p> <p>I am welcome to live in my home even if I am a widow.</p>	<p>Some of us are beaten.</p> <p>We have fights that cause us distress.</p> <p>Our family members tell us to leave.</p>	<p>We have learned about conflict mediation in our group: we use this to support families.</p> <p>NGO led an "end domestic violence" workshop for men.</p>	

Friends and support outside the family (PICTURE)	When we are sad we can talk to friends. We have a place to turn when bad things happen at home.	Sometimes we feel hopeless and sad. We meet friends when we go for water or daily work.	We meet every two weeks and when a member is missing we check on her. We listen to one another's problems in the group.	
Voice at home, community and beyond (PICTURE)	I can speak in my family and people listen. I attend community meetings.	We don't speak at home. We don't attend community meetings. We have no voice.	Each woman says her name at each meeting. We go to important meetings together.	

3 Accountability and learning

After charting the results, the participants can evaluate for themselves whether the group is “on the right track”. Are the actions they are taking really improving their sense of psychosocial well-being? This is an important piece of accountability. Following the evaluation, participants can plan the activities they would like to see continue as they move forward. They can also note any changes they would like to make. These changes (sometimes called “course correction”) should be reflected in the charts.

The results of each monitoring exercise should be presented to all stakeholders at a community meeting.

At the end of the programme, include the progress and changes recorded in the charts in the qualitative section of the final programme evaluation. These results should be widely distributed and, if possible, presented at a public learning conference so that the entire community can learn from successes and challenges, and create a community-owned way forward.

Creating and charting participatory indicators for children and adolescents

While IOM's signature MHPSS programmes focus on adults and families, there may be times when IOM finds it necessary to initiate programmes specifically for children and adolescents, especially during emergencies, when other actors may not be in the field.

The Community Participatory Evaluation Tool engages families, communities and children themselves to define and operationalize child well-being in a cultural context, based on age and stage of development. This method is recommended for use in *The Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings* (IASC, 2007) under Action Sheet 2.

The process engages parents, elders, children and adolescents in discussing their cultural views of child well-being by age and stage of development. Participants are asked to discuss how they coped with problems in the past – what worked, what didn't, and what they would need to restore their capacity to raise their children as well as possible in conditions of current adversity. Participants are asked to discuss which practices from the past should be restored and which discarded as ineffective or harmful. In that way, the process encourages activated development, as participants use the emergency as an opportunity to reflect on their children's lives and best interest. The process often promotes social cohesion, as disparate groups in the community can unite for the benefit of their children.

Bragin (2005c) includes a complete discussion of how to conduct the exercise, including model charts to use for monitoring, evaluation, accountability and learning.

For all references please see bibliography.

Reviving or establishing community groups¹

Mariam Tankink

When reflecting on establishing a new group, the following should be considered:

- The specific role and tasks of the group and the skills required of groups members.
- Eight to fifteen members is a manageable size for most groups.
- A member of the committee may be part of the group, unless there is a reason that he/she will be a hindrance to the decision-making process or other groups activities.
- Make sure that all sub-groups; children, youth, men, elderly (men and women), disability, religious, ethnic and political somehow are represented, but also social and sport clubs, community-based organisations (e.g. parents-teachers committees), schools, cooperatives and other possible business sectors, etc.
- Individuals with technical expertise can be part of one of the groups or as technical advisors directly in the committee.
- Ensure that individuals become members of groups voluntarily and not under pressure from a third party. there should be selection process for groups members which ensures voluntary participation.

An example from War Child experience can illustrate some of the challenges in working with group of 'appointed' volunteers. During a meeting with key stakeholder representatives in one community, it was decided that the first group to be formed should be a group which could facilitate games and other creative and recreational activities for children, which was one of the 'ideal' situations prioritized. The group, it was decided, should be composed of two people per village, thus 32 people. Village leaders then returned to their villages and appointed two people to participate in the group who they felt showed potential and interest in participating in such a group. This action in itself shows a fundamental misunderstanding between War Child and the community. It is not possible to avoid all misunderstandings in a community mobilization project, however the result of this action was that appointed participants felt that they were performing a service for their village leaders and War Child and thus expected some sort of 'payment' for the 'service' they were providing. Although the volunteer concept had been discussed and agreed upon with village leaders and the group of games facilitators, the manner in which the group was selected did not reflect this principle and thus the expectation of compensation persisted. The lack of compensation, in turn adversely, affected the group's motivation and after six months the group was no longer functioning other than to attend meetings initiated by War Child in the hopes of gaining compensation. (War Child Holland 2009, p. 29)

¹ Partly copied from Guidelines Community mobilization, War Child Holland, draft 2009.

1. Community-based organizations

It is possible that there are already existing community-based organizations (CBOs) and groups who can be identified to take responsibility for a certain set of activities. A CBO selected by the community to take responsibility for an activity e.g. should be chosen in a transparent way which includes demonstrated experience in conducting similar activities/project and basic operational capacity. An existing CBO will require a different level of support than a newly formed group as members will most likely already experience working within the community setting. Ideally, representatives of all relevant CBOs will have participated in the mapping and assessment processes and therefore have a good understanding of the project. This is an asset to the project as these organizations are an imbedded part of the community. However, in the context of the community project, the same expectation should be applied to them as to the new community groups created for the project: demonstrating a clear commitment to the objectives, wellbeing of community members, and participation in the development and implementation of activities, having their plan approved by the community and holding regular progress updates with the community including transparent reporting of resources used and expenditures.

