



Mental Health and Psychosocial Support

MINIMUM SERVICE PACKAGE





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Translations

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Color guide

For ease of reference, different colours are used in this document to represent the following main sectors and Areas of Responsibility:

-  Health
-  Protection
-  Child Protection
-  Gender-Based Violence
-  Education
-  Mine Action
-  Nutrition
-  Camp Coordination & Camp Management (CCCM)
-  Other sectors: Shelter & Settlements, Water, Sanitation & Hygiene (WASH), Food Security and Livelihoods (FSL)
-  Key Considerations in grey are relevant to all sectors and areas of work

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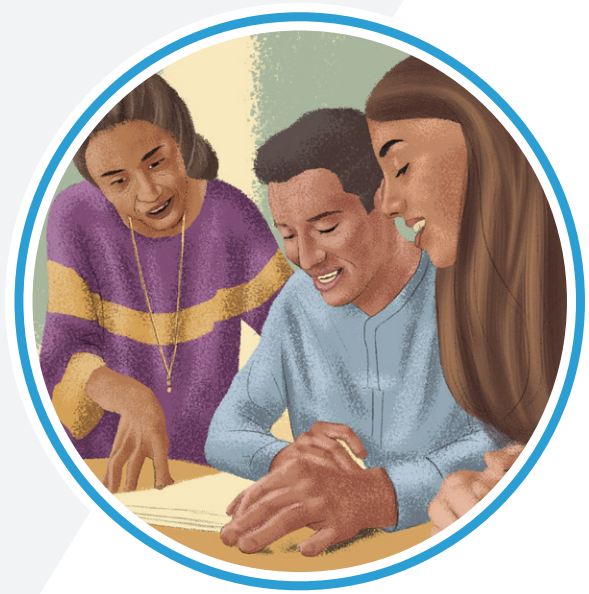
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List of abbreviations

AAP	Accountability to Affected Populations
AoR	Area of Responsibility
CBOs	Community based organizations
CBT	Cognitive-behavioural therapy
CCCM	Camp Coordination and Camp Management
CP	Child Protection
CPMS	The Minimum Standards for Child Protection in Humanitarian Action
CSOs	Civil society organizations
ECD	Early childhood development
EO	Explosive Ordnances
FSL	Food Security and Livelihoods
GBV	Gender-Based Violence
HLP	Housing, land and property
HMIS	Health management information systems
HR	Human resources
IASC	Inter-Agency Standing Committee
IDP	Internally displaced person
IEC	Information, education and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IHME	Institute for Health Metrics and Evaluation
INEE	The Inter-agency Network for Education in Emergencies
INGOs	International Non-Governmental Organization
IOM	International Organization for Migration
IPV	Intimate partner violence
IRC	International Rescue Committee
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer

LIVES	Listen, Inquire, Validate, Enhance safety and Support
M&E	Monitoring and evaluation
mhGAP-HIG	mhGAP Humanitarian Intervention Guide
mhGAP-IG	mhGAP Intervention Guide
MHPSS	Mental health and psychosocial support
MNS	Mental, neurological and substance use
MoV	Means of verification
MSCM	Minimum Standards for Camp Management
MSP	Minimum Service Package
NGOs	Non-governmental organizations
OCHA	Office for the Coordination of Humanitarian Affairs
PFA	Psychological first aid
PTSD	Post-traumatic stress disorder
SEL	Social and emotional learning
SOGIESC	Sexual orientation, gender identity, gender expression and sex characteristics
SOPs	Standard operating procedures
SPRP	Strategic Preparedness and Response Plan
SRH	Sexual and reproductive health
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Emergency Fund
WASH	Water, Sanitation and Hygiene
WGSS	Women and girls safe spaces
WHO	World Health Organization

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INTRODUCTION



Overview

WHY IS RESPONDING TO MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) NEEDS IMPORTANT IN EMERGENCIES?

Humanitarian emergencies cause widespread suffering, affecting people's mental health and psychosocial well-being. Affected populations experience a **range of stressors** that can have both immediate and long-term consequences. These include exposure to violence, separation from or loss of loved ones, poor living conditions, poverty, food insecurity, loss of livelihoods and means of survival, physical injuries and illnesses, and a lack of access to services such as health care, education and social care. Emergencies can also erode protective supports such as family and community networks and can lead to sudden changes in social roles and relationships.

Many people affected by emergencies experience **common reactions** such as difficulties with sleeping, fatigue, worry, anger and physical aches and pains. For most people, these problems are manageable and improve over time, but for others, they impair daily functioning.



Globally, **one in five** (22.1%) people living in areas affected by conflict is estimated to have a **mental health condition**.¹

Mental health and psychosocial support services are often sparse even before a crisis occurs, and emergencies can disrupt the availability of services and people's access to them. People with **pre-existing mental health conditions** are at risk of relapse or deterioration, often face stigma and discrimination and need continued access to care and protection.



For **children**, adverse conditions in emergencies can disrupt cognitive, emotional, social and physical development, with enduring consequences for their future.

Effective MHPSS programming provides critical services and supports across the life course to reduce suffering and improve people's mental health and psychosocial well-being. This can lead to improvements in people's abilities to meet their basic needs to survive, recover and rebuild their lives.



The **integration of MHPSS** into emergency responses **can enhance the impact of programming across sectors** and can contribute to saving lives. MHPSS programmes can also help strengthen health, social and education systems in the longer term.

¹ Charlson F. et al. (2019). [New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis](#). The Lancet 394 (10194), pp. 240-248.

WHAT IS THE MHPSS MINIMUM SERVICE PACKAGE (MHPSS MSP)?



The MHPSS MSP outlines a set of **activities** that are considered to be of the **highest priority** in meeting the immediate critical needs of emergency-affected populations, based on existing guidelines, available evidence and expert consensus. Each activity comes with checklists of **core** and **additional** actions.



In principle, MSP activities, and respective core actions, can be implemented within a **12-month** timeframe, and most will need to **continue beyond** that. The checklists of additional actions should be reviewed in each context to determine their level of priority and sequence, based on local needs and available resources



The MSP activities should be:

- ▶ **available** and **accessible to people in all emergencies**
- ▶ of **high quality**
- ▶ **appropriate to the specific context** (e.g. existing systems and services, community considerations)
- ▶ provided in an **acceptable manner** to affected populations in line with the gender, age and diverse characteristics of individuals.

If an activity is not in place, it should be **made available as soon as possible**.



The extent to which all MSP activities are implemented in a specific setting, depends on many factors such as existing capacities and available resources. However, even in resource-poor settings the MSP can provide major directions on what MHPSS services and activities to strive for.



Use of the MHPSS MSP is expected to lead to **better-coordinated, more predictable** and **more equitable responses** that make **effective use of limited resources** and thus improve the **scale and quality of programming**.

This will ultimately result in substantially better mental health and psychosocial well-being for larger numbers of people.



The MHPSS MSP is not a comprehensive list of all feasible or effective MHPSS activities, and thus MHPSS responses should not be limited to MSP activities. Rather, the MHPSS MSP **provides a foundation** for progressive strengthening and further scale-up of MHPSS activities.



The development of sustainable, comprehensive and inclusive **MHPSS systems** requires a **longer-term outlook and investment**, with close coordination between **humanitarian and development funders** and with respect for the central role of **government**, local authorities, civil society organizations and communities.

WHY IS AN MHPSS MSP NEEDED?



MHPSS is a **multisectoral** and **cross-cutting** area of work with relevance for the Health, Protection (including Child Protection (CP), Gender-Based Violence (GBV) and Mine Action), Education, Nutrition, Water, Sanitation and Hygiene (WASH), Shelter and Settlements, Camp Coordination and Camp Management (CCCM) and Food Security and Livelihoods (FSL) sectors/clusters/Areas of Responsibility (AORs) in all emergencies.²







² Summary Record, [IASC Principals meeting](#), 5 December 2019.

The MSP encompasses a **wide range of activities** that can be implemented by staff and volunteers with diverse backgrounds, qualifications and levels of experience. While standards, guidelines and tools for MHPSS have been developed, there is a recognized need for an **intersectoral package to operationalize these various guidelines and standards**.

HOW CAN THE MHPSS MSP BE USED?

The MHPSS MSP is a resource for humanitarian actors **who plan, support, coordinate, implement and evaluate** humanitarian activities within and across sectors. These include government actors, MHPSS Technical Working Groups (TWGs), national and international non-governmental organizations (NGOs), civil society and other advocacy groups, Red Cross and Red Crescent networks, UN agencies, coordinators of sectors/clusters/AoRs and donors.

The MHPSS MSP informs the development and implementation of **humanitarian response planning** processes and documents including Humanitarian Needs Overviews, Humanitarian Response Plans, Refugee Response Plans, cluster strategy development and specific donor funding calls and mechanisms.

Who should use the MSP?	Coordinators	Implementers	Technical advisers	Donors
	e.g. MHPSS TWGs; government and UN agencies with coordination and planning responsibilities; sector/cluster coordination groups*, Inter-Cluster Coordination Teams and Humanitarian Country Teams	Implementers of MHPSS programmes (e.g. national/local government agencies, NGOs, UN agencies)	i.e. those with expertise in MHPSS who are advising and supporting programme implementation	Donors and others making decisions about funding
For what purpose can the MSP be used?				
 Identifying and addressing gaps in the MHPSS response	✓	✓	✓	✓
 Advocating and communicating with donors and other decision-makers about MHPSS needs and gaps	✓	✓	✓	
 Deciding which programme activities to prioritize for implementation		✓	✓	
 Obtaining guidance on what actions to take when implementing each activity		✓	✓	
 Estimating costs of MHPSS activities	✓	✓	✓	✓
 Deciding which MHPSS activities to fund				✓

* Sector/cluster coordination groups particularly in Health, Education, Protection and associated AoRs (GBV, CP, Mine Action).

For further information on how individual organizations and coordination groups can use the MSP, [please see the step-by-step guides for different users of the MSP](#).

WHO SHOULD IMPLEMENT MHPSS MSP ACTIVITIES?

No single organization is expected to implement the entire MHPSS MSP. Rather, relevant organizations must **coordinate and work together across sectors** to ensure that MSP activities are implemented and a comprehensive response is delivered in each specified geographical area (e.g. district, camp, village, city, neighbourhood). Depending on their mandate and capacities, some organizations will be better placed than others to implement certain activities.

For ease of reference, **icons are provided alongside each MSP activity to indicate sectors, clusters or AoRs that are typically well placed to deliver or contribute to it** (e.g. Health, Education, Protection - including CP, GBV, and Mine Action- and Nutrition). Table 1 shows the icons representing the sectors, clusters, AoRs and other areas of work included in the MSP. Throughout the MSP, coloured icons indicate that the area of work is well placed to deliver an activity, while dark-blue icons indicate that the area of work is well-placed to contribute to or facilitate implementation.



Table 1. Icons depicting sectors, clusters, AORs and other areas of work referenced in the MSP

Sector/ AoR/ cluster/area of work	Relevant actors (<i>who commonly coordinate or implement programmes</i>)
 Health	Health cluster, health coordination groups; ministry of health, health facilities and providers; organizations implementing health-related programmes.
 Education	Education cluster; education coordination groups; ministry of education; schools and other educational facilities and associated personnel; organizations implementing education-related programmes.
 Protection	Protection cluster; protection sector coordination groups (e.g. in refugee responses); ministry of social welfare and other relevant ministries (e.g. ministry of justice, ministry of health); social services facilities and providers; organizations implementing protection-related programmes, including through facilities such as community centers.
 Child Protection	Child Protection AoR of the Protection Cluster; child protection coordination groups (e.g. child protection subsector in refugee responses); social welfare and other relevant ministries (e.g. ministry of education, ministry of justice, ministry of interior/internal affairs); social welfare, community and education facilities and providers; organizations implementing child protection-related programmes.
 Gender-Based Violence	GBV AoR of the Protection Cluster; GBV coordination groups (e.g. GBV subsector in refugee responses); social welfare and other relevant ministries (e.g. ministry of justice, ministry of health, ministry for women and families); women-and-girl-friendly spaces personnel; health providers, including sexual and reproductive health; organizations implementing GBV programmes.
 Mine Action	Mine Action AoR of the Protection Cluster; Mine Action Centre; national mine action authority and relevant ministries; mine Action coordination groups; organizations implementing mine action programmes.
 Nutrition	Nutrition cluster; nutrition coordination groups; Ministry of Health and other relevant ministries (e.g. ministry of food and agriculture); supplementary feeding centres and providers; organizations implementing nutrition-related programmes.
 Camp Coordination & Camp Management (CCCM)	CCCM cluster; CCCM coordination groups; relevant government ministries (e.g. interior/internal affairs, disaster management and relief); organizations implementing CCCM.

Sector/ AoR/ cluster/area of work	Relevant actors (<i>who commonly coordinate or implement programmes</i>)
 Shelter & Settlements	Shelter & settlements cluster and related coordination groups; relevant government ministries (e.g. those responsible for civil emergencies and/or housing); local government; organizations implementing shelter-related programmes.
 Water, Sanitation & Hygiene (WASH)	WASH cluster; WASH coordination groups; relevant government ministries (e.g. infrastructure, health, social welfare, water & environment); organizations implementing WASH programming.
 Food Security & Livelihoods (FSL)	Food security cluster; food security coordination groups; relevant government ministries (e.g. ministry of food and agriculture, ministry of labour, ministry of social welfare); farmers/pastoralists associations and cooperatives; organizations implementing food-security and livelihoods programmes.

All aspects of a humanitarian response, including the behaviour and attitudes of staff and volunteers, can impact the psychological well-being of affected populations. Therefore, all sectors play a critical role in ensuring that their activities are delivered in a way that promotes mental health and psychosocial well-being (this is sometimes known as using an “MHPSS approach”). Actors across a wide range of sectors can also play a key role in enhancing the effectiveness of MHPSS activities. This can be achieved, for example, by coordinating and collaborating to:

- ▶ Include mental health and psychosocial well-being in **needs assessments**: (*see MSP activities* [↔ 1.2](#) and [↔ 2.1](#)): For example, inclusion of MHPSS in multi-sectoral site needs assessments organized by CCCM actors.
- ▶ **Provide humanitarian assistance in ways that support mental health and psychosocial well-being** (*see MSP activity* [↔ 3.1](#)): All humanitarian actors can take MHPSS considerations into account when planning their activities, such as prioritizing privacy and dignity when constructing WASH facilities, setting up safe community and recreational spaces when planning and managing camps and ensuring that affected populations have ways to communicate with loved ones and access information (e.g. phones, phone charging facilities).
- ▶ **Engage in mutual advocacy**: This includes actors from different areas of work advocating to address MHPSS needs and MHPSS actors advocating to address needs relevant to other sectors, e.g. MHPSS actors advocating for improved shelter, given the impact on mental health (*see MSP activity* [↔ 3.1](#)).
- ▶ **Orient frontline workers in basic psychosocial support** (*see MSP activity* [↔ 3.2](#)): MHPSS actors can facilitate orientations³ on basic psychosocial support for those working in protection, CCCM, shelter, WASH, nutrition, livelihoods and other areas.
- ▶ **Disseminate key MHPSS messages** (*see MSP activity* [↔ 3.3](#)): Many actors can incorporate MHPSS messages into their activities and information materials, e.g. at registration facilities and camps, and as part of health, nutrition, WASH, and Mine Action activities.
- ▶ **Capitalize on the interconnections between MHPSS outcomes and outcomes from other areas of work** (*see MSP activities* [↔ 2.1](#) and [↔ 3.1](#)): Mental health and psychosocial well-being shape how people behave and make decisions. Programmes that incorporate MHPSS and other elements can therefore be mutually reinforcing. For example, given that maternal distress can impact child nutritional outcomes, early childhood development (ECD) programmes that incorporate efforts to improve maternal well-being are likely to have additional benefits for child nutrition and development. Given that both poor living conditions and a lack of agency can increase psychological distress, programmes that involve community members in decisions about shelter and camp management are likely to improve living conditions, mental health and psychosocial well-being.
- ▶ **Ensure that services and supports are accessible and meet the needs of people with mental health conditions**: For example, by ensuring that people in psychiatric institutions have adequate food and WASH facilities (*see MSP activity* [↔ 3.14](#)) and by including people recovering from mental health conditions in livelihoods programmes.

³ In the MSP the term ‘orientation’ is used to refer to brief, one-off sessions, while the term ‘training’ refers to more comprehensive capacity building that requires ongoing support and supervision.

- ▶ **Monitor MHPSS-related outputs and outcomes:** Where programmes in other areas of work contribute to improving mental health and psychosocial well-being, it can be useful to capture these outputs and outcomes (e.g. number of people with mental health conditions engaged in livelihoods programming; improvements in well-being following a participatory shelter programme).
- ▶ **Ensure cross-referral mechanisms:** This includes mapping of MHPSS services and facilitating the identification and referral of persons with possible mental health conditions by workers from different sectors. This also requires MHPSS workers to identify and refer persons to help meet their different needs (e.g. housing, livelihoods, social services).

The following key considerations provide examples of how MHPSS can be integrated into programming across different sectors and areas of work.


Key Consideration 1: Integrating MHPSS into health programming



Mental health is an integral part of health. Mental health and physical health are strongly interconnected, with one influencing the other.

Health actors can integrate MHPSS into programming by:

- ▶ Including MHPSS in **health assessments** (see *MSP activity* ↗ [1.2](#)).
- ▶ **Advocating** for the provision of health services in ways that are inclusive, person-centered, promote dignity, enhance social support and respect human rights.
- ▶ Advocating for addressing **social determinants** of mental health, including risks and protective factors.
- ▶ Engaging in advocacy, **promotion and prevention** together with other sectors and actors to build awareness of mental health, and to end stigma and discrimination.
- ▶ Orienting health workers on **basic psychosocial support** (see *MSP activity* ↗ [3.2](#)).
- ▶ Integrating programs that promote mental health for **caregivers, children and adolescents** into health services (see *MSP activities* ↗ [3.5](#) and ↗ [3.7](#)).
- ▶ **Integrating mental health care** into general health care and other health services (see *MSP activity* ↗ [3.10](#)).

 See [relevant resources](#) on the MHPSS MSP web platform.

Key consideration 2: Integrating MHPSS into education programming




Education can offer a stable routine and structure, support a sense of normality, promote children's social and emotional development, play and foster hope. Learning spaces provide opportunities for peer and adult support and can unite the wider community. MHPSS is inherent to this work, helping children, caregivers and education personnel to cope, build resilience and promoting a supportive environment.

Education actors can integrate MHPSS into programming by:

- ▶ Including the mental health and psychosocial well-being of target communities (including children, caregivers and education personnel) in education **needs assessments** (see *MSP activities* ↗ [1.2](#) and ↗ [2.1](#)).
- ▶ Providing and advocating across sectors for the provision of services in ways that promote the **dignity** of crisis-affected people and are **inclusive, participatory, person-centred, and rights-based**.
- ▶ Advocating to **address social determinants** of mental health and psychosocial well-being, including risk and protective factors.
- ▶ Orienting all frontline education staff in **basic psychosocial support** for children and adults (see *MSP activity* ↗ [3.2](#)).
- ▶ Incorporating **key MHPSS messages** into education activities and informational materials (see *MSP activity* ↗ [3.3](#)).
- ▶ Providing **MHPSS services** as a part of Education work (see *MSP activities* ↗ [3.4](#) to [3.8](#)).
- ▶ Working closely with actors in **child protection, ECD, GBV, health and other areas of work** to define roles and responsibilities, avoid duplication, improve the quality of care and ensure MHPSS activities are consistent and mutually-reinforcing.

- ▶ Establishing **joint referral pathways and SOPs** for the referral of children and adults, including facilitating access to the full range of MHPSS activities and services as needed.
- ▶ Ensuring that education activities are **accessible** and meet the needs of people with **mental health conditions**.
- ▶ Monitoring **MHPSS-related outputs and outcomes** (e.g. improvements in knowledge, attitudes and skills of education personnel participating in MHPSS orientations and trainings; improvements in subjective well-being among children following participation in structured group activities).

 See [relevant resources](#) on the MHPSS MSP web platform.


Key consideration 3: Integrating MHPSS into protection programming



Protection programming in humanitarian crises contributes to the centrality of protection in humanitarian action. It supports understanding, respect for and access to rights of affected people in line with humanitarian principles and in accordance with relevant bodies of international human rights and humanitarian law. In practice, it involves a series of activities and services aimed at analyzing and monitoring protection risks, needs, vulnerabilities and capacities of individuals to address those needs; at preventing and mitigating exposure to protection risks and violations; at supporting affected people to claim their rights, access available remedies, and recover from the effects of violence, coercion, discrimination, and abuse. Protection programming includes integrating age, gender, and diversity⁴ considerations and applying a community-based approach, providing specialized protection services; integrating protection activities into the programming of other sector-specific responses; and supporting the mainstreaming of protection throughout the humanitarian response.

Incorporating MHPSS aspects effectively into protection programming and activities helps to mitigate immediate and long-term risks to the dignity, mental health, and psychosocial well-being of affected people.

Protection actors can integrate MHPSS into programming by:

- ▶ Ensuring that protection activities and services are **accessible** to and consider the specific needs of people **with mental health conditions**.
- ▶ Including basic references to the mental health and psychosocial well-being needs of affected population in **protection needs assessments** and protection monitoring (*see MSP activities* [↔ 1.2](#) and [↔ 2.1](#)).
- ▶ Incorporating **key MHPSS messages** into information materials and in communications with communities during all phases of humanitarian action (*see MSP activity* [↔ 3.3](#)).
- ▶ Including MHPSS service providers in protection **service mapping** to support information sharing and referrals.
- ▶ Establishing **joint referral pathways** between protection and MHPSS actors to facilitate access to the full range of MHPSS activities and services by individuals in need.
- ▶ Orienting all frontline protection staff in **basic psychosocial support** for girls, boys, women and men, and other individuals with diverse characteristics (*see MSP activity* [↔ 3.2](#)).
- ▶ **Training** case managers on relevant MHPSS topics (*see MSP activity* [↔ 3.13](#) and the  [recommended MHPSS training topics for case managers](#)).
- ▶ Advocating with duty bearers for **non-discrimination, access** to social services and equal enjoyment of **basic human rights** by people with mental health conditions and psychosocial problems.
- ▶ Advocating to address **social factors** influencing mental health and psychosocial well-being amongst affected populations (e.g. mitigating risk factors, promoting protective factors).
- ▶ Contributing to monitor overall **MHPSS-related outcomes** (e.g. improvements in subjective well-being, functioning, coping, and/or social connectedness following participation in protection activities).
- ▶ Reinforcing **joint advocacy** between protection and MHPSS across sectors to consider MHPSS as a cross-cutting issue in the humanitarian response, and for the provision of services in ways that promote dignity are inclusive, community-based, participatory, people-centred, and rights-based (*see MSP activity* [↔ 3.1](#)).

 See [relevant resources](#) on the MHPSS MSP web platform. See also key considerations [↔ 4](#), [↔ 5](#) and [↔ 6](#).


⁴ Diversity refers to differences in values, attitudes, cultural perspectives, beliefs, ethnic background, nationality, sexual orientation, gender identity, health, social status, impairments, and other specific personal characteristics (as defined in the [2019 IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action](#)).


Key consideration 4: Integrating MHPSS into child protection programming



Child protection is the prevention of and response to abuse, neglect, exploitation, and violence against children. MHPSS is inherent to this work, helping children to cope, recover, and build resilience in the face of adversity.

Child protection actors can integrate MHPSS into programming by:

- ▶ Including the mental health and psychosocial well-being of boys and girls of different ages in child protection **needs assessments** (see *MSP activities* [↔ 1.2](#) and [↔ 2.1](#)).
- ▶ Providing and advocating across sectors for the provision of services in ways that are **inclusive, participatory, child-centred, rights-based**, and promote the **dignity** of children and adolescents.
- ▶ Advocating to **address social determinants** of mental health and psychosocial wellbeing among children, adolescents, and caregivers, including risk and protective factors.
- ▶ Orienting all frontline child protection staff in **basic psychosocial support** for children and adults (see *MSP activity* [↔ 3.2](#)).
- ▶ **Training** child protection case managers on relevant MHPSS topics (see *MSP activity* [↔ 3.13](#) and the  [recommended MHPSS training topics for case managers](#)).
- ▶ Incorporating **key MHPSS messages** for children, adolescents, and caregivers (see *MSP activity* [↔ 3.3](#)) into child protection activities and informational materials.
- ▶ Providing **MHPSS services** for children and caregivers as a part of child protection work (see *MSP activities* [↔ 3.4](#) to [3.8](#), [↔ 3.12](#) to [3.14](#), and [↔ 4.2](#)).
- ▶ Working closely with actors in **education, ECD, GBV, health and other areas of work** to ensure MHPSS activities for children, adolescents and caregivers are consistent and mutually-reinforcing.
- ▶ Establishing **joint referral pathways and SOPs** for the referral of children, adolescents, and caregivers to needed services, including facilitating access to the full range of child-friendly MHPSS activities and services as needed.
- ▶ Ensuring that child protection activities are **accessible** and meet the needs of children and adolescents with **mental health conditions**.
- ▶ Monitoring **MHPSS-related outputs and outcomes** (e.g. improvements in knowledge, attitudes and skills of caregivers participating in MHPSS orientations and trainings; improvements in subjective well-being among children and adolescents following participation in structured group activities).

 See [relevant resources](#) on the MHPSS MSP web platform.

Key consideration 5: Integrating MHPSS into GBV programming



GBV programming focuses on prevention of and response to Gender-Based Violence. GBV disproportionately affects women and girls, though, men and boys can also experience sexual violence and abuse. MHPSS is an essential component of GBV programming. While survivors' experiences vary, the impacts of GBV on mental health and psychosocial well-being can have extensive consequences for individuals, families, and communities. Addressing the mental health and psychosocial needs of survivors and those at risk of GBV, as well as preventing violence, is critical to promoting gender equality, resilience and recovery.

GBV actors can integrate MHPSS into programming by:

- ▶ Including the mental health and psychosocial well-being of women, men, boys, girls and persons with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) in **needs assessments** (see *MSP activities* [↔ 1.2](#) and [↔ 2.1](#)).
- ▶ Providing and advocating across sectors for the provision of services in ways that promote **safety and dignity** of GBV survivors, particularly women and girls, and are safe, confidential, inclusive, community-based, participatory, survivor-centred, and rights-based.
- ▶ Advocating to **address social determinants** of mental health and psychosocial well-being (e.g. levels of social support, exclusion, deprivation, poverty) among GBV survivors, particularly women and girls, including addressing risks and promoting protective factors.
- ▶ Orienting all frontline GBV staff in **basic psychosocial support** (see *MSP activity* [↔ 3.2](#)).

- ▶ **Training** case managers on relevant MHPSS topics (see [MSP activity ↗ 3.13](#) and the [recommended MHPSS training topics for case managers](#)).
- ▶ Incorporating **key MHPSS messages** into GBV activities and informational materials (see [MSP activity ↗ 3.3](#)).
- ▶ Providing **MHPSS services** for women, girls and survivors as a part of GBV work (see [MSP activities ↗ 3.4](#), [↗ 3.7](#), [↗ 3.9](#), [↗ 3.11 to 3.13](#) and [↗ 4.2](#)).
- ▶ Working closely with actors in **Protection** (including **child protection**), **education**, **health** and **other areas of work** to ensure MHPSS activities for GBV survivors, particularly women and girls are consistent and mutually-reinforcing.
- ▶ Establishing **joint referral pathways and SOPs** for the referral of women, girls and survivors to needed services, including facilitating access to the full range of MHPSS activities and services as needed.
- ▶ Ensuring that GBV activities are accessible and meet the needs of people with **mental health conditions**.
- ▶ Monitoring **MHPSS-related outputs** and outcomes (e.g. improvements in subjective well-being, functioning, coping, and/or social connectedness following participation in GBV activities).


 See [relevant resources](#) on the MHPSS MSP web platform. See also [key considerations ↗ 28](#).

Key consideration 6: Integrating MHPSS into mine action programming

Survivors of explosive ordnances (EO) may have a range of MHPSS needs associated with their injuries or experiences of diminished independence, restricted access to activities, problems with self-image, chronic pain, phantom pain and social challenges (e.g. unemployment, changes to social roles, stigma, discrimination). The UN Policy on Victim Assistance in Mine Action and the International Mine Action Standards (IMAS 13.10) include ‘psychological and psychosocial support’ as one of six key components of Victim Assistance. Activities to prevent injuries and reduce risks can also be opportunities to integrate MHPSS, for example, incorporating key messages on MHPSS as part of Mine/EO risk education.

Mine action actors can integrate MHPSS into programming by:

- ▶ Orienting all frontline mine action workers on **basic psychosocial support**, including support with motivation and perseverance in physical therapies, and the identification and referral of children and adults who may need MHPSS services and supports (see [MSP activity ↗ 3.2](#)).
- ▶ Integrating relevant **key MHPSS messages** into victim assistance and risk reduction information materials and activities (see [MSP activity ↗ 3.3](#)).
- ▶ Including information on **injury prevention from EOs in relevant MHPSS activities** (e.g. see [MSP activities ↗ 3.6](#), [↗ 3.7](#), [↗ 3.8](#), [↗ 3.9](#)).
- ▶ Facilitating the **inclusion** of survivors of EO and their caregivers and families in **community, cultural, sports and recreational activities** (e.g. strengthening survivor networks and facilitating support groups at rehabilitation centres, orthopaedic wards, and health clinics; see [MSP activity ↗ 3.4](#)).
- ▶ Training **rehabilitation workers** and victim assistance **case managers** on relevant MHPSS topics (see [MSP activity ↗ 3.13](#) and the [recommended MHPSS training topics for case managers](#)).
- ▶ Working with mine action centres and coordination groups to develop **referral mechanisms** and ensure access to MHPSS services and supports for EO survivors.
- ▶ **Monitoring MHPSS-related outputs and outcomes** (e.g. improvements in well-being following the inclusion of support groups at rehabilitation centres, the strengthening of survivor networks).

 See [relevant resources](#) on the MHPSS MSP web platform.

Key consideration 7: Integrating MHPSS into nutrition programming


The cognitive, social and emotional development of children depends on both adequate nutrition and nurturing care. Emergencies can severely limit caregivers’ abilities to provide these, due to both the practical disruption to food supply and the impact of the emergency on their own mental health and psychosocial well-being. Nutrition, mental health and development are interlinked in a range of ways that can be disrupted in emergencies. For example, malnourished children may show reduced activity and seek less interaction with caregivers; where caregivers consequently reduce the amount of

stimulation provided, this can lead to further developmental disadvantages. Caregiver well-being can also impact child nutrition; for example, mothers experiencing depression are less likely to continue breastfeeding their child and provide less stimulation.

Nutrition actors can integrate MHPSS into programming by:

- ▶ **Providing nutrition services in ways that support mental health and psychosocial well-being**, for example, by engaging target communities and ensuring that nutrition services are provided in a dignified manner and in a safe and culturally appropriate environment. MHPSS considerations should be taken into account in the design of therapeutic feeding centres and outpatient therapeutic programmes (see Sphere Management of Malnutrition standard 2.1).
- ▶ **Orienting nutrition workers on basic psychosocial support** and on **nurturing care**, including identification and referral of children and adults who may need MHPSS services and supports (see *MSP activity* ↗ 3.2; Sphere Management of Malnutrition standard 2.2).
- ▶ Integrating relevant **key MHPSS messages** into nutrition information materials (see *MSP activity* ↗ 3.3).
- ▶ **Monitoring MHPSS-related outputs and outcomes** (e.g. improvements in well-being following the implementation of mother-baby and child group activities at outreach therapeutic programmes).

For further information on the linkages between MHPSS and Nutrition, see *key consideration* ↗ 24.

 See [relevant resources](#) on the MHPSS MSP web platform.



Key consideration 8: Integrating MHPSS into camp coordination and camp management programming




The mental health and psychosocial well-being of people residing in camps and camp-like settings is significantly impacted by the extent to which they can participate in decision-making that affects their lives, access information, and access appropriate facilities and services. The distress caused by their displacement can be exacerbated or mitigated depending on the degree to which their sense of agency and independence is promoted or diminished.

CCCM actors, through their direct and regular interaction with displaced families and communities, have a key role to play in enhancing the well-being of those living in displacement sites (see also  [Minimum Standards for Camp Management: MSCM](#)).

CCCM actors can integrate MHPSS into programming by (see *MSP activity* ↗ 1.1 and MSCM 4.1) to:

- ▶ Including **MHPSS in multi-sectoral site needs assessments** (see *MSP activity* ↗ 1.2 and MSCM 4.2).
- ▶ Engaging in **monitoring and advocacy** regarding gaps in services and needs, through close collaboration and exchange between CCCM and MHPSS actors (see *MSP activity* ↗ 3.1 and MSCM 4.1, 4.2).
- ▶ Providing **humanitarian assistance in ways that support mental health and psychosocial well-being** (see *MSP activity* ↗ 3.1), by:
 - Engaging site residents in **decision-making related to the management of the site** (e.g. by supporting inclusive and representative governance structures, child committees, sectoral committees and community-led initiatives; see MSCM 2.1, 2.4), especially related to sites for planned MHPSS activities (e.g. *MSP activities* ↗ 3.4, ↗ 3.6, ↗ 3.9).
 - Ensuring appropriate and inclusive **planning** to promote adequate protection and assistance, according to site residents' needs (including mental health related needs), throughout the lifecycle of the site (see *MSP activity* ↗ 2.1, MSCM 1.2, 5).
 - Providing **sufficient communal space** e.g. for socio-relational and recreational activities (e.g. for *MSP activities* ↗ 3.4, ↗ 3.6, ↗ 3.9, also see MSCM 3.1, 3.2).
 - Ensuring that site residents live in a dignified **environment** that promotes mental health and psychosocial well-being and is safe, secure, and physically, socially and culturally appropriate (see *MSP activity* ↗ 3.1, MSCM 3.1, 3.2).
 - Organizing **community discussions and accessible feedback and complaints** mechanisms that are responsive and contribute to improving accountability towards the affected populations (see *MSP activity* ↗ 2.1, MSCM 2.3).
- ▶ Organizing **orientations in basic psychosocial support** (e.g. psychological first aid) for site management teams, including the identification and referral of children and adults who may need MHPSS services and supports (see *MSP activity* ↗ 3.2 and MSCM 4.3).
- ▶ **Referring** people to MHPSS activities, including to mental health care providers, as needed.

- ▶ Including **key messages on mental health and psychosocial support** (see [MSP activity ↗ 3.3](#)) as part of regular provision of information to site residents utilizing their preferred communication formats and languages, including on services available in the site (MSCM 2.2).
- ▶ Monitoring **MHPSS-related outputs and outcomes** (e.g. improvements in well-being following a participatory approach to the management of the site).

 See [relevant resources](#) on the MHPSS MSP web platform.


Key consideration 9: Integrating MHPSS into shelter and settlement programming



Living conditions during humanitarian crises can affect people's physical and mental well-being as much as the initial crisis or disaster. Overcrowding, poor ventilation, inadequate or unsafe toilets and washing facilities, inadequate menstrual hygiene facilities, inadequate water supply and poor waste management all increase stress, protection risks and ill health.