The community groups and CBOs working on the project will essentially become partners of each other. An important role for IOM will be to ensure that these groups avoid competition and work together, by facilitating:

- A shared sense of purpose, working for the vision of the community.
- Clearly-defined roles and responsibilities for each group.
- Detailed action plans that do not compete but complement each other (especially timing).
- Effective communication processes.
- Adequate resources.
- Commitment to evaluation and adaptation.

For all references please see bibliography.

Considerations in livelihood interventions

1. Keep expectations realistic

In an emergency setting, people's mobility may be severely restricted, and social networks may have been lost or damaged. This is particularly the case in harsh settings such as camps, or post-conflict areas. Raising expectations beyond what people can reasonably achieve risks doing harm.

You may need to start small and build up. Whether interventions can work toward promoting sustainability, at least initially, will depend on the volatility of the context. Be honest with your beneficiaries on the intended objective of the livelihood opportunity.

2. Avoid adding more stress

People living in emergency situations already experience stress from a variety of sources. With this in mind, a Do No Harm approach should always be maintained, as there are significant risks of raising expectations (and disappointing) or leading to new or increased stresses. Any livelihood intervention needs to be chosen and designed carefully with this in mind, or else it risks adding rather than alleviating stress (Lund et al, 2011). As one example, micro-credit programs have been promoted for their potential to increase savings and stimulate economies. However, for people in volatile and uncertain situations, microcredit can add stress because of the pressure to plan for the future, and ultimately pay back loans (Kumar and Willman 2017).

Direct cash transfers have gained ground in recent years as a means of stimulating local economies and promoting autonomy and are increasingly seen as a favorable alternative to conventional delivery of food and other relief items (Doocy and Tappis; 2016; Oxfam, 2010), and they are likely to create less stress than microcredit. In some cases, cash transfers have been combined with MHPSS programming and shown promising result.

Box 1

An impact evaluation of a program in Liberia providing cash grants with Cognitive Behavioral Therapy sessions to youth found that youth that received cash with CBT achieved significantly higher earnings and a 30-50 percent reduction in violent behavior compared to the control group (Blattman, Jamisen and Sheridan, 2015).

3. Focus on building assets

Livelihood interventions that build assets have demonstrated a positive impact on mental health and psychosocial well-being (Lund et al 2011). Building assets can be instrumental in increasing people's ability to weather shocks and achieve sustainability over time. In emergency settings, this may mean focusing on assets that are transferable to other environments, such as trade or employment skills, or portable assets like small livestock or solar phone chargers.

Box 3

The CONCUR program, in Nigeria's Middle Belt Region (2012-16) supported capacity building in conflict mitigation with economic projects that were jointly implemented by pastoralists and farmer communities. An impact evaluation found increased trust, decrease in tensions, and perceptions of greater mobility (Mercy Corps, 2018).

7. Consider sensitivities of targeting

Given the high perception of value from livelihoods interventions, particularly those which involve cash or asset transfers, targeting must be sensitively dealt with. Consult with stakeholders to understand dynamics of resentment, ensure that targeting does not privilege certain groups, and that decisions are communicated clearly.

For all references please see bibliography.

Market assessment

Alys Willman

When

In most cases, it is best to conduct the assessment once the immediate emergency situation has stabilized, people have settled (even if temporarily), basic needs are mostly met, and local market actors have had the opportunity to recover and devise coping strategies. Until those conditions exist, contingency planning is important; resources to guide this can be found in the IASC Reference Group Mental Health and Psychosocial Support Assessment Guide.

Because crisis contexts are prone to shocks – outbreaks of violence, an influx of new entrants to the area, or weather patterns, for example - it is important to continually assess the market conditions throughout the intervention. The initial market assessment should feed into the broader monitoring and evaluation system so that feedback can be incorporated, and adjustments made throughout the intervention.

Whom

it is critical to get perspectives of people from different backgrounds, genders, ages, ethnicity, religion and identified vulnerabilities in the assessment. The Women's Refugee Commission (<https://www.womensrefugeecommission.org/resources/document/1046-a-double-edged-sword-livelihoods-in-emergencies>), Oxfam (<https://www.oxfam.org/en/tags/household-economy-approach>) and the CDA Collaborative offer useful resources to apply a gender lens to increase representation in assessments.

Be sure to involve the communities, including the host community if appropriate, in the design. Host communities often play key roles in local supply chains. Identify potential risks and negative impacts and try and put mitigating mechanisms in place. Could the intervention deepen resentments? Could there be a backlash? Would a whole-of-community (territorial approach) be more appropriate? Who are the local champions that need to be mobilized?