Shelter actors can integrate MHPSS into programming by:

- ▶ Including **MHPSS and cultural considerations** in shelter **assessments** (see [MSP activity ↗ 1.2](#)).
- ▶ **Advocating** for improved living conditions and adequate shelter. Safe, adequate shelter supports well-being and contributes to recovery from disaster and displacement. There is also a link between physical recovery/reconstruction and psychosocial recovery: community-led repair and/or (re)construction of homes contributes to people's dignity and sense of agency in humanitarian settings (see [MSP activity ↗ 3.1](#)).
- ▶ **Providing assistance in ways that support mental health and psychosocial well-being** (see [MSP activity ↗ 3.1](#)) by:
 - Promoting the **participation of community members**, including people at heightened risk (e.g. women, persons with disabilities, displaced people, and older adults), in assessments, programme planning, and implementation, for example, by enabling people to choose their own shelter arrangements, neighbours and living areas where possible (see Sphere Shelter and settlement standards 1, 2, 3 and 5).
 - Selecting and designing sites that enable access to **communal spaces for social, cultural, religious, educational and information-sharing activities** (e.g. markets, schools, places of worship, community centres, recreational areas; see Sphere Shelter and settlement standards 2 and 3).
 - Using **familiar and locally-available construction materials** that allow families to make their own repairs to avoid dependency.
 - Promoting and facilitating homemaking activities (e.g. gardening) (see Sphere Shelter and settlement standard 5).
 - Maximising **privacy, ease of movement, and social support** (e.g. by providing, wherever possible, family-size shelters, avoiding separating people who wish to be together, enabling reunited families to live together, integrating traditional positioning of neighbouring houses, facilitating the provision of shelter for isolated, at-risk individuals, such as people with severe mental health conditions and their families; see Sphere Shelter and settlement standard 2).
- ▶ Organizing orientations in **basic psychosocial support** (e.g. psychological first aid), for shelter workers, including the identification and referral of children and adults who may need MHPSS services and supports (see [MSP activity ↗ 3.2](#)).
- ▶ Monitoring **MHPSS-related outputs and outcomes** (e.g. improvements in well-being following a participatory approach to emergency shelter programming).

 See [relevant resources](#) on the MHPSS MSP web platform.

Key consideration 10: Integrating MHPSS into water, sanitation and hygiene programming




The way in which water, sanitation and hygiene is provided to affected populations can have a substantial impact on their dignity, mental health, and psychosocial well-being. Emergency-affected populations are likely to face substantially increased stress, protection risks, and illness where WASH facilities are unclean, unsafe, or culturally inappropriate; where there is a lack of menstrual hygiene management, where the water supply is inadequate; or where waste management is poor. There is also growing evidence that mental health and psychosocial well-being (e.g. levels of anxiety, self-efficacy, social connectedness) shape the extent to which people engage in certain health and hygiene behaviours during public

health emergencies (e.g. handwashing, physical distancing, restricting movement). MHPSS and WASH outcomes are therefore closely interlinked.

WASH actors can integrate MHPSS into programming by:

- ▶ Including **MHPSS and cultural considerations** in WASH **assessments** (see [MSP activity ↗ 1.1](#)).
- ▶ **Providing assistance in ways that support mental health and psychosocial well-being** (see [MSP activity ↗ 3.1](#)) by:
 - Promoting the **participation of target communities**, including at-risk groups such as women, persons with disabilities and older adults, in assessment, programme planning and implementation. (e.g. formation and engagement of gender-balanced water committees consisting of community members and including representatives from various sub-groups) (see Sphere Hygiene promotion standards 1.1, 1.3).
 - Promoting **safety, dignity and protection** in all water and sanitation activities, including **BabyWASH** interventions (interventions that integrate WASH across programme areas such as ECD, Nutrition, and Maternal, Newborn and Child Health to improve child health outcomes).
 - **Preventing and managing conflict** in a constructive manner (e.g. by asking water committees or other community groups to develop a system for preventing and managing conflict).
 - Advocating for the inclusion of **menstrual hygiene management and incontinence** interventions that include MHPSS considerations for women and girls (see Sphere Hygiene promotion standard 1.3).
- ▶ Orienting WASH workers on basic psychosocial support, including identification and referral of children and adults who may need MHPSS services and supports (see [MSP activity ↗ 3.2](#)).
- ▶ Including **key messages on mental health and psychosocial support** (see [MSP activity ↗ 3.3](#)) as part of WASH activities.
- ▶ Providing for **WASH needs as part of MHPSS activities** (e.g. handwashing/hygiene included in activities for children, meeting WASH needs of persons in mental hospitals and institutions - see [MSP activity ↗ 3.14](#)).

 See [relevant resources](#) on the MHPSS MSP web platform.

Key consideration 11: Integrating MHPSS into food security and livelihoods programming


Emergencies often disrupt access to food and cash, with many people losing their livelihoods and means of survival. This can cause severe stress and force people to engage in risky coping strategies, which may further impact their health, well-being, safety, and social relationships. For example, people may engage in risky migration or trafficking, sex work, child labour, or child marriage. The consequences of food insecurity are often gendered, with women and girls eating last and least. Harmful practices such as these can be extremely detrimental to mental health and psychosocial well-being and may have long-term effects on individual and community-wide recovery. Where food insecurity leads to malnutrition, children are at severe risk of disrupted cognitive, emotional, and social development (see [key consideration ↻ 24](#) and [MSP activity ↗ 3.5](#)).

As community members recover from a humanitarian crisis, FSL programming can help restore their independence, sense of social identity, and meaningful participation in community life. Engaging in safe, dignified FSL activities can promote a sense of resilience, agency, and self-efficacy - factors that can be central to mental health and psychosocial well-being. MHPSS activities can help people to build skills in positive coping, communication, conflict resolution, and many other areas that facilitate effective participation in livelihoods.

FSL actors can integrate MHPSS into programming by:

- ▶ Including MHPSS-related factors in **needs assessments**: e.g. assessing social and cultural factors related to food security, nutrition and food aid such as dietary beliefs and practices, household roles, and cultural taboos (see [MSP activity ↗ 1.1](#)). Assessments should also consider the extent to which people recovering from mental health conditions can access livelihoods (see [MSP activity ↗ 1.2](#) and Sphere Livelihoods standard 7.2).
- ▶ Providing **assistance in ways that support mental health and psychosocial well-being** (see [MSP activity ↗ 3.1](#)) by:
 - Promoting the **participation** of target communities in FSL programming and long-term food-security planning, including groups at heightened risk such as women, persons with disabilities, persons with mental health conditions and older adults. Engaging community members in recovery efforts not only improves the appropriateness and effectiveness of interventions but can also foster a sense of agency and combat feelings of helplessness and resignation (see Sphere Food security standard 5).

- Delivering **food aid in a culturally appropriate manner** that protects the identity, integrity and dignity of communities, e.g. considering religious and cultural practices related to food items and food preparation; and ensuring that food aid reaches all intended recipients without discrimination (see Sphere Food assistance standards 6.1 and 6.2).
 - Using food assistance to create and/or restore informal **social protection networks and community groups** e.g. distributing food rations via volunteers providing home-based care (see [MSP activity ↗ 3.4](#) and Sphere Food security standard 5).
 - Ensuring livelihood options are **context-appropriate** and **promote community cohesion**.
 - Taking steps to ensure that livelihood programmes **do not privilege certain groups or increase the risk of conflict** (e.g. engage community members from different groups, including women, in the mapping of risks and identification of risk mitigation and protection strategies).
 - Conducting **group-based community MHPSS activities** (see [MSP activity ↗ 3.4](#)) with livelihoods groups.
- ▶ Orienting FSL workers on **basic psychosocial support**, including the identification and referral of children and adults who may need MHPSS services and supports (see [MSP activity ↗ 3.2](#)).
 - ▶ Including **key messages** on mental health and psychosocial support (see [MSP activity ↗ 3.3](#)) as part of livelihoods activities.
 - ▶ Providing for **food security needs as part of MHPSS activities**, for example, food security initiatives involving community groups (see [MSP activity ↗ 3.4](#)), and food security for persons in mental hospitals and institutions (see [MSP activity ↗ 3.14](#)).
 - ▶ Facilitating **access to livelihood opportunities** for people with mental health conditions and psychosocial disabilities and their families.
 - ▶ Connecting with pre-existing **community groups** (see [MSP activity ↗ 3.4](#)) to facilitate the formation of community-based livelihoods groups.
 - ▶ Monitoring **MHPSS-related outputs and outcomes** (e.g. improvements in well-being following a participatory approach in the design of livelihoods programmes).

 See [relevant resources](#) on the MHPSS MSP web platform.

HOW IS THE MHPSS MSP STRUCTURED?

MHPSS MSP activities are organized as follows:

Section 1



Inter-agency and intersectoral coordination and assessment

This section includes activities to ensure effective inter-agency and intersectoral coordination and assessment, which are particularly relevant to TWGs/coordination groups, as they rely on interagency work.

Section 2



Essential components of all MHPSS programmes

This section includes activities that are essential to the quality and effective administration of all MHPSS programmes (e.g. programme design, monitoring and evaluation (M&E)). Organizations engaging in any type of MHPSS activity should implement these activities.

Section 3



MHPSS programme activities

This section includes MHPSS programme activities, which agencies should select based on their capacities and the unmet needs in the overall response.

Section 4




Activities and considerations for specific settings

This section includes MHPSS programme activities for specific settings, which agencies should select based on the context, their capacities, and the unmet needs in the overall response.

Note that the programme activities (Sections 3 and 4) are not listed in order of priority or chronology. All of these activities should be implemented through coordination across agencies.

Each MSP activity is presented along with:

- ▶ **Core actions:** a checklist of actions to deliver the activity safely and effectively.
- ▶ **Additional actions for consideration:** a checklist of related additional actions that can be prioritized depending on context-specific needs and available resources.
- ▶ **A link to relevant guidelines, standards and tools:** these resources provide additional guidance to support the planning and implementation of the activity and are available on the [MHPSS MSP web platform](#).

ACTIVITY
Core actions
✓ <input type="checkbox"/>
✓ <input type="checkbox"/>
Additional actions for consideration
✓ <input type="checkbox"/>
✓ <input type="checkbox"/>
Guidelines, standards and tools
 Click here to access relevant guidelines, standards and tools.

The MHPSS MSP is an IASC product. The [MHPSS MSP web platform](#) includes additional appendixes, links and tools, from a wide range of humanitarian partners, that can facilitate implementation but are not an integral component of the product.

IS THE MHPSS MSP ONLY FOR HUMANITARIAN SETTINGS?



The purpose of the MHPSS MSP is to respond to MHPSS needs in all types of new, cyclical or protracted humanitarian emergencies that require a **coordinated international response**, including armed conflicts, natural disasters and public health emergencies such as infectious disease outbreaks. Many activities included in the MHPSS MSP will also be relevant for **smaller emergencies**, for **emergency preparedness as part of disaster risk reduction**, and for **longer-term development programming** (see also additional resources listed in the table below).

Because humanitarian crises have a long-lasting impact on mental health and psychosocial well-being, it is essential to “build back better” systems and services.⁵

From the **beginning** of an emergency, it is important to plan how to build or rebuild sustainable government and civil society systems of care through the health, social services, protection, education, and other relevant sectors⁶ and to encourage the inclusion of marginalized groups in these systems.⁷ The MHPSS response should thus contribute to longer-term recovery and development, supporting the **humanitarian–development nexus**.



Demonstration projects, with short-term emergency funding, can provide proof of concept for better services and can create momentum to attract further support and funding for **longer-term system development**.

See [relevant resources on emergency preparedness and longer-term MHPSS system strengthening on the MHPSS MSP web platform](#).

5 Charlson F et al. (2019). [New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis](#). The Lancet 394, pp. 240-248.

6 CHS Alliance, Groupe URD and Sphere Association (2018). [Core Humanitarian Standard on Quality and Accountability](#).

7 UNICEF (2019). [Guidelines to Strengthen the Social Service Workforce for Child Protection](#).

IS AN MHPSS NEEDS ASSESSMENT NECESSARY TO JUSTIFY IMPLEMENTATION OF MHPSS MSP ACTIVITIES?



An MHPSS needs assessment is not necessary to justify the implementation of MHPSS MSP activities, as all emergency-affected communities have significant MHPSS needs.

However, situation analyses and assessments of MHPSS needs and resources are important for **planning, designing and contextualizing** MSP activities (*see MSP activities* ↗ [1.2](#) and ↗ [2.1](#)).

In addition, an analysis of **MHPSS MSP gaps in selected geographical areas** can aid decision-making about which MSP activities and actions need to be initiated, strengthened or scaled up (*see* ↗ [MHPSS MSP Gap Analysis Tool](#)).⁸

HOW CAN GROUPS AND PERSONS AT INCREASED RISK BE PRIORITIZED AND REACHED WITH MHPSS MSP ACTIVITIES AND SERVICES?

Population coverage of MHPSS activities and services (especially at the beginning of an emergency and when resources fall short of needs) will often be limited initially and should be **progressively scaled up over time**.



Persons considered to be at risk should be proactively included to ensure that they can access MHPSS services and activities made available to the general population.



Who is considered as being especially at risk depends on the context.⁹ **Every emergency therefore requires a context-specific analysis of risk factors and groups at higher risk.**



Persons and groups at risk may include adults and children who:

- ▶ Are refugees, migrants, internally displaced persons, stateless persons or returnees
- ▶ Have protection concerns (e.g. have been subjected to various forms of violence, abuse, exploitation, including GBV, trafficking etc.)
- ▶ Are experiencing severe social and economic stressors
- ▶ Have physical, cognitive or sensory disabilities, or experience serious or chronic physical health conditions;
- ▶ Are survivors of EO
- ▶ Are pregnant
- ▶ Have acute nutritional deficiencies (e.g. caregivers with infants in emergency nutritional feeding programmes)
- ▶ Are experiencing severe psychological distress
- ▶ Have mental, neurological or substance use (MNS) disorders or have associated psychosocial or intellectual disabilities (e.g. children with developmental disabilities)
- ▶ Have limited family or social supports (e.g. single parents, unaccompanied children, out-of-school children, widows, older persons)
- ▶ Are survivors of torture and/or armed violence
- ▶ Are older people at risk
- ▶ Belong to groups that experience marginalization and/or discrimination (e.g. minority ethnic groups, persons who identify as lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ+), women and girls).

⁸ Information on how the MSP activities correspond to the IASC (2014) MHPSS 4Ws activity codes is available on the [MHPSS MSP web platform](#).

⁹ Also see pp. 2-3 in Inter-Agency Standing Committee (2007). [IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#).

To avoid fragmentation and stigmatization, MHPSS activities and services for people at risk should be **integrated into wider systems and services** (e.g. existing community support mechanisms, education systems, livelihoods support, general health care) and efforts should be made to reach and engage relevant subgroups of the affected population (e.g. people who have experienced violence (including GBV survivors), people with severe mental health conditions). Activities that are broader and more integrated tend to reach more people, are often more sustainable and tend to be more acceptable to community members.¹⁰



The most effective ways to reach at-risk groups depend on the context and may include:

- ▶ **Working with community-based organizations** (CBOs), community leaders, mobilizers and outreach workers who have existing relationships of trust and connections with specific groups
- ▶ **Strengthening referral pathways** developed through coordination among relevant government and humanitarian agencies across sectors
- ▶ **Organizing community activities** involving community engagement, discussions and dissemination of information about MHPSS and available services and activities (*see MSP activity* → 3.3)
- ▶ **Providing remote and mobile outreach and programming** (*see key consideration* ↔ 18 and [Resources on MHPSS for at-risk groups on the MHPSS MSP web platform](#)).

Ways to ensure that MHPSS MSP services and activities are accessible, inclusive and appropriate also depend on the context and may include:

- ▶ **Facilitating access** (e.g. providing transport, offering child care, flexible and adapted hours of operation, choice of location or provision of mobile services and remote services¹¹)
- ▶ Using **universal design principles**¹² for facilities and equipment, providing reasonable accommodation measures,¹³ and providing communications and resources in accessible formats¹⁴
- ▶ **Ensuring safety** (e.g. confidentiality of personal information);
- ▶ **Addressing stigma and discrimination** (e.g. through community awareness-raising and advocacy);
- ▶ Ensuring that the **needs of specific groups are met** (e.g. inclusion of information about developmental disabilities and mental health conditions in parenting programmes, tailoring some MHPSS activities to men and boys).



In many contexts involving displacement, **host population groups** that are not directly affected by the humanitarian crisis should be able to access MHPSS services and support as appropriate.

KEY TERMS

Mental health and psychosocial support (MHPSS): The composite term “mental health and psychosocial support” is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental health conditions.¹⁵

MHPSS needs include a wide range of issues including interpersonal problems, emotional distress, common mental disorders (such as depression and anxiety disorders, e.g. post-traumatic stress disorder (PTSD)), severe mental disorders (such as psychosis), alcohol and substance abuse and intellectual disabilities.

10 See page 11 in [Inter-Agency Standing Committee \(2007\). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#).

11 *See key consideration* ↔ 18.

12 UNICEF (2020). [Not just hotlines and mobile phones: GBV service provision during Covid-19](#). Universal design” is the design and composition of an environment (or any building, product or service in that environment) so that it can be accessed, understood and used to the greatest extent possible by all people regardless of their age, size, ability or disability.

13 ‘Reasonable accommodation’ refers to making necessary and appropriate modifications and adjustments, where needed, not imposing a disproportionate or undue burden, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

14 Humanity and inclusion (2009). [How to design and promote an environment accessible to all?](#)

Based on the Convention on the Rights of Persons with Disabilities (CRPD), Article 2, communication includes languages (spoken and signed), display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology (ICT).

15 Inter-Agency Standing Committee (2007). [IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#).

Mental health condition: A broad term covering mental disorders and psychosocial disabilities. It also covers other mental states associated with significant distress, impairment in functioning or risk of self-harm.¹⁶

Persons with disabilities (adults, children, youth) include persons who have long-term sensory, physical, psychosocial, intellectual, or other impairments that, in interaction with various barriers, may prevent them from participating in, or having access to, humanitarian programmes, services or protection.¹⁷

Psychosocial disability: The IASC Guidelines on the inclusion of persons with disabilities in humanitarian action define “psychosocial disability” as resulting “from barriers to social participation and access to rights linked to mental health or cognitive conditions or disturbance in behaviour that is perceived as socially unacceptable. The term is usually reserved for people with more persistent or recurrent functional impairment, who are confronted with systematic exclusion and participation barriers. The term is less often used for those with temporary mental health conditions who recover quickly, sometimes in response to MHPSS interventions. During humanitarian emergencies, distress leading to functional impairment is often transient, and it is important not to label such response as a medical condition or disability.”¹⁸ Though the definitions and terms used may vary, the central aspect is the persistent or recurrent functional impairment experienced, which, in interaction with various barriers, may hinder the person’s full and effective participation and access to services.

WHAT CRITERIA WERE USED TO DECIDE WHAT SHOULD GO INTO THE MHPSS MSP?

The MSP includes activities that:

- ▶ Aim to promote and improve **mental health and psychosocial well-being** and **reduce suffering**
- ▶ Focus on problems that are **common and/or severe**
- ▶ Have been identified as **priorities in key guidance documents** and published **expert reviews** (e.g. the Sphere Handbook, IASC MHPSS guidelines and resources, CP minimum standards, the Inter-Agency Minimum Standards for GBV in Emergencies Programming, the INEE Minimum Standards, the IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action, the Nurturing Care Framework)
- ▶ Are informed by the **best available evidence**
- ▶ Are **affordable at scale** and are informed by cost-effectiveness and other value-for-money considerations
- ▶ Promote human rights and support the protection of at-risk populations from **human rights** violations (e.g. neglect, exploitation, violence, abuse, discrimination)
- ▶ Are **feasible** in most emergency contexts at different phases of the emergency (i.e. despite insecurity, scarce human resources, logistical constraints and other limitations inherent in humanitarian settings)
- ▶ Can be implemented within a **12-month** timeframe
- ▶ Are **adaptable and acceptable** across cultures and contexts
- ▶ Are **readily implementable** (e.g. global guidance/manuals are available to support implementation).

16 WHO (2022). [World Mental Health Report: Transforming mental health for all](#).

17 See [UN Convention on the Rights of Persons with Disabilities](#) and IASC (2019) [IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action](#).

18 IASC (2019). [IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action](#), p. 132.

General principles and considerations

The following general principles and considerations are important for the implementation of the MHPSS MSP.¹⁹



Promote human rights and equity for all affected persons through the protection of individuals and groups who are at greater risk of human rights violations. Promote non-discrimination and the proactive inclusion of at-risk groups to ensure their equitable access to MSP activities across identified geographical areas (*see also* → [Overview, “How can groups and persons at increased risk be prioritized and reached with MHPSS MSP activities and services?”](#)).



Ensure inclusion and participation: Ensure the inclusion of all affected groups in the assessment, design, implementation, monitoring and evaluation of the response, as well as in MHPSS activities. Facilitate this by ensuring that stakeholders representing all groups, especially the most at-risk, have access and can participate to the greatest extent possible and from the earliest phase of the emergency. It is key to leverage the existing capacities within communities in providing MHPSS, considering that community members are usually the first respondents, particularly at the onset of an emergency situation. Include people of different ages and genders, and people with diverse characteristics (e.g. different ethnic groups, minorities, LGBTIQ+, persons with diverse SOGIESC), including persons with disabilities. Promote the localization of the response by building on existing resources, channelling decision-making power and additional resources to government actors/local authorities, local partner organizations (including organizations for persons with lived experience of mental health conditions and psychosocial disabilities) and affected communities. Ensure that existing MHPSS programmes address stigma and discrimination and are adapted to safeguard accessibility for a range of disabilities. Where needed, deliver services through outreach and mobile teams to access individuals and communities.



Do no harm: Cultivate an awareness of how ill-conceived or poorly executed MHPSS programmes might cause harm (e.g. avoid harmful treatment practices; ensure that actions respond to assessed needs; commit to ongoing monitoring, evaluation, learning and accountability; support evidence-informed, culturally appropriate responses; acknowledge the power relations between groups participating in the emergency response; enforce codes of conduct for humanitarian workers that prevent sexual exploitation and abuse; and adhere to the humanitarian principles of neutrality, impartiality, humanity and independence). Ensure that all MHPSS programming is overseen and supported by appropriately qualified personnel. Adhere to safe recruitment and safeguarding procedures when engaging workers that will be interacting with children and others at heightened risk (e.g. reference checks; criminal record/police checks; declarations confirming no previous relevant convictions, investigations or complaints; interviews to assess relevant attitudes, experiences, and views on safeguarding, codes of conduct, and related policies).^(ibid.)



Uphold Accountability to Affected Populations: Accountability to Affected Populations (AAP) aims to ensure that all at-risk and crisis-affected populations supported through humanitarian action are able to hold organizations to account for promoting and protecting their rights, generating effective results, taking into account their needs, concerns and preferences, and working in ways that enhance their dignity, capacities and resilience. Affected populations should understand the standards of conduct expected of humanitarian personnel and should have access to safe and confidential complaint mechanisms, including for complaints about sexual exploitation and abuse.²⁰

19 See also the humanitarian charter and protection principles outlined in [The Sphere Handbook](#). For additional key principles relating to GBV and Child Protection, see the [GBV Minimum Standards](#) and [Child Protection Minimum Standards](#).

20 For more information on AAP, see the [IASC AAP Operational Framework](#); and UNICEF's information, toolkits and guidance on AAP at <https://www.corecommitments.unicef.org/cc-2-1> and <https://www.corecommitments.unicef.org/aap>.



Ensure informed consent/assent and safe information-sharing practices: Individuals have the right to choose what information they disclose and to whom, and the right to withdraw their consent at any time. Any information disclosed should be shared onwards only with their informed consent. Informed consent means that information provided by or about someone is shared only if they understand what is to be shared, with whom, how the information will be used, and the risks and benefits of providing the information. Children below the age of 15 should have consent from their caregiver. Children of over 15 can provide “informed assent”.²¹ Consent needs to be obtained for sharing information and referring a person to services. Organizations that regularly manage referrals should ensure that they have clear protocols for sharing information and for data protection.²² Information sharing must be done with respect for confidentiality, must be limited to essential information and must follow information-sharing protocols (*see key consideration* ↻ 19).



Ensure confidentiality and understand mandatory reporting: Confidentiality entails guaranteeing the privacy and security of individuals, their families and wider communities. Actors need to be familiar with the laws of the country in which they are operating and be aware of what they are officially required to report. National laws criminalize some acts (such as child abuse, rape, violence or terrorism and, in some countries, suicide and self-harm) and may require MHPSS providers, including those working in health, protection, education and GBV services, to report these acts to police or to other government officials. Mandatory reporting can conflict with the principles of confidentiality, person-centred care and assistance and, in particular, taking a survivor-centred approach and considering their best interests (*see key considerations* ↻ 28 and ↻ 30).²³ Some persons may not want to disclose their experiences, and doing so may put them (or their families) at further risk. It is important that service providers discuss with their supervisors what the best course of action should be in each case. Providers must explain to service users the limitations of confidentiality during the process of informed consent and before providing MHPSS-related services, so that they can make informed decisions about what they choose to disclose to providers because of mandatory reporting laws.



Build on available resources by working with government and civil society actors and with affected people themselves, building local capacities, supporting self-help, strengthening the resources already present and adapting new initiatives so that they complement and enhance existing activities.



Develop integrated support systems so that MHPSS activities are closely linked to each other, to other emergency response activities and to relevant formal and informal support systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, social services, etc.). Cultivate strong relationships and connections between sectors and services to create a mutually reinforcing network of supports, including those targeting individual, family, community and societal levels.



Adopt a life course approach, ensuring that the MHPSS response is informed by the full range of needs, vulnerabilities and strengths experienced at different stages of life. Particular efforts should be made to understand and address the needs of people at sensitive developmental stages and during more vulnerable periods of life, such as infants, young children, adolescents and older adults. When developing MHPSS activities, seek the participation of people at different life stages, including children, adolescents and older persons, to capitalize on their diverse insights and to ensure the relevance and effectiveness of services across age groups.



Take gender-related considerations into account: MHPSS programmes must consider the specific needs of women, men, boys and girls with respect to both biological sex differences and sociocultural gender differences. Actors implementing MHPSS activities must understand how the experiences, strengths, needs and vulnerabilities of women, men, boys and girls may differ, and how these differences affect their coping strategies, help-seeking behaviour and access to supportive resources. Programmes should also promote gender equality and should be grounded in a rights-based approach. This requires humanitarian actors to collaborate across sectors to simultaneously tackle different dimensions of gender inequality. It may also involve challenging harmful

21 “Informed assent is the expressed willingness to participate in services. For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child’s ‘informed assent’ is sought. Informed assent is the expressed willingness of the child to participate in services.” International Rescue Committee/UNICEF (2012). *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*; and The Alliance for Child Protection in Humanitarian Action (2019). *Minimum Standards for Child Protection in Humanitarian Action*, 3.3.8: Informed consent/assent.

22 IASC (2017). *Inter-Agency Referral Form and Guidance Note*.

23 See UNHCR (2021). *UNHCR Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child* and United Nations (2013). *Convention on the Rights of the Child*.

sociocultural norms and stereotypes related to masculinity and femininity (e.g. by promoting changes in gender relations, as well as access to opportunities and resources). For example, women disproportionately carry the burden of caregiving for children, older persons, persons with mental health conditions and persons with disabilities, which affects their ability to access support services and restricts the time they have available for education, livelihoods, and social activities. Activities and services should be designed with these considerations in mind, including: supporting women to use services by ensuring convenient opening hours and facilitating childcare and transport as needed; addressing protection issues faced by women and girls that may hinder participation; and encouraging men to take on caregiving responsibilities. It is important to note that traditional gender norms also greatly affect the mental health and well-being of men and boys. For example, men may struggle with strict and unrealistic expectations of masculinity that can result in negative behaviours and coping mechanisms. Social conceptions of masculinity can fuel child labour, gang violence, disengagement from school and recruitment into armed groups. Programmes should therefore consider aspects related to gender, including tailoring programmes to the needs of different groups, ensuring access and promoting gender equality.²⁴



Key consideration 12: The effectiveness of MHPSS activities will be limited if a person's basic protection needs are not being met

MHPSS interventions, such as group activities and focused individual support, may have a limited impact if a person is facing ongoing abuse, neglect or violence. This should be considered in the coordination of services for each individual, so that urgent needs are met in the most effective manner. This is particularly important where children are concerned, as they are often less able to communicate their priorities and typically have less power than adults to address or avoid protection risks. Other groups at heightened risk may also face additional barriers, such as older people and people with diverse SOGIESC (see → [“How can groups and persons at increased risk be prioritized and reached with MHPSS MSP activities and services?”](#) and ✎ [Resources on MHPSS for At-Risk Groups on the MHPSS MSP web platform](#)). MHPSS and protection actors must work together closely, facilitating mutual referrals. Given the trusting relationships built between facilitators and participants over time, group activities for child well-being can be an important means through which protection needs are identified and appropriate links to services and supports are made.



Key consideration 13: Meeting the needs and ensuring the inclusion of persons with disabilities

Persons with disabilities represent a diverse group, varying in age, race, sex, gender identity, language, religion, ethnic, indigenous or social origin, type and severity of disability and barriers faced. In emergency contexts, people with psychosocial, cognitive or intellectual disabilities and those living in institutions may be at increased risk of being left behind and exposed to discrimination, violence, human rights violations, under-identification, exclusion and isolation. They may face barriers to accessing MHPSS services and participating in the MHPSS response based on: stereotypes, prejudices and stigmatizing beliefs among frontline workers (e.g. erroneous ideas about persons with disabilities being unable to make decisions or to contribute to the emergency response); limited resources, capacity and knowledge of MHPSS staff on how to adapt services to meet their needs; and/or limited opportunities to participate in and influence the design of MHPSS activities.

MHPSS policies and programmes must respond to the differing needs of children, youth and adults with disabilities and respect their rights. This can be achieved by:

- ▶ Mainstreaming disability inclusion within MHPSS planning, programming and budgeting
- ▶ Designing and implementing tailored actions as part of the MHPSS response to ensure that the specific disability-related requirements of persons are met, through reasonable accommodation measures
- ▶ Building the capacity of MHPSS workers on the communication requirements of persons with disabilities and relevant approaches such as the rights-based approach, the twin-track approach, supported decision-making, universal design features and reasonable accommodation measures.



See [relevant resources](#) on the MHPSS MSP web platform.

²⁴ See also UNICEF & UNFPA (2021). [Technical Note on Gender Responsive and/or Transformative Approaches](#) and UNICEF (2022). [Technical Note on Gender in Adolescent Mental Health](#).

SUMMARY OF MHPSS MSP ACTIVITIES



The MHPSS MSP goal:

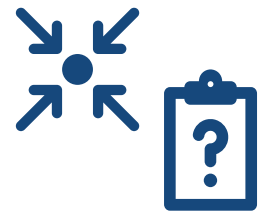
Reduced suffering and improved mental health and psychosocial well-being among populations affected by humanitarian crises.

Sectors or AoRs typically well placed to deliver the activities

Sectors or AoRs typically well placed to contribute to implementation of activities

Section 1: Inter-Agency Coordination and Assessment			
1.1 Coordinate MHPSS within and across sectors			» The humanitarian MHPSS response is well coordinated and responsive to the context, needs and gaps
1.2 Assess MHPSS needs and resources to guide programming			
Section 2: Essential components of all MHPSS programmes			
2.1 Design, plan and coordinate MHPSS Programmes			» MHPSS programs are well designed, monitored and evaluated and workers are supported
2.2 Develop and Implement an M&E System			
2.3 Care for staff and volunteers providing MHPSS			
2.4 Support MHPSS competencies of staff and volunteers			
Section 3: MHPSS programme activities			
Orient humanitarian actors and community members on MHPSS			» Humanitarian actors and community members are oriented on MHPSS and equipped with basic psychosocial support skills
3.1 Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions			
3.2 Orient frontline workers and community leaders in basic psychosocial support skills			
Strengthen self-help and provide support to communities			» Affected communities have access to information and activities to promote their mental health and psychosocial well-being
3.3 Disseminate key messages to promote mental health and psychosocial well-being			
3.4 Support new and pre-existing group-based community MHPSS activities			
3.5 Provide early childhood development (ECD) activities to support young children and their caregivers			
3.6 Provide group activities for children's mental health and psychosocial well-being			
3.7 Promote caregivers' mental health and psychosocial well-being and strengthen their capacity to support children			
3.8 Promote the mental health and psychosocial well-being of education personnel and strengthen their capacity to support children			
3.9 Provide MHPSS through women and girls safe spaces			
Provide focused support for people impaired by distress or mental health conditions			
3.10 Provide mental health care as part of general health services			
3.11 Provide MHPSS as part of clinical care for survivors of sexual violence and intimate partner violence			
3.12 Initiate or strengthen the provision of psychological interventions			
3.13 Provide MHPSS through case management services			
3.14 Protect and care for people in psychiatric hospitals and other institutions			
Section 4: Activities and considerations for specific settings			» MHPSS considerations and activities are appropriately integrated in specific types of emergency situations
4.1 Integrate MHPSS considerations and support into clinical case management for infectious diseases			
4.2 Provide mental health and psychosocial support to persons deprived of their liberty			

SECTION 1



INTER-AGENCY COORDINATION AND ASSESSMENT FOR THE MHPSS RESPONSE



1.1 Coordinate MHPSS within and across sectors

Effective MHPSS programming requires close coordination among **diverse actors across multiple sectors**.²⁵

A multi-sectoral MHPSS coordination mechanism, adequate to the context and number of agencies implementing MHPSS should be established. Especially in larger emergencies where there are multiple MHPSS actors, this should be a single **cross-sectoral MHPSS Technical Working Group** (MHPSS TWG) which should be established early in the emergency response. This group may be co-led by a health and a protection humanitarian organization and/or a governmental organization when feasible.^{26,27}

The MHPSS TWG should promote the coordination of MHPSS activities across **both national actors** (e.g. CBOs, government) and **international actors** (e.g. INGOs, UN agencies), provide technical input, and help to ensure consistent **standards and quality** within MHPSS work.

Coordination helps to ensure that the **full range** of complementary **MHPSS activities and services** is provided in line with global guidelines.

Poor MHPSS coordination (e.g. separate coordination groups for mental health and for psychosocial support, or linking MHPSS only to one sector or cluster) is associated with ineffective, inefficient, duplicative, inappropriate and potentially harmful programming. It may also result in specific MHPSS issues and/or geographical areas being left out.

25 The IASC Handbook of MHPSS Coordination aims to establish a consensus-based approach to guiding the work of MHPSS TWGs working at country level. The handbook includes several functions for MHPSS coordination, including 1. (Re)establishing and maintaining a technical working group, 2. Information management, 3. Establishing links between stakeholders, 4. Building capacity, knowledge exchange and peer support, 5. Monitoring and evaluation, 6. Promoting long-term sustainability, 7. MHPSS advocacy.

26 Sphere (2018). *The Sphere Handbook*.

27 Summary Record, *IASC Principals meeting*, 5 December 2019.

ACTIVITY

Coordinate MHPSS within and across sectors



Core actions

1. (Re)establishing and maintaining a technical working group²⁸

- ✓ Establish a **single cross-sectoral** MHPSS Technical Working Group (TWG) and, if needed, **subnational** TWGs.²⁹
- ✓ **Facilitate coordination between different actors** to avoid duplication, address obstacles and **fill gaps in the response** based on the MHPSS MSP and relevant assessments.
- ✓ Facilitate a dialogue between government and humanitarian actors to **establish MHPSS-specific roles and responsibilities in the emergency response** (e.g. government, INGOs, NGOs, CBOs and other key partners in Health, Protection, Education, Nutrition, CCCM, Shelter and other sectors).

2. Information management

- ✓ Support **MHPSS needs assessments** and the inclusion of MHPSS in the needs assessments and ongoing monitoring of relevant sectors to inform response planning (e.g. Humanitarian Needs Overviews, Humanitarian and Refugee Response Plans). Maintain a joint depository of existing needs assessments or studies related to the country and/or affected population.
- ✓ Conduct, maintain and distribute a comprehensive **mapping of MHPSS actors, services and activities** (e.g. 4Ws MHPSS service mapping, MSP Gap Analyses). Review gaps in services at regular intervals to inform planning.
- ✓ Regularly **share information** among humanitarian MHPSS and other actors (e.g. assessment reports, service directories and collated information in designated groups on mhpss.net).
- ✓ Develop, strengthen, update and implement joint **referral pathways** (e.g. a directory of services and referral information, common referral forms and pathways, standard operating procedures; SOPs) to facilitate access to the full range of MHPSS services and activities and to additional support as needed (e.g. protection including CP and GBV, health, education, food security and livelihoods, and community-based support). Referral pathways should support a survivor-centred approach and, where a child is concerned, the best interest of the child.