How

The Emergency Market Mapping and Analysis toolkit (EMMA) (<https://policy-practice.oxfam.org.uk/publications/emergency-market-mapping-and-analysis-toolkit-115385>) is one of the most commonly used tools, and includes an online community of practice for support. The SEEPS Network (<https://seepnetwork.org/>) also offers guidance on minimum standards for conducting assessments. The Assessment Capacities Project (ACAPS) (<https://www.acaps.org/rapid-humanitarian-assessment-urban-settings>) offers guidance for humanitarian emergencies in urban areas specifically.

In summary here, a market assessment is typically comprised of three segments:

Gap or Demand Analysis

This includes identification of the target population and assessment of their priority needs and constraints, such as the assets and skills people bring, their expenditures, and any constraints on their movement or participation that might hinder or facilitate their access to programs.

Market analysis

These typically focus on one or a few market systems for particular products or services. The information is drawn from interviews with different market actors, which can include private enterprises (especially small and medium businesses), government agencies and service providers. The aim of this analysis is to identify: laws and regulations for key markets; legal ability for displaced people to work; products and supply chains; infrastructure for production, transport, and distribution and any bottlenecks. It can also explore seasonal changes and opportunities in markets, social norms that affect who participates in these markets and how, and assess how market systems have been affected by the emergency. Finally, the market analysis should identify risks and potential negative impacts; for example, is there a risk of displacing local labor?

Map of existing services

This will include a general overview of the service providers in the area, their roles and capacities, and any gaps. In more unstable settings, it is important to identify ancillary services within the aid delivery infrastructure where a livelihood intervention could: (1) create income, (2) restore normalcy and (3) create social value. For example, there could be opportunities for re-tooling construction workers, training people as MHPSS volunteers, or selling food.

For all references please see bibliography.

CASE STUDY: Nigeria, Community-Based Conflict Management and Cooperative Use of Resources (CONCUR)

The CONCUR program, a four-year (2012-2016) intervention in Nigeria's Middle Belt region, aimed to reduce conflicts between pastoralists and farmer communities, and enhance economic activities. The program combined conflict mitigation measures with jointly-implemented economic projects.

Mercy Corps conducted an impact evaluation of 10 CONCUR sites and six comparison sites, finding that program activities generated important changes in trust and cooperation. For example: 86 percent of participating households reported a decrease in tensions, compared to the control group (56 percent); perceptions of trust between conflicting groups increased by 49 percent, and perceptions of freedom of movement increased by 44 percent. In addition, participating households were 47 percent more likely to say that conflict did not affect their livelihoods.

Economic impacts were weaker. The evaluation noted an increase in income and investments for the CONCUR communities; however, these were not statistically significant. In addition, the evaluation found no significant difference in access to goods, jobs, or assets. These findings are not surprising, given that economic impacts often take longer to manifest, especially in a situation of active conflict.

For all references please see bibliography.

Terms of reference and desirable qualifications for IOM referral team

1 Nurse

Terms of reference:

- Identify people with severe mental disorders
- Act as community catalysts for referrals.
- Receiving referrals of people with severe mental disorders from the PMTs, families and/or other partners.
- Facilitating appointments for people with severe mental disorders to the closest care facility, avoiding institutionalization to the extent possible, always preferring outpatient care, and limiting inpatient care to the minimum when the conditions of the client or the logistics of the movement do not allow outpatient care.
- Checking on whether medication protocols are being followed.

Desirable qualifications:

- Degree in psychiatric nursing or related discipline.
- Previous experience in MHPSS work, community work and in managing small teams.
- Experience in communicating and working with a wide range of people, including people of culturally diverse backgrounds.

2 Social worker

Terms of reference:

- Keep on mapping the provision of basic services and protection activities at the microlevel, and disseminate information on how to reach those services–resources.
- Following up with the client in the community.
- Supporting social needs through referral.
- Supporting caregivers in their role, through psychoeducation and counselling.
- Making sure that a continuum of care is granted, linking the client and the caregivers with the various activities offered by the PMTs at recreational, socialization, artistic and counselling levels.
- Organizing peer-support for caregivers.

Desirable qualifications:

- Bachelor's degree in social sciences or social work.
- Previous experience in social and protection activities in related areas of intervention is an advantage.
- Experience in communicating and working with a wide range of people, including people of culturally diverse backgrounds.

3 Translator

Desirable qualifications:

- Be responsible for Translations in the language of affected people reached by referral teams.
- Have the ability to conduct consecutive, accurate translation of services and/or activities.
- Translation of relevant documents in the referral process.
- Ability to conduct oneself in accordance with the local culture and customs.

Desirable qualifications:

- Bachelor's degree in translation or languages.
- Previous experience in social and protection activities in related areas of intervention is an advantage.
- Experience in communicating and working with a wide range of people, including people of culturally diverse backgrounds.

4 Cultural mediator

Terms of reference:

- Facilitates mutual understanding between the person of concern and referral team member or other services.
- Takes into account cultural elements of MHPSS and other services.
- Advice all parties regarding appropriate cultural behaviors.

Desirable qualifications:

- Bachelor's degree in cultural mediation or social sciences.
- Previous experience in social and protection activities in related areas of intervention is an advantage.
- Experience in communicating and working with a wide range of people, including people of culturally diverse backgrounds.