3. Establishing links between stakeholders

- ✓ **Coordinate with all relevant sectors, clusters and coordination groups** (e.g. Health, Education, CCCM, Shelter, WASH, Nutrition, Protection including AORs (e.g. CP, GBV, Mine Action, Housing, Land and Property (HLP), and the disabilities TWG); with civil society (e.g. CBOs, CSOs); with **faith-based actors or spiritual leaders**; and with **government actors** (e.g. ministries of health, social welfare, education). This includes ensuring mutual **representation**, participation, and contribution at coordination meetings.

4. Building capacity, knowledge exchange and peer support

- ✓ Disseminate and adapt **MHPSS guidance** (e.g. IASC resources) and conduct **rapid orientations** on this guidance for coordination groups and for agencies funding, planning or implementing MHPSS activities across sectors.

5. Monitoring and evaluation

- ✓ Support the reporting of MHPSS activities and indicators. This includes defining **MHPSS M&E** indicators for humanitarian information systems (e.g. inter-agency/cluster reporting systems) and orienting agencies on how to use these systems.

²⁸ These subheadings correspond to the coordination functions of MHPSS TWGs outlined in the Handbook of MHPSS Coordination.

²⁹ To avoid fragmentation and duplication, it is important that only one MHPSS coordination group is operational. Where separate coordination groups exist (e.g. a “mental health” coordination group and a “psychosocial support” coordination group), they should be joined or merged into one overarching group to coordinate the MHPSS response as a whole. See the IASC (2007). *Guidelines on MHPSS in Emergency Settings*; Summary Record, *IASC Principals meeting*, 5 December 2019; Sphere (2018). *The Sphere Handbook 2018*; and Global Protection Cluster (2020). *MHPSS and protection outcomes*.

6. Promoting long-term sustainability

- ✓ Support the development of **sustainable mental health, social care, education, livelihoods support and protection systems** as part of early recovery planning and during protracted crises. Link MHPSS emergency activities with comprehensive and complementary development activities in coordination with donors and government actors (e.g. supporting long-term planning with government and national actors, workforce development activities, demonstration projects showing system reform across a geographical area).

7. MHPSS advocacy

- ✓ Support and coordinate the development and dissemination of **MHPSS advocacy materials and key messages** (see *MSP activities* → [3.1](#) and → [3.3](#)).
- ✓ Advocate for the inclusion of MHPSS in **funding and resource allocation** across multiple sectors (e.g. targeting donors, funding mechanisms).
- ✓ **Advocate for MHPSS considerations for adults and children in different sectors** and by different actors (e.g. delivering humanitarian aid in a way that reduces distress and promotes dignity, including MHPSS in referral pathways developed by other sectors; see *MSP activity* → [3.1](#)).
- ✓ Make MHPSS a recurring agenda item at **inter-agency meetings** (e.g. UN country meetings, inter-agency coordination meetings and multisector refugee coordination meetings) and forums to help ensure an intersectoral response and support for MHPSS priorities.

Additional actions for consideration (depending on context and available resources)

1. (Re)establishing and maintaining a technical working group

- ✓ Establish (further) **subnational** MHPSS TWGs if needed (e.g. when the humanitarian response spans multiple regions/districts).
- ✓ Establish multidisciplinary **taskforces** to work on urgent context-specific issues that are not being addressed elsewhere (e.g. addressing an upsurge in suicide, MHPSS for older people, MHPSS for children associated with armed forces and groups, perinatal mental health, etc.).

3. Establishing links between stakeholders

- ✓ **Develop joint workplans** for MHPSS within MHPSS TWGs, linking and supporting collaboration in activities within and across sectors and organizations.

4. Building capacity, knowledge exchange and peer support

- ✓ Orient additional coordination groups across diverse sectors or AoRs to identify how their respective sectors contribute to MHPSS outcomes and how MHPSS activities can contribute to outcomes in other sectors, and to identify opportunities for effective integrated programming.
- ✓ Develop and maintain a register of national expert trainers and supervisors for MHPSS curricula (e.g. basic psychosocial skills, mhGAP-HIG, psychological interventions, social and emotional learning (SEL), positive parenting packages).

6. Promoting long-term sustainability

- ✓ Advocate for local and national policies and interventions to reflect international good practice guidelines for MHPSS, and support government actors in designing, implementing or strengthening services.
- ✓ Support the building of national-level capacity for the continuation of coordination by supporting or developing sustainable coordination structures, including government and civil society stakeholders.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

Key contacts for technical support:

IASC The **Inter-Agency Standing Committee (IASC)** MHPSS Reference Group offers technical support, mentoring and training to country-level MHPSS working groups on topics such as establishing an MHPSS TWG, conducting needs assessments, linking with cluster/sectoral groups, conducting situational analysis, referral guidance and service mapping, and M&E. Requests must be inter-agency and can be submitted by email to mhpss.refgroup@gmail.com.

Surge support mechanisms increasingly deploy MHPSS experts to support in establishing coordination structures to strengthen MHPSS capacity. Experts are deployed through standby partnerships with UN agencies such as WHO, IOM, UNHCR and UNICEF. The MHPSS surge support mechanism, which is implemented in collaboration with the IASC MHPSS Reference Group, has a specific focus on the deployment of MHPSS experts (*contact: mhpss@rvo.nl*).



Key consideration 14: What to do if referral options for mental health services are not accessible?



In a range of humanitarian settings, mental health services may not be available or sufficiently accessible (e.g. due to geographical distance or costs). In these situations, it can be helpful to work with MHPSS TWGs and relevant coordination groups (e.g. health cluster/sector) to:

- ▶ Work with local actors to identify existing facilities and systems in which to **integrate mental health** services.
- ▶ **Advocate** to government actors and external funders for the needed mobilization of funds and resources to fill service gaps;
- ▶ Discuss which actors may be able to support needs in the **short-term**;
- ▶ Work with actors to improve access to any **existing mental health services**, if applicable (e.g. covering financial costs, facilitating transport);

If a coordination group does not exist, one should be established in collaboration with other MHPSS actors (*see MSP activity* ⇒ [1.1](#)).

When strengthening existing or establishing **new mental health services**:

- ▶ Aim to shift the locus of care away from psychiatric hospitals towards **community-based mental health** services. This not only involves strengthening mental health care in primary health care but also making sure that specialized care is accessible through for example, district general hospitals, community mental health teams or community mental health centers. Long-stay psychiatric hospitals should be closed once there are adequate alternatives;
- ▶ **Avoid setting up parallel systems** if possible and aim to integrate services into existing health and social care systems (e.g. mental health care as part of general health services);
- ▶ Promote effective **collaboration** between formal and informal care providers and across different sectors (e.g. referral pathways).


See MSP activities ⇒ [3.10](#) and ⇒ [3.12](#) for more information and relevant guidelines.




1.2 Assess MHPSS needs and resources to guide programming

An in-depth needs assessment is not required to justify the initiation of MHPSS services and activities.

Nonetheless, it is important to assess MHPSS needs and resources to **guide planning** of more detailed and context-specific programme activities. This includes collecting initial information on the humanitarian context, the target populations, existing MHPSS national/local capacities, policies, plans and emergency response activities.

 A **coordinated approach** (see [MSP activity ↗ 1.1](#)) to the assessment of an emergency and to the prioritization of the needs of affected people lays the **foundation for a coherent and efficient MHPSS response**.

 Regardless of whether organizations conduct independent or collaborative inter-agency rapid assessments, the resulting **reports should be made available** through the MHPSS TWG to avoid duplication and to inform the humanitarian response.

ACTIVITY

Assess MHPSS needs and resources to guide programming



Core actions

- ✓ **Review existing information and previous assessments** covering MHPSS within the affected population and the current humanitarian emergency. **Coordinate new assessments** with the MHPSS TWG (or other relevant coordination mechanism if a MHPSS TWG does not exist).
- ✓ Support actors from different sectors to **incorporate** MHPSS considerations and questions into the planning, design, implementation and analysis of **multi-cluster/sector assessments** (e.g. Education, Protection, Health, CCCM, Shelter, as well as AoRs such as CP, GBV, Mine Action) in consultation with MHPSS TWGs.³⁰
- ✓ Conduct a **brief desk review** of existing information on MHPSS (e.g. national systems for MHPSS, policies and plans, country and sociocultural contexts, affected populations, previous assessments and regularly published reports, such as WHO Mental Health Atlas Country Profiles, WHO Global Health Observatory mental health data and Institute for Health Metrics and Evaluation (IHME) data on mental health burden in the country). Consider and include the needs and resources of persons of different ages, genders and capacities, including persons with disabilities and other diverse characteristics.
- ✓ Train staff and volunteers collecting MHPSS data from affected populations in **ethical principles** and safety recommendations, sociocultural considerations, basic interviewing skills and **basic psychosocial support skills** including referral as needed (*see MSP activity ↗ 3.2*).
- ✓ **Conduct community-level needs assessments** to collect and analyse information (e.g. on perceived MHPSS needs and coping mechanisms; risk and protective factors; at-risk groups; cultural understandings and manifestations of mental well-being and distress; terms used to discuss mental health and well-being; ways of help-seeking; barriers to receiving care; community-led MHPSS activities and resources; and wishes of community members, including those with lived experience of mental health conditions, regarding types of support needed). Disaggregate by gender, age and disability and ensure mixed-gender data collection teams where appropriate (*see ↗ relevant tools on community participation in assessments*).
- ✓ Conduct an **assessment of existing systems and capacities** (e.g. information on mental health and other relevant systems and services (e.g. social care, education); existing MHPSS activities; organizational capacities; undergraduate and postgraduate education systems for various MHPSS cadres; staff competencies and training needs; and referral pathways).
- ✓ **Share and discuss assessment findings** with humanitarian actors and affected populations (e.g. via local and international mailing lists such as those of the IASC MHPSS Reference Group; presentations and discussions of findings with relevant national/local and international stakeholders, coordination groups or clusters; community discussions or brief assessment summaries (with translation in relevant languages and in accessible formats for person with disabilities)).
- ✓ Facilitate inclusion of the findings from MHPSS needs assessments in **humanitarian response planning tools and funding documents** (e.g. Humanitarian Needs Overviews, Humanitarian Response Plans, Refugee Response Plans, Strategic Preparedness and Response Plans, cluster strategies, calls for funding).

Additional actions for consideration (depending on context and available resources)

- ✓ Conduct **comprehensive in-depth situation analyses and community-level needs assessments** as needed, to learn from different subgroups of affected populations. Use methods tailored to maximize the safe and meaningful participation of people of different genders, age groups and other subgroups (e.g. refugees, migrants, victims of trafficking, persons with disabilities); and ensure adequate training and appropriate composition of data collection teams (e.g. mixed-gender or female teams, relevant language skills).
- ✓ **Conduct and publish a comprehensive literature review** on MHPSS specific to the country/affected population and/or crisis (*see examples in ↗ Relevant Guidelines, Standards and Tools*).

30 See also IASC (2022). Handbook of MHPSS Coordination: Annex 10, Tips for integrating MHPSS into rapid needs assessments.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.



Key consideration 15 : Assessments showing prevalence estimates of mental health conditions in humanitarian settings are not essential to initiate services



Epidemiological surveys are challenging to do well, are costly and time-intensive, and consistently show that the identified needs are much higher than the capacity to respond. In emergency contexts, epidemiological surveys often become outdated before they can even be published. Global WHO estimates already exist which can be used to justify MHPSS programmes:³¹

- ▶ Most people affected by emergencies will experience psychological distress, which for most will improve over time.
- ▶ One person in **five** (22%) living in an area affected by conflict in the previous 10 years is estimated to have a mental health condition; one in 11 (9%) has a moderate or severe mental disorder.³²

31 Charlson F et al. (2019). [New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis](#). The Lancet 394, pp. 240-248.

32 Ibid.

SECTION 2



ESSENTIAL COMPONENTS OF ALL MHPSS PROGRAMMES



2.1 Design, plan and coordinate MHPSS programmes

MHPSS programmes need to be carefully designed, planned and coordinated to maximize effectiveness and mitigate the risk of harm.

Information gathered through MHPSS coordination mechanisms and assessments should be used to **identify existing resources, prioritize needs and select or adapt programme activities and actions** in collaboration with **key stakeholders** (e.g. government actors, service providers and service users, and other community members, including people of different ages, and people with disabilities and other diverse characteristics). Programmes that are designed with close involvement from key stakeholders are likely to be more **relevant, acceptable and sustainable**.



Activities that are **integrated into wider systems** (e.g. existing community support mechanisms, formal/non-formal school systems, health and social services) can reach more people, tend to carry less stigma and can contribute to more sustainable **strengthening of systems and services**.

ACTIVITY

Design, plan and coordinate MHPSS programmes

Core actions

- ✓ Engage with and **regularly participate in MHPSS TWG** meetings, communications and activities and other relevant coordination mechanisms to **share information** about current or planned MHPSS activities; to **obtain feedback**; to **promote best practice** according to international standards; and to optimize **coordination** (e.g. filling gaps, avoiding duplication, following global guidance, utilizing referral pathways).
- ✓ Engage **representative stakeholders** (e.g. government, community members and service users) in **designing and planning programmes** that are relevant to their needs and priorities; build on their existing capacities; are sensitive to differences in age, gender, disability, and other forms of diversity; are culturally relevant; and do not cause harm (e.g. engagement through meetings, focus group discussions (FGDs), participatory design workshops, etc.).
- ✓ Identify existing **human resources and initiatives in each community** that can be engaged in response activities (e.g. health and social service providers, community education committees, community-based child protection committees, advocacy campaigns, women's groups and other community groups). Where existing support models are showing benefits in one setting, assess if they could also be used effectively elsewhere.

- ✓ Assess opportunities for **collaboration with local and national partners** to implement MHPSS activities and to build such partnerships into funding proposals where feasible (e.g. through technical support and institutional capacity-building partnerships).
- ✓ **Select programme activities** based on community needs, capacities and priorities identified during assessments; on identified gaps in the humanitarian MHPSS response (e.g. [see MSP activity ↗ 1.1](#)); and human resources (HR) available, including the availability of appropriately qualified and experienced staff to provide technical oversight of MHPSS activities. Identify how different teams/sectors within the organization can contribute and collaborate to holistically address MHPSS needs.
- ✓ Where multiple teams within an organization (e.g. CP, GBV, Health) contribute to MHPSS outcomes, clarify the **scope and boundaries of each role** and the criteria for referral between roles/services, both internally and externally.
- ✓ Contribute to **coordination group tasks** such as mapping exercises, dissemination of MHPSS guidance to different actors, advocacy for MHPSS funding, reporting of MHPSS activities and common indicators and development of common referral pathways.
- ✓ Develop a local **crisis management procedure** to guide staff who may encounter persons at increased risk of suicide, self-harm or harm to others, including what to do when referral options are not available ([see also key consideration ↗ 14](#)).
- ✓ Take steps to plan for and develop **sustainable mental health, social and education systems** during early recovery and protracted crises (e.g. support capacity-building in government services, work with educational institutions to build MHPSS capacity, work with relevant ministries to develop/strengthen MHPSS policies, strategies and plans).
- ✓ Develop a provisional **exit strategy** with relevant local and national stakeholders and with service users and their families, and update this as the programme evolves.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

Key consideration 16: Contextualization

Activities and programme materials should be **selected and adapted in collaboration with affected community members**.



Participatory methods should be used to learn from community members how best to adapt manuals, curricula and informational materials to improve their appropriateness and relevance to the specific emergency context ([see resources on participatory methods in the relevant guidelines, standards and tool sections of MSP activities ↗ 2.1 and ↗ 2.2 on the MHPSS MSP web platform](#)).



Considerations include the type of emergency; the age, gender, capacity, needs, resources, language(s), culture(s) and other diverse characteristics of the affected populations; the available human and material resources; and the available communication media and preferences of different population subgroups.

Programme and M&E materials will be most valid and will have the greatest impact if they address pertinent needs, use local terminology for MHPSS-related concepts, and use case examples that resonate with the local context (e.g. using locally meaningful terminology, images and names). [See also the relevant ↗ guidelines, standards, and tools on contextualization, available on the MHPSS MSP web platform.](#)



Key consideration 17: Considering the needs of: i) migrants caught in crisis, ii) refugees and asylum seekers, iii) internally displaced persons (IDPs), iv) stateless people

Humanitarian emergencies may involve people who are not nationals or habitual residents of the country. This includes people who have been displaced across borders such as refugees and asylum seekers, those who are displaced within their own countries (internally displaced persons), stateless people, and migrants caught in the crisis (including labour migrants, domestic workers, foreign students, and undocumented migrants who may remain where the crisis occurs or move internally or across borders, without being considered eligible for asylum). These groups require specific attention as they may face legal, practical, and cultural barriers to accessing services on the same grounds as others and may not speak the same language as most of the population. In these situations, it is important to:

- ▶ **Advocate** for affordable and non-discriminatory access to MHPSS services for all, regardless of legal status;
- ▶ **Provide clear information** to both service users and providers about entitlements to MHPSS services, how to access such services, referral processes, and principles of consent and confidentiality;
- ▶ Consult the communities on their preferred means of communication and provide this information in **appropriate languages, in relevant formats** (e.g. radio, leaflets, social media, public art, through outreach volunteers), and **at accessible venues** (e.g. reception facilities, transit centres, registration venues, community centres, schools, religious or cultural settings);
- ▶ Train and deploy **interpreters and cultural mediators** where needed and work with refugee, migrant or community-based organisations to better understand messaging, terminologies, cultural aspects etc;
- ▶ **Train providers** in person-centred care, using a rights-based approach, and cultural competence (e.g. addressing stigma and prejudice; fostering positive attitudes towards refugees, asylum seekers and migrants; working with translators and recruit for diverse profiles amongst them).



See [relevant resources](#) on the MHPSS MSP web platform.



Key consideration 18: Implementing MHPSS activities remotely

MHPSS activities may need to be implemented remotely in some contexts, such as in certain public health emergencies (e.g. COVID-19), and in areas where access is restricted due to security threats and geographical barriers (e.g. very remote locations, flooding).

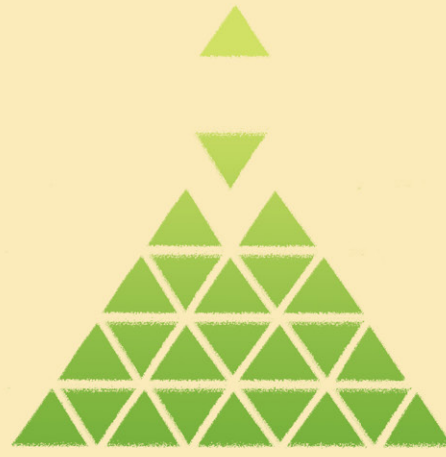
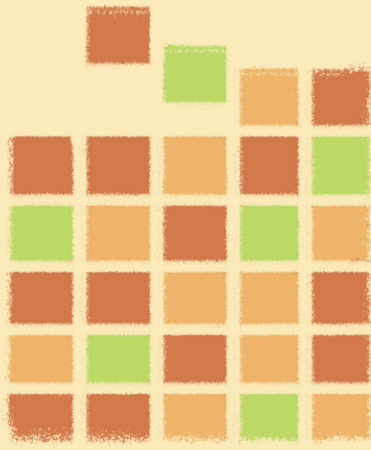
The specific service adaptations needed (e.g. timing, models of remote implementation, and criteria for providing services remotely) will **vary between programmes and contexts and workers must be trained and supervised in the use of new and adapted modalities**. Remote services may be delivered by phone or accessed online using smartphones, tablets, or computers (e.g. via apps and chatbots), and outreach and key messaging may be conducted through radio, social media and megaphone messaging. MHPSS services may also be delivered following a hybrid model, combining in-person and remote engagement (e.g. starting with in-person service delivery, with subsequent follow-up and management over the phone).

Adaptations and considerations for at-risk groups may be needed to increase their access when normal access to MHPSS services is restricted. For example, priority access to in-person services may be given to certain at-risk groups, such as survivors of GBV, persons with diverse SOGIESC, individuals with suicidality or risk of self-harm or of harming others and those with severe mental health conditions.

While remote service delivery brings some unique challenges (e.g. apprehension among community members about unfamiliar modalities of service delivery; challenges in accessing communication technology and high-speed internet; costs of establishing secure digital platforms), it can also **facilitate access for individuals who might otherwise be excluded** or have difficulty in seeking in-person services (e.g. people with impaired mobility, people who cannot afford transportation to services, women who are not at liberty to travel in public without being accompanied by men). During public health emergencies, remote services can ensure continuity of care and support for individuals in quarantine.



See [relevant resources](#) on the MHPSS MSP web platform.



2.2 Develop and implement a monitoring and evaluation (M&E) system

An M&E framework for MHPSS programming should be **developed as part of the initial programme design**.

Where MHPSS is being incorporated into existing programme activities, M&E plans and frameworks should be **updated to include MHPSS components**.

The **IASC Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings**³³ provides broad guidance and suggests appropriate means of verification (MoV) for collecting data on relevant indicators. The **MSP M&E Indicator Guide** provides example indicators for monitoring and evaluating each MSP activity. The following domains of mental health and psychosocial wellbeing may be measured to assess progress toward achieving the overall goal of reduced suffering and improved mental health and psychosocial well-being:

- ▶ functioning;
- ▶ subjective well-being;
- ▶ social behaviour;
- ▶ social connectedness;
- ▶ ability of people with mental health and psychosocial problems to cope with problems;
- ▶ disabling distress and/or presence of MNS disorder (or symptoms thereof).

ACTIVITY

Develop and implement a monitoring and evaluation (M&E) system

Core actions

- ✓ Select appropriate **indicators and measurement tools** (known as means of verification or MoV) that align with the objectives of each activity.³⁴

33 IASC (2021). [Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings: Version 2.0 with Means of Verification](#). See also the associated MoV toolkit on [MHPSS.net](#). The IASC MHPSS Reference Group hosts an MHPSS M&E help desk to support use of the Common M&E Framework for MHPSS ([contact: mhpssmande@gmail.com](mailto:mhpssmande@gmail.com)).

34 In some circumstances it may be necessary to begin delivering urgent services before M&E tools and systems are fully established.

- ✓ **Develop/select** → **adapt and translate M&E tools** to assess programme **reach** and **changes**³⁵ in **knowledge, skills, attitudes, mental health and psychosocial well-being over the course of an activity**. Tools must be appropriate to the age, gender and capacities of participants, considering disability and other forms of diversity. Data collection must allow for disaggregation by age, gender and disability.
- ✓ Analyse the potential for **unintended harm**³⁶ that may be caused by data collection processes and actively prevent or mitigate these risks e.g. by training enumerators and M&E staff in basic psychosocial support skills (*see MSP activity* → 3.2); ensuring that particularly sensitive data are collected by appropriately trained workers; and informing participants that providing information (e.g. in focus groups, interviews or surveys) is voluntary and can be stopped at any time without affecting their access to services.
- ✓ **Share anonymized data** on relevant key indicators with MHPSS TWGs (*see MSP activity* → 1.1) and inter-agency information management teams as needed (e.g. information management systems led by clusters, AoRs or the Office for the Coordination of Humanitarian Affairs (OCHA); see also the related additional actions below).
- ✓ Work with a representative cross-section of community members to develop a **feedback and complaints mechanism** that is accessible and sensitive to cultural, gender, disability, diversity, and age considerations (including ease of use by children and older adults). Distribute information widely on how to use this mechanism and ensure that programme participants and other community members understand it and know how to use it.
- ✓ Engage **representative programme participants and workers** in ongoing programme M&E to identify changing needs, assess MHPSS outcomes and assess service user satisfaction.
- ✓ Conduct regular **participatory programme reviews** of M&E data to generate lessons learned and inform ongoing programme improvements.
- ✓ Discuss the **findings of assessments and evaluations** with community representatives (e.g. programme participants, government officials and relevant coordination groups) to better understand programme impacts and inform ongoing programme improvements (e.g. to explore any unintended positive and negative impacts, identify whether any groups may have been missed, learn how to improve reach etc.). Information must be shared in a conflict-sensitive manner, consistent with local information-sharing protocols. Data that could cause harm or compromise impartiality should not be shared (e.g. in contexts of conflict or civil unrest).

Note: Organizations that do not deliver direct MHPSS services (e.g. those delivering orientations on basic psychosocial support; *see MSP activity* → 3.2) should measure relevant outcomes (i.e. changes in knowledge/competency) but may not need to implement all the actions in the M&E checklist.

Additional actions for consideration (depending on context and available resources)

- ✓ **Share comprehensive information on the impact of programmes, lessons learned, programme indicators and MoVs** at MHPSS TWG meetings and through reports to improve learning and accountability within the response as a whole. Advocate for the use of common data collection tools and templates to facilitate easy data aggregation across different systems.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

Key consideration 19: Design secure systems for information management



It is essential to develop secure systems, protocols, and tools for the safe documentation and management of personal data. Access to personal information must be strictly controlled in accordance with national data protection laws and organizational policies, and granted only to those for whom the information is absolutely necessary to perform their work. *See the* [relevant guidelines, standards and tools on the MHPSS MSP web platform](#) for guidance on information sharing, data processing and the development of data protection protocols.

³⁵ Indicators to measure reach are often known as 'output indicators'. Indicators to measure change are often known as outcome or impact indicators. See the MSP M&E Indicator Guide for detailed guidance.

³⁶ Harmful outcomes could include increasing distress by pressuring children or adults to discuss a difficult experience, increasing stigma by using harmful language, data collectors disclosing sensitive information to others or changing power balances within a family or a community by selecting some individuals and families to participate over others.



2.3 Care for staff and volunteers providing MHPSS

Humanitarian work often involves exposure to distressing events, widespread suffering, long working hours, overwhelming workloads and security threats.

Local staff and volunteers may themselves be survivors of the crisis and often live and work in the affected communities. They often have to juggle family and community responsibilities with heavy work-related demands. If they are perceived to be working with stigmatized groups or parties to a conflict, they are sometimes subject to hostility and accusations from fellow community members.

International staff can also face unique stressors such as being far from their support networks, living in compounds with restricted freedom, and administrative and logistical challenges associated with working in a new country.

In infectious disease outbreaks, frontline workers are sometimes stigmatized due to a perceived risk of contagion.

Humanitarian organizations have a **duty of care** to protect the mental health, psychosocial well-being and safety of international and national workers, including paid staff, incentive-workers, and volunteers. Interventions to protect and promote mental health and psychosocial well-being may be implemented **before, during and after assignments**, and can involve actions at individual, team, managerial and organization-wide levels. The support offered should be culturally appropriate and consistent with global MHPSS best practice guidelines.³⁷

³⁷ The MSP outlines activities and actions that are needed to implement MSP MHPSS activities safely and effectively. This section therefore focuses on the well-being of staff implementing MHPSS activities. Nonetheless, organizations should provide for the well-being of all staff, regardless of what type of programme they are involved in, and this checklist may be used as a guide for staff well-being systems more broadly.

ACTIVITY

Care for staff and volunteers providing MHPSS

Core actions

- ✓ Establish policies and concrete **organizational mechanisms** to protect and promote the mental health and psychological well-being of workers delivering MHPSS programmes.
- ✓ Cite potential work-related stressors in **recruitment** postings and discuss these with candidates during the recruitment process to assess their suitability for the post.
- ✓ Provide workers with information on the support services available during **onboarding induction**, including MHPSS services (e.g. peer-to-peer support systems, self-care resources) and how to access support.
- ✓ Define **working hours**, monitor **overtime** and provide for **rest and recuperation** for both national and international workers (e.g. by ensuring that staff have sufficient paid time off and promoting an expectation that workers will take sufficient breaks during the working day).
- ✓ **Assess work for potential stressors and risks to mental health**, including any specific requirements of workers with disabilities. Take action to address, mitigate or eliminate these risks. Monitor workforce wellbeing and evaluate progress at regular intervals, and in response to relevant changes in circumstances (e.g. increased insecurity); and ensure that data on workforce well-being are collected, stored and reported confidentially.
- ✓ Train MHPSS workers (including frontline workers, managers and support staff) on **self-care and basic psychosocial support skills** to help them to look after their own mental health and psychosocial well-being and to interact with each other in a supportive way (see [MSP activity ↗ 3.2](#)).
- ✓ **Train** all managers, team leaders and supervisors of MHPSS workers on their roles in monitoring and mitigating **work-related stressors**, and on how to respond to workers who are experiencing distress or have experienced or witnessed extremely distressing events (i.e. by using basic psychosocial support skills, guiding the staff member through reporting protocols and connecting them with available supports) (see [MSP activity ↗ 2.1](#)).
- ✓ Develop an explicit **HR protocol** for reporting on and responding to **highly adverse/distressing events** (e.g. client suicide, sexual harassment, assaults, other security incidents), which should include offering basic psychosocial support immediately after the event (see [MSP activity ↗ 3.2](#)).³⁸
- ✓ Provide a **forum for workers** to ask questions, express concerns about risks to themselves and their colleagues, and share ideas for improvement.
- ✓ Prevent and mitigate the effects of stress, including by providing easy, equitable and affordable access to **culturally appropriate emotional support** for all workers.³⁹
- ✓ Where external providers are contracted to provide workforce support, ensure that their **services** are evidence-based, of high quality and consistent with global guidance.

³⁸ Do not offer psychological debriefing to staff who have experienced a distressing event (see [key consideration ↗ 3.2](#)).

³⁹ Support services may be in-house or provided by external contracted organizations. This coverage is sometimes extended to family members of workers.

Additional actions for consideration (depending on context and available resources)

- ✓ Make support available **before, during and after assignments and contracts** (e.g. voluntary consultations with a therapist/psychologist; resources listing available professional and peer-support options).
- ✓ Arrange for a mental health professional to contact **workers who have survived an extremely distressing event** between one and three months after the event to assess how they are functioning and feeling, and to offer referrals for those in need of further support or treatment.
- ✓ Hold workforce mental health and psychosocial well-being **review meetings** annually to review the organization's workforce care experience and to ensure that national and international staff are offered similar support (ensuring that support is adapted to cultural considerations).
- ✓ Conduct **awareness-raising, stigma-reduction** and other initiatives to promote workforce mental health and well-being and to cultivate a culture of mental health promotion among workers and managers.
- ✓ Provide for **evacuations** and **time away from work** on the basis of mental as well as physical illness.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.



Key consideration 20: Staff responsible for providing MHPSS to people affected by humanitarian emergencies should not also be responsible for workforce well-being

Workforce mental health and well-being are the **responsibility of management, HR departments and occupational health** departments (where they exist). MHPSS workers employed to provide support to populations affected by humanitarian crises, should not be tasked with also providing support to their own colleagues. However, because of their knowledge and skills, MHPSS staff often receive requests for support from colleagues and requests to advise on workforce well-being initiatives.



If MHPSS staff who are supporting programs for affected populations are asked to also provide mental health services or support to colleagues, problems can arise. Such a dual role can be ethically problematic and can put staff in a difficult position, potentially exposing them to conflicts of interest and making it difficult to maintain **professional boundaries**. This can also be an inappropriate use of staff time and donor funds if their roles are intended to benefit affected community members through programme activities.

Organizations should therefore **clearly delineate the roles** of MHPSS workers engaged to deliver programming to affected populations and staff members responsible for workforce well-being (e.g. staff counsellors, HR teams).

While all MHPSS workers may have useful insights to share on workforce well-being strategies, the suitability of support services and organizational plans, it is crucial that this remains primarily the responsibility of management and HR departments.



2.4 Support MHPSS competencies of staff and volunteers

MHPSS workers should be adequately **trained, supervised and supported** based on the requirements of the activity or activities that they are involved in.

Observing, assessing and supporting the development of competencies (knowledge, skills and attitudes) helps to **ensure high-quality programmes**. Assessing and monitoring competencies can also help in tailoring training, support and supervision.

Continued supervision can support staff members and volunteers in their **roles**, create a **safe place** to discuss challenges, support continuous **competency development**, ensure that **ethical considerations** are addressed and reinforce **staff self-care**.

EQUIP: 
Ensuring Quality in
Psychological Support

The [EQUIP platform](#) and tools support teams and organizations to plan, design, adapt and implement existing and new competency-based MHPSS trainings for various sectors (e.g. child protection, education, health, etc.).

ACTIVITY

Support MHPSS competencies of staff and volunteers

Core actions

- ✓ Establish the competencies needed to effectively provide each activity⁴⁰ (see [MSP programme activities in Sections 3 and 4](#), and the recommended training topics for specific programmatic activities on the MHPSS MSP web platform).
- ✓ Assess the **training needs** of staff and volunteers to inform and [⇒ adapt training and supervision](#) (see [MSP activity ⇒ 1.2](#)).
- ✓ Equip workers with responsibility for oversight, training and supervision with the necessary skills and knowledge to provide effective **competency-based supervision and training**.
- ✓ Establish a **schedule and structure** for providing regular monitoring, support and supervision to MHPSS workers (e.g. weekly team meetings, monthly supervision meetings, remotely or in-person).
- ✓ Establish clear **lines of responsibility and communication** between persons responsible for training, supervision and/or management.
- ✓ Identify **confidential spaces** and/or **confidential means** of communication for regular support and supervision.

Additional actions for consideration (depending on context and available resources)

- ✓ Conduct regular **competency assessments** of workers to inform additional training and supervision.
- ✓ Institute or facilitate access to **ongoing training programmes** to continue building competencies of workers in their technical areas of work and to contribute to professional development.
- ✓ **Establish benchmarks** for minimum safe and effective levels of key competencies of workers, relevant to the sector, complexity and context of service provision.
- ✓ **Strengthen supervision** structures by engaging experienced senior supervisors to provide supervision, mentorship and training to programme-level supervisors.
- ✓ Ensure that different persons are tasked with **management and supervision/mentorship responsibilities**.
- ✓ Assess and support the **competencies of supervisors**.
- ✓ Assess and support the **competencies of trainers**.

Guidelines, standards and tools



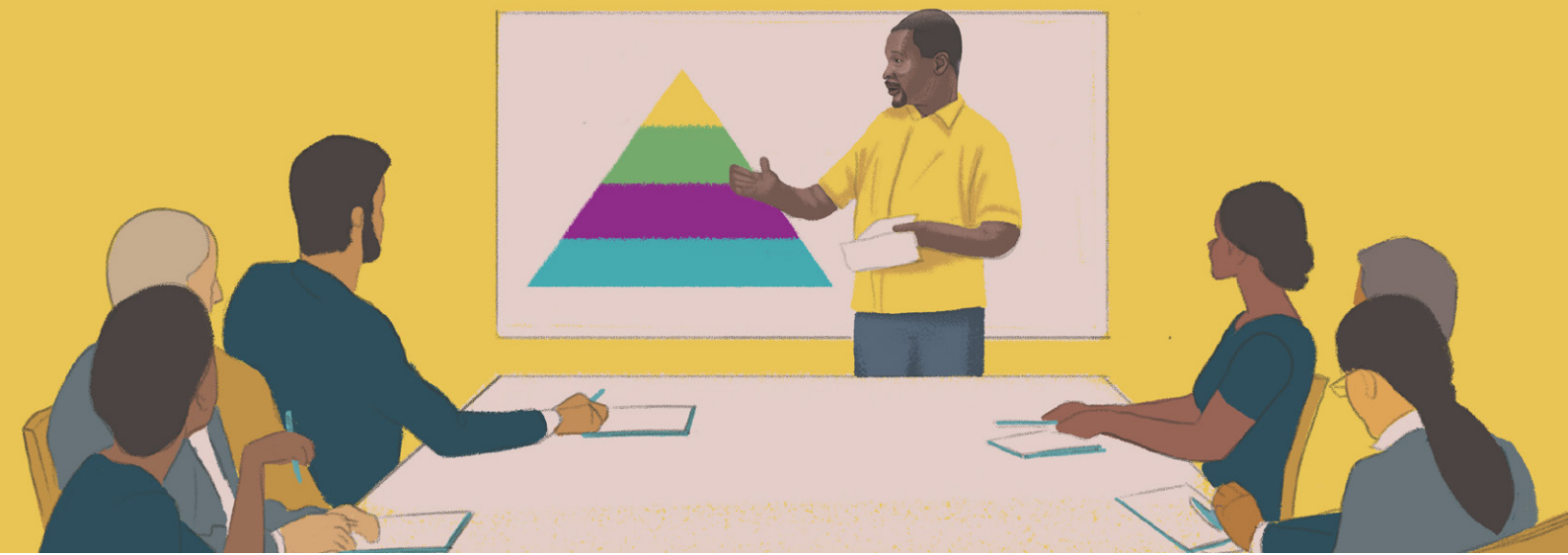
[Click here](#) to access relevant guidelines, standards and tools.

⁴⁰ Seek alignment with any relevant competency frameworks developed by national licencing bodies and national professional associations, as appropriate.

SECTION 3



MHPSS PROGRAMME ACTIVITIES



Orient humanitarian actors and community members on MHPSS

3.1 Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions

MHPSS orientation and advocacy can **influence different humanitarian actors** to take MHPSS considerations into account, thereby promoting and protecting mental health and psychosocial well-being.

This includes delivering aid in a compassionate manner that **promotes dignity, autonomy, safety, self-efficacy and social support** while minimizing psychological distress.

Humanitarian actors and community members should be informed about the importance of **integrating MHPSS** into the **emergency response activities of different sectors**, along with expected outcomes and relevant considerations (*see also* ⇒ [“Who should implement MSP activities?”](#)).

MHPSS orientations and advocacy can help decision-makers to **recognize the value of MHPSS** and can lead to increased resources, including funding allocations.

 Carefully **planning and coordinating** orientation and advocacy efforts can help to ensure consistent messaging and can amplify effectiveness (*see MSP activity* ⇒ [1.1](#)).

ACTIVITY

Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions



Core actions

- ✓ Develop a **plan for orientation and advocacy** workshops and discussions on MHPSS for targeted participants (e.g. humanitarian responders and decision-makers; government actors; service providers across sectors; community committees in different sectors; community leaders; CBOs/CSOs, including women-led organizations and organizations for persons with disabilities, youth advocates and caregivers, etc.).
- ✓ Develop **messages to be delivered** (e.g. on available MHPSS services and supports and on the role of different actors and sectors in supporting and promoting mental health and psychosocial well-being; [see MSP activity ↗ 3.3](#)).
- ✓ **Organize and develop informational materials** appropriate to the context and the affected populations, considering literacy; culture; access to technology (e.g. discussion sessions, radio broadcasts, videos, posters, information leaflets, PowerPoint presentations, handouts); diversity and the inclusion of persons of different ages and genders, persons with disabilities and other diverse characteristics, and sub-groups with specific needs (e.g. hard-to-reach populations).
- ✓ **Conduct orientations and meetings** in appropriate, safe and accessible spaces.
- ✓ **Follow up** to provide additional information as needed and support humanitarian actors and community members in integrating MHPSS activities and considerations.
- ✓ **Engage staff with MHPSS technical expertise** and **coordinate with MHPSS TWGs** throughout to select advocacy target groups/actors, develop key messages to be delivered, organize meetings, and disseminate messages.

Additional actions for consideration (depending on context and available resources)

- ✓ Organize **larger meetings or workshops** that bring multiple stakeholders together and mobilize longer-term efforts and resources for MHPSS services and activities (e.g. government actors from different ministries, donors).
- ✓ Work with local and national partners (e.g. government actors, CBOs/CSOs such as service user organizations, organizations for persons with disabilities) to **build capacity** (e.g. through orientations and seminars) for conducting MHPSS advocacy activities.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.



3.2 Orient frontline workers and community leaders in basic psychosocial support skills

Frontline humanitarian staff, volunteers and key community members should be equipped with **basic psychosocial support skills** to support people in distress. It is recommended that frontline workers from all sectors and trusted community members deliver this form of support as part of their duties as they meet people in acute distress or with acute needs.

This form of support is not a psychological intervention but rather a **basic, humane and supportive response** to suffering and an entry point to further support and **referral**. Additional interventions will be required to address impairment due to psychological distress or mental health conditions (*see MSP activities* [↔ 3.10](#), [↔ 3.11](#) and [↔ 3.12](#)).

Basic psychosocial support skills involve **listening** carefully, **assessing basic needs**, promoting **social support**, **protecting** people from further harm and **connecting** them with relevant services and resources.

This support should be provided in relevant settings (e.g. health clinics, protection services, the general community) for **different segments of the population**, and should be one part of a **larger MHPSS response** across **multiple sectors** implemented alongside comprehensive MHPSS services and activities.



Organizations should **coordinate and collaborate** to organize orientations in basic psychosocial support skills.

ACTIVITY

Orient frontline workers and community leaders in basic psychosocial support skills



Core actions

- ✓ Identify **relevant settings and target groups**, including frontline workers in the humanitarian response and key community leaders, to whom people may turn for support (e.g. frontline workers working at points of entry and reception facilities; guards; health workers; ambulance drivers; nutrition and food distribution workers; WASH workers; camp management and shelter workers; teachers; youth and women's leaders; religious leaders; community leaders; translators/cultural mediators and local authorities) in coordination with relevant actors/sectors.

- ✓ Develop/select, ⇒ [adapt](#) and translate **orientation materials** on basic psychosocial support skills for selected target groups (e.g. psychological first aid (PFA), PFA for children, LIVES for GBV responders, GBV Pocket Guide for supporting survivors of GBV when a GBV actor is not available; [see key consideration ↻ 21](#) and [key consideration ↻ 16](#)).
- ✓ Develop a **list of available services and supports** to provide to staff and volunteers oriented in basic psychosocial support.
- ✓ **Implement orientations** on basic psychosocial support skills, supported by staff with MHPSS technical expertise.

Additional actions for consideration (depending on context and available resources)

- ✓ Deliver **refresher orientations and follow-up** sessions to provide frontline staff and volunteers with an opportunity to improve their skills and provide coaching.
- ✓ Build the capacity of **local organizations and agencies** to orient their own staff on basic psychosocial support.
- ✓ Provide basic psychosocial support via **hotlines** (e.g. suicide prevention, GBV support) operated by well-trained and supervised staff.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

Key consideration 21: Guidance on psychosocial support skills for specific groups or types of emergency

“Basic psychosocial support skills” are also sometimes referred to as “basic psychosocial competencies”, “basic helping skills”, “foundational helping skills” or “core clinical skills”. The actions in [MSP activity ↻ 3.2](#) relate to the training of frontline workers and community leaders on basic psychosocial support skills, regardless of sector or setting. Several relevant models and training packages have been developed to build these skills, with some focusing on specific humanitarian contexts and target populations:



- ▶ **Psychological first aid:** e.g. [World Health Organization, War Trauma Foundation and World Vision International \(2011\)](#). [Psychological First Aid Guide for Field Workers](#), [Facilitator’s Manual for orienting field workers](#). This covers general PFA principles that are generally applicable for people in acute distress after exposure to a crisis event in different settings and populations.
- ▶ **Psychological first aid specifically for children:** e.g. [Save the Children \(2013\)](#). [PFA Training Manual for Child Practitioners](#), and [2017 online PFA for Children course](#). These resources have more detailed information for supporting children in acute distress after exposure to a crisis event.
- ▶ **GBV responders:** e.g. [WHO \(2014\)](#). [Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook](#). This resource provides health care providers with information about first-line support for survivors of intimate partner violence and sexual violence according to the principles of LIVES (Listen, Inquire about needs and concerns, Validate, Enhance safety, and Support). [GBV AoR \(2018\)](#) [GBV Pocket Guide-How to support survivor of gender based violence when a GBV actor is not available in your area](#), provides additional guidance for non-GBV responders on supporting survivors of GBV.
- ▶ **Psychosocial support skills in infectious disease outbreaks:** e.g. [WHO, CBM Global, World Vision International, UNICEF \(2014\)](#) [Psychological First Aid during Ebola Virus Disease Outbreaks](#) and [IASC \(2020\)](#) [Basic Psychosocial Skills – A Guide for COVID-19 Responders](#). The Guide for COVID-19 responders can also be adapted to other healthcare settings where people may experience increased distress.⁴¹

See the relevant [Guidelines, Standards and Tools](#) for a more comprehensive list of materials, as well as the [recommended training topics on basic psychosocial support skills for frontline workers and community leaders, available on the MHPSS MSP web platform](#).

41 For a brief description of basic psychosocial skills (“core clinical skill”) in the context of COVID see WHO (2021). [COVID-19 Clinical management: living guidance](#), Chapter 17: Management of neurological and mental manifestations associated with COVID-19.

Key consideration 22: Training for protection actors with specific roles



In addition to basic psychosocial support skills (see *MSP activity* → 3.2), some protection actors may require more specific training and knowledge in MHPSS. See the [recommended MHPSS training topics for protection caseworkers](#), available on the MHPSS MSP web platform.

Some areas of protection may require more in-depth training. For example, workers interviewing survivors of torture and violence, monitoring and documenting protection and human rights violations, and conducting in-depth work with at-risk populations may require a deeper understanding of the effects of exposure to distressing events on memory and other aspects of cognitive function.

Key consideration 23: Providing basic psychosocial support in health care settings



Persons who experience **serious physical health conditions** or **injuries** in the context of humanitarian crises are likely to experience distress and are at higher risk of developing mental health conditions.



This includes persons and their families who may have **life-threatening** injuries or conditions (e.g. persons in acute care); people who have suffered **injuries** resulting in permanent **disabilities or impairments** (e.g. survivors of EO, people injured in conflict and disaster settings); and people in need of **palliative care** (see *MSP activity* → 4.1).



Many **sexual and reproductive health** issues can lead to severe distress, including early and unwanted pregnancy; prolonged and complicated delivery; infant loss; miscarriage; abortion; infertility; diagnosis of STIs (e.g. HIV, syphilis, gonorrhoea, etc.); obstetric fistula and intimate partner violence (IPV) or sexual violence (see *MSP activity* → 3.11; and *WHO's statement on providing person-centred and compassionate care and respectful maternity care*⁴²).



Orienting **health care providers** (e.g. physicians, nurses, midwives, medical assistants, staff providing sexual and reproductive health (SRH) services, emergency care or palliative/end-of-life care) who work in relevant **settings** (e.g. hospitals, SRH services, rehabilitation facilities) in basic psychosocial support can have a **significant impact** on the well-being of persons in their care and their family members. The **selection of workers** and **volunteers** to orient will depend on the **emergency context** (e.g. specific needs, populations at risk, available time and resources).



Community health workers and volunteers can play an important role in providing **basic psychosocial support** as part of health-related **awareness-raising** and **education activities** (e.g. when helping to promote inclusion and address stigmatization towards people living with HIV/AIDS, obstetric fistula or infectious diseases; when providing SRH education to specific groups such as adolescents; when following up with persons and families who have experienced serious health-related conditions or the loss of family members).

42 In September 2014, WHO released a statement on the prevention and elimination of disrespect and abuse during childbirth. Globally, many women experience disrespectful, abusive or neglectful treatment during childbirth in health care facilities. These practices can violate women's rights, deter them from seeking and using maternal health care services and can have implications for their health and well-being. WHO (2014). [Prevention and elimination of disrespect and abuse during childbirth](#).



Strengthen self-help and provide support to communities

3.3 Disseminate key messages to promote mental health and psychosocial well-being

In emergency settings, most people experience **psychological distress** (e.g. sadness, fear, anger).

Most affected individuals will gradually start to feel better, especially if they use helpful ways of **coping** with stress and receive **support** from their families and communities.

Disseminating key messages can encourage positive coping, help-seeking and support for people experiencing distress.

Key messages may be **newly developed** for the specific emergency and context or may be **adapted** from a pool of existing key messages.

Key messaging should be simple, focused and concrete and should help people to understand **normal** and **common** stress reactions, communicate an expectancy of **resilience**, emphasize culturally and age-appropriate **coping mechanisms**, discourage harmful ways of coping (e.g. heavy alcohol use) and include information on how and where to access **MHPSS services and support**.

ACTIVITY

Disseminate key messages to promote mental health and psychosocial well-being



Core actions

- ✓ **Review relevant information** (e.g. existing key messages for specific groups on relevant topics) and **messaging** efforts already in place (e.g. by other humanitarian actors) to aid planning and coordination (e.g. through MHPSS TWGs).⁴³
- ✓ **Collaboratively develop/identify, ⇒ adapt and translate** culturally relevant key messages with targeted groups (e.g. through participatory discussions with community members of different ages and genders, people with disabilities and other diverse characteristics, and other relevant stakeholders such as persons working in health, protection or education settings, government actors, faith-based actors, and persons with lived experience of mental health conditions; *see also actions on community engagement in MSP activity ⇒ 2.1*).⁴⁴
- ✓ Get **community feedback** on communication materials and messages before and after dissemination, and check accuracy and appropriateness of translations.
- ✓ **Disseminate key messages** together with community members and other humanitarian actors using media appropriate to the context, considering culture, literacy, accessibility and access to technology (e.g. discussion sessions, posters, information leaflets, radio messaging, social media campaigns, videos, community theatre, comic strips, digital tools such as chatbots).⁴⁵
- ✓ Engage **staff with MHPSS technical expertise** to provide technical oversight of the development and dissemination of MHPSS messages.

Additional actions for consideration (depending on context and available resources)

- ✓ Develop and disseminate **additional key messages that are tailored for specific subgroups** as appropriate (e.g. men, women, older persons, adolescents, caregivers, caregivers of children with disabilities, persons with disabilities, GBV survivors, LGBTQ+ persons, migrants and refugees with different languages and backgrounds, etc.).
- ✓ Develop **larger participatory campaigns** in multiple accessible formats to promote the mental health and psychosocial well-being of persons with mental health conditions, to promote and protect their rights (e.g. inclusion and access to services and opportunities) and to highlight their capacities.
- ✓ **Monitor and evaluate** use, impact and perceptions of communication materials and messages.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

43 Collaboration with social and behavioural change (SBC) specialists can improve the effectiveness of messaging campaigns and other MHPSS activities. SBC involves using social science and evidence to understand and address the cognitive, social and structural factors that shape behaviour and social norms. Using different approaches, such as communication, social mobilization and community engagement, SBC teams collaborate with community members to understand attitudes, beliefs and behaviours and to promote positive change, collect feedback, address rumours, and co-design solutions, while reinforcing communities' empowerment and ownership. For example, online and offline 'social listening'/feedback exercises are conducted to identify concerns, information gaps, existing sources of support, and coping mechanisms. SBCC is sometimes known as Communication for Development (C4D), Communicating With Communities (CWC), and Community Engagement & Accountability.

44 For source materials for key messages, *see the relevant guidelines, standards and tools associated with this activity available on the MHPSS MSP web platform.*

45 For examples of digital tools, *see the relevant section of the relevant guidelines, standards and tools associated with this activity available on the MHPSS MSP web platform.*



3.4 Support new and pre-existing group-based community MHPSS activities

Community members are usually the first people to respond to an emergency, and they have the greatest **knowledge** of local resources, coping strategies, culture and geography. **Community-led activities** are likely to be relevant and sustainable and can reduce dependency on external support. They usually take the form of group activities.

Humanitarian actors can support **pre-existing community initiatives** that promote mental health and psychosocial well-being (e.g. re-establishing cultural and religious activities, support groups, youth networks and other groups based on shared interests, problems, traditions or activities) and can partner with these initiatives to strengthen their capacity to respond to MHPSS needs (e.g. providing safe spaces in which to convene, capacity-building in MHPSS and/or group facilitation skills, facilitating the inclusion of persons with disabilities).

Humanitarian actors can also **facilitate new group-based community MHPSS initiatives** (e.g. discussion and support groups, self-help initiatives, appropriate communal healing practices, arts-based activities).

Engaging together in response activities can help community members to restore feelings of **agency** and **hopefulness**, strengthen **social connections** and provide a sense of collective **identity and belonging**, factors that promote well-being and recovery.



Community members of different ages, genders, and other diverse characteristics, including those with disabilities, should be supported to participate in community-led activities to capitalize on their different skills, ideas and experiences. These activities provide an opportunity to proactively **include and support at-risk groups**, such as people with mental health conditions, migrants, refugees, IDPs and persons with disabilities. (see ⇒ [Overview, “How can groups and persons at increased risk be prioritized and reached with MHPSS MSP activities and services?”](#) and [Resources on MHPSS for at-risk groups on the MHPSS MSP web platform](#)).

ACTIVITY

Support new and pre-existing group-based community MHPSS activities



Core actions

- ✓ Identify **pre-existing community-led initiatives**, structures and support mechanisms (e.g. support groups, faith communities and other groups based on shared interests, problems, traditions or activities) and assess the support needed to preserve or expand activities (*see MSP activity ↗ 1.2*).
- ✓ Promote and support **new group-based community MHPSS activities** to strengthen coping resources and social supports (e.g. peer support networks; groups focused on specific issues of concern; support groups for older adults, for persons with disabilities and for their carers).
- ✓ Provide **technical, financial or in-kind support** for pre-existing and/or new community activities that promote mental health and psychosocial well-being (e.g. support the repair/replacement of damaged equipment; facilitate participatory discussions and activities; provide self-help resources and information; provide short participatory trainings on MHPSS, group facilitation and/or promoting social cohesion).
- ✓ Support social, recreational and cultural **activities**.
- ✓ Facilitate access to a **safe, appropriate space** (e.g. for older adults, persons with disabilities, persons with diverse SOGIESC) in which to conduct activities if needed.
- ✓ Support adults and children to access information and connect with family members and other social supports, (e.g. through **information technology, phones and phone-charging** services, as appropriate to context, culture, literacy, and access to technology).
- ✓ Facilitate **links and referrals** to any needed services and supports (e.g. mental health services, health, protection and education services, food security and livelihoods support).
- ✓ Engage **staff with MHPSS technical expertise** to provide technical oversight as needed (e.g. ensuring that activities promote well-being and do not cause harm).

Additional actions for consideration (depending on context and available resources)

- ✓ Provide additional **technical, financial or in-kind support** for the longer-term maintenance and/or expansion of community-led support mechanisms (e.g. longer-term CBOs or less formal groups).

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.




3.5 Provide early childhood development (ECD) activities to support young children and their caregivers⁴⁶

Caregivers⁴⁷ have a substantial impact on children’s physical, cognitive, emotional and social development through their **caregiving practices**, particularly during the first three years of life.

Children who do not receive **responsive care**⁴⁸ or adequate opportunities for **early learning**⁴⁹ tend to have poorer physical, social, emotional and cognitive development, with potential long-term effects on mental health, behaviour and overall functioning, including effects on school performance and employment.

The **consequences of humanitarian emergencies**, such as food insecurity, poverty, violence, limited access to services and **poor mental health**, can significantly reduce caregivers’ abilities to support children’s development.

Supporting **caregivers’ mental health and well-being**, as well as their ability to provide responsive care and early learning opportunities for the children in their care, can have positive impacts on child development.

 ECD activities can also strengthen **social support networks** and provide non-stigmatizing ways of prioritizing, including, and supporting **at-risk caregivers and children** (e.g. children with developmental disabilities or mental health conditions, caregivers and children with protection vulnerabilities; [see ⇨ Overview, “How can groups and persons at increased risk be prioritized and reached with MHPSS MSP activities and services”](#) and [↗ Resources on MHPSS for at-risk groups on the MHPSS MSP web platform](#)).

46 Early childhood development (ECD) is the process of cognitive, physical, language, temperament, social and emotional, and motor development experienced by young children from the time of conception until the age of eight. WHO (2020). [Improving Early Childhood Development: WHO Guideline](#).

47 The term “caregivers” refers to those with parental responsibilities, regardless of whether or not they are the biological or legal parents of the children in their care.

48 “Responsive caregiving” refers to care that is prompt, consistent, and appropriate to the child’s cues, behaviours, and needs for safety, education and development. WHO (2020). [Improving Early Childhood Development: WHO Guideline](#).

49 This refers to any opportunity for a baby, toddler or child to interact with a person, place or object in their environment, recognizing that every interaction (positive or negative, or absence of an interaction) is contributing to the child’s brain development and laying a foundation for later learning. WHO (2020). [Improving Early Childhood Development: WHO Guideline](#).

ACTIVITY

Provide early childhood development activities to support young children and their caregivers



Core actions

- ✓ **Identify opportunities** for integrated ECD activities (e.g. in nutrition, health, education, child protection programmes).
- ✓ Engage with caregivers and community leaders to **assess capacities, needs, and issues** that may need to be addressed through ECD activities (e.g. building on positive social norms and practices, tackling harmful practices, identifying and supporting at-risk groups).
- ✓ In consultation with caregivers and other relevant stakeholders, develop/identify, ⇨ **adapt** and translate **orientation, training and programme materials** on ECD (e.g. key messages on early stimulation and responsive caregiving) and on caregiver mental health and psychosocial well-being (*see MSP activity ⇨ 2.1*).
- ✓ **Train and supervise facilitators** and/or **outreach workers** to lead and support ECD activities (e.g. orientations, message dissemination, caregiver capacity-building, new or pre-existing early childhood care supports; *see [the recommended MHPSS training topics for workers supporting new and expectant caregivers and young children on the MHPSS MSP web platform](#)*).
- ✓ **Orient staff** in relevant sectors on **integrating and delivering key ECD messages** as part of their work (e.g. health and social care staff in existing nutrition, health and prenatal care programmes).
- ✓ Support new or pre-existing **early childhood care supports** by facilitating learning through play, creating opportunities for caregivers and young children to interact and play, and promoting informal parent gatherings.
- ✓ **Provide orientations and/or skills training** to caregivers of young children and to those expecting children, including caregivers of children with disabilities and children with specific protection risks (e.g. children with developmental disabilities, children with mental health conditions, children associated with armed forces and armed groups, child survivors of sexual violence or GBV; *see key consideration ⇨ 34*), to improve their knowledge and skills in ECD (e.g. through coaching, demonstration, practice, role-playing).
- ✓ **Disseminate ECD messages using media** appropriate to the context, considering culture, literacy and access to technology (e.g. posters, information leaflets, radio messaging, social media campaigns).
- ✓ Conduct **home visits** to support caregivers with nutrition, mental and physical health, hygiene, parent-child interaction and responsive caregiving. Prioritize caregivers with mental health conditions (such as maternal depression) and caregivers of children with developmental disabilities and with mental health conditions.
- ✓ Ensure access to a **safe and appropriate space** (e.g. baby-friendly spaces) in which to conduct activities if needed.
- ✓ Facilitate **links and referrals** to any needed services and supports (e.g. mental health services, health, protection, nutrition, education and other relevant services for young children and caregivers).
- ✓ **Engage staff with ECD technical expertise** to provide ongoing technical oversight, supervision and support to facilitators and outreach workers.

Additional actions for consideration (depending on context and available resources)

- ✓ **Promote caregiver support networks** by establishing or strengthening social groups, peer-to-peer support groups, play groups and self-help groups (see *MSP activity* → [3.4](#)).
- ✓ Integrate ECD considerations and activities in **dedicated safe spaces** for pregnant and breastfeeding women/adolescents.
- ✓ Provide **structured group MHPSS interventions** for caregivers.
- ✓ Take steps to support the sustained **integration of ECD** activities and considerations into systems of care (e.g. health, social care and education systems).

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.



Key consideration 24: Integrating early childhood development activities into nutrition programmes



In situations of food insecurity, including situations of emergency and famine (IPC 4 and 5), caregivers of young children are themselves likely to be deprived of food, are often distressed, and are thus less able to provide children with positive and emotionally nurturing environments. Children's growth and brain development depend on good nutrition as well as on stimulation and emotional responsiveness from caregivers.

Combined ECD and nutrition programming can have a mutually reinforcing impact on child development, mother-child interaction and caregiver mental health. Together, they can equip caregivers with greater levels of confidence and responsiveness while enhancing their ability to nurse and feed their children. Examples of such programming include:

- ▶ Integrating key ECD messages into infant and young child feeding activities, such as nutritional counselling (e.g. while weighing/assessing children and distributing supplements; see Sphere Management of malnutrition standard 2.2);
- ▶ Organizing regular mother-baby and child group activities (e.g. at outreach therapeutic programme and supplementary feeding programme sites);
- ▶ Setting up baby-friendly spaces (e.g. in tents for feeding, therapeutic feeding centres) that provide a safe space for babies and young children to interact with their caregivers and with each other, while caregivers can learn about ECD by watching others and "learning by doing".



See [relevant resources](#) on the MHPSS MSP web platform.



3.6

Provide group activities for children’s mental health and psychosocial well-being

Play and **positive social interactions** are crucial to a child’s social, emotional, physical and cognitive development.

Emergencies greatly **disrupt** opportunities for these experiences and interrupt routines that afford a sense of security, normality and predictability.

Facilitating regular **recreational and structured group activities**⁵⁰ in safe environments⁵¹ can provide a sense of **routine** and **stability** and provide opportunities for children to **play**, to develop **social and emotional skills** and to foster supportive **social connections**.⁵² Group activities for children are **typically implemented by child protection and education actors** and integrated into wider protection and education programming. The activities often have multiple objectives; for example, they may be primarily designed to improve MHPSS, protection, learning, or a combination of these outcomes. For the purposes of the MHPSS MSP, “group activities for children’s mental health and psychosocial well-being” refers to those activities that have an explicit objective related to improving mental health and psychosocial well-being and that measure associated indicators (whether or not they also have other objectives).



Convening activities for children also provides **respite for caregivers**, who may be struggling to cope with the pressures of the emergency, and creates opportunities to prioritize and facilitate access for **at-risk groups** (e.g. children experiencing protection issues, children with developmental disabilities or mental health conditions; see ⇒ [Overview, “How can groups and persons at increased risk be prioritized and reached with MHPSS MSP activities and services?”](#) and ✎ [Resources on MHPSS for at-risk groups on the MHPSS MSP web platform](#)).

50 Structured group activities for child well-being (sometimes known as “guided” or “manualized” programmes) involve a series of facilitated sessions, planned according to a curriculum with explicit MHPSS goals (see [relevant guidelines, standards and tools](#)).

51 The 2012 version of the Child Protection Minimum Standards in Humanitarian Action (CPMS) included “Standard 17: Child Friendly Spaces”. In the [2019 edition](#), this has been replaced by the broader “Standard 15: Group activities for child well-being”. This reflects the fact that while activities sometimes take place in a fixed space, group activities may also be mobile and be facilitated in varied, rotating accessible locations. Reviews of the evidence on child-friendly spaces have noted that the creation of a safe space alone may have a limited impact, and that the nature and intensity of the activities facilitated, and the relationships established between facilitators and children, appear to be crucial in determining efficacy.

52 Other group activities, such as vocational training programmes and GBV awareness programmes, also affect well-being both directly and indirectly. Similarly, programmes focused on “life skills” can cover diverse issues of relevance to mental health and psychosocial well-being, from critical thinking, communication and coping skills to reproductive health, GBV prevention, and mine risk education. These programmes vary widely in the extent to which they explicitly address mental health and psychosocial issues, have MHPSS-focused objectives, and measure MHPSS outcomes.

ACTIVITY

Provide group activities for children's mental health and psychosocial well-being



Core actions

- ✓ **Develop/select and adapt structured activities and programme content** based on the needs and resources identified in assessments and community priorities **identified through participatory discussions** (see [actions on community engagement in MSP activity](#) [↔ 2.1](#)). Ensure programme content is appropriate to the affected community, considering age, gender, disability, and other forms of diversity.
- ✓ Develop/select, [↔ adapt](#) and translate **training curricula and information, education and communication (IEC) materials** for the selected activities.
- ✓ Incorporate **sessions for caregivers** into structured group activities to share information on how emergencies affect children and on supportive caregiving practices (see [MSP activity](#) [↔ 3.7](#)).
- ✓ **Train facilitators** to deliver the selected structured group activities, including group facilitation skills for children of different ages (see the [recommended MHPSS training topics for facilitators of group activities for child well-being on the MHPSS MSP web platform](#)).
- ✓ Provide **structured group activities** for children and sessions for caregivers.
- ✓ Implement supervised **recreational activities (e.g. free play, sports, creative activities)** designed to improve psychosocial well-being (e.g. through events, workshops, festivals or campaigns).
- ✓ Facilitate access to **safe spaces** for structured group activities and recreation.
- ✓ **Provide information to affected communities and families** on why structured group activities are being offered and how to access them (e.g. the impact of crises on well-being and development; the goals and expected outcomes of the activities being offered).
- ✓ Facilitate **links and referrals** to any needed services and supports for children and caregivers (e.g. mental health services, health, protection and education services).
- ✓ Engage **staff with MHPSS technical expertise** to supervise facilitators and oversee activities.

Additional actions for consideration (depending on context and available resources)

- ✓ **Train teachers, child-care workers, and other community members such as youth leaders** in structured group activity curricula so that programmes can be sustained in the longer term.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.



3.7 Promote caregivers' mental health and psychosocial well-being and strengthen their capacity to support children

Children who grow up in a **safe, loving, responsive and caregiving environment** tend to be more emotionally secure, socially competent and better able to cope with adversity.

Emergencies can severely disrupt **caregivers'**⁵³ **abilities** to provide nurturing care⁵⁴ and undermine their **well-being** by introducing risk factors such as economic insecurity, social upheaval and extreme stress.

Integrated activities can **support caregivers** to look after their own physical and **mental health needs** and promote **positive caregiving skills**.

MHPSS activities for caregivers should build on existing **positive family relationships, roles and traditions**. While women and girls constitute the majority of caregivers, it is also important to consider male caregivers and to acknowledge the roles that siblings and grandparents often play in providing care.



MHPSS activities for caregivers can also be helpful in strengthening **social support networks** and should prioritize access and inclusion of **at-risk caregivers** (see ⇒ [Overview, "How can groups and persons at increased risk be prioritized and reached with MHPSS MSP activities and services?"](#) and ✎ [Resources on MHPSS for at-risk groups on the MHPSS MSP web platform](#)).

⁵³ In this section, "caregivers" refers to those with parental responsibilities, regardless of whether or not they are the biological or legal parents of the children in their care. Particular care should be taken to support caregivers who are themselves children.

⁵⁴ Nurturing care involves responsive, affectionate, emotionally supportive caregiving that protects children against threats, provides opportunities for learning and meets the child's health, security and nutritional needs.

ACTIVITY

Promote caregivers' mental health and psychosocial well-being and strengthen their capacity to support children



Core actions

- ✓ Identify opportunities for **integrated caregiver activities** (e.g. in health, education, child protection or nutrition programmes).
- ✓ Assess the **needs and priorities** of caregivers to inform the development of materials and planning of activities.
- ✓ **Develop/select, → adapt and translate orientation, skills training and IEC materials** on caregiver self-care (e.g. stress management and coping skills), positive caregiving, child development and supporting children in distress, (see [the recommended training topics for building caregiver skills in child development, positive caregiving and supporting children in distress on the MHPSS MSP web platform](#)).
- ✓ **Train facilitators** to provide orientations, capacity-building and supportive follow-up to caregivers (see [the recommended MHPSS training topics for workers providing activities that build MHPSS capacity and support well-being among caregivers and teachers on the MHPSS MSP web platform](#)).
- ✓ Provide **orientations and/or skills training** to caregivers on positive caregiving, child development, supporting children in distress and on self-care. Include caregivers of children with disabilities and children with specific protection vulnerabilities (e.g. children with developmental disabilities, children associated with armed forces and armed groups, child survivors of sexual violence or GBV; see [key considerations 25 and 34](#)).
- ✓ Facilitate access to a **safe space** in which to conduct activities as needed.
- ✓ Engage **staff with MHPSS technical expertise** to oversee activities and provide ongoing supervision to facilitators (e.g. ensuring that activities promote well-being and do not cause harm).
- ✓ Facilitate **referrals** for caregivers and other family members to access any needed services and supports (e.g. social services, mental health services, health, protection and education services).

Additional actions for consideration (depending on context and available resources)

- ✓ **Promote support networks for caregivers** by establishing or strengthening social groups, peer-to-peer support groups, play groups and self-help groups (see [MSP activity 3.4](#)).
- ✓ Provide **structured group MHPSS interventions** to caregivers.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

Key consideration 25: Supporting caregivers when a child has been sexually abused



When a child has been sexually abused, their non-offending caregivers may feel anger, disbelief, worry, guilt, shame, sadness and fear. These emotions can interfere with their ability to provide the child with the support, care, and attention they need.

Non-offending caregivers should be offered emotional support, basic education about sexual abuse, and information on how to support the child in dealing with the emotional, social, and physical consequences of abuse. For information on how to provide this support, see [UNICEF and IRC \(2012\). Caring for Child Survivors of Sexual Abuse Guidelines and Training Package](#).



3.8

Promote the mental health and psychosocial well-being of education personnel and strengthen their capacity to support children

Integrating MHPSS with education can contribute to effective learning and can help protect children from the negative effects of crisis by creating stable **routines**, fostering **hope**, reducing **stress**, encouraging **self-expression** and promoting **collaborative behaviour**.

Teachers should be trained and supported to increase their **mental health literacy** so they can strengthen their own resources and competencies and are better able to support children's mental health and psychosocial well-being. Other education personnel should be empowered to support teachers in their roles.

Teaching can be one of the most stressful occupations and teachers not only influence students' **learning** but also their **social, emotional and cognitive development**. Teachers also play an important role in **supporting at-risk children** (e.g. those with MHPSS needs, developmental disabilities or protection vulnerabilities).

The mental health and psychosocial **well-being of teachers** is particularly important in crises as it affects their teaching and their ability to support the mental health and psychosocial well-being of their students.

ACTIVITY

Promote the mental health and psychosocial well-being of education personnel and strengthen their capacity to support children



Core actions

- ✓ **Assess needs and capacities** to support the mental health and psychosocial well-being of children in learning spaces and the mental health and psychosocial well-being of teachers and other education personnel⁵⁵ (e.g. through consultations with communities, caregivers, teachers and other education personnel and with education authorities such as Ministry of Education officials).
- ✓ Develop/select, ⇒ **adapt** and translate **orientation, training, programme, and IEC materials to support the well-being of teachers** and other education personnel (e.g. check-ins that gauge teachers' emotional well-being and needs for additional support; peer-to-peer networks/support groups; social and emotional learning (SEL)⁵⁶ workshops; orientations on stress management and coping skills), based on needs and priorities identified in assessments and through participatory discussions (*see actions on community engagement in MSP activity ⇒ 2.1*).
- ✓ Develop/select, ⇒ **adapt** and translate **orientations, training programme and IEC materials** to help build the capacity of teachers and other education personnel to **support the mental health and psychosocial well-being of children**, including children with disabilities and children with protection vulnerabilities (e.g. children with developmental disabilities, children associated with armed forces and armed groups, child survivors of sexual violence or GBV; *see key consideration ↻ 34 and the ↻ recommended MHPSS training topics for teachers and other education personnel on the MHPSS MSP web platform*).
- ✓ **Train and supervise facilitators** to support the well-being of teachers and other education personnel and to provide orientations, training, and supportive follow-up on promoting the mental health and psychosocial well-being of children (*see the ↻ recommended MHPSS training topics for workers providing activities that build MHPSS capacity and support well-being among caregivers and teachers on the MHPSS MSP web platform*).
- ✓ Provide **ongoing support** to teachers and other education personnel to promote their own mental health and psychosocial wellbeing, and ongoing capacity building to enhance their abilities to support children (e.g. via in-service training, mentoring, and peer-learning methods).
- ✓ Provide **orientations and/or training** to teachers and other education personnel to promote the **mental health and psychosocial well-being of children**.
- ✓ Provide **orientations to teachers and other education personnel** (e.g. head teachers, principals, school supervisors and other education officials) on the rationale for integrating MHPSS into education in emergencies programming and the role of teachers in crisis contexts.
- ✓ Facilitate access to **safe spaces** in which to conduct activities as needed.
- ✓ Facilitate **referrals** from education settings to any needed services and supports (e.g. MHPSS services, health services, protection services).
- ✓ Engage **staff with MHPSS technical expertise** to provide ongoing supervision to facilitators and oversight of activities.

55 The term "teachers and other education personnel" includes classroom teachers and classroom assistants; early childhood or pre-school teachers; educators of people with disabilities; subject specialists and vocational trainers; facilitators in child-friendly spaces; community volunteers, religious educators and life skills instructors; and head teachers, principals, school supervisors and other education officials. INEE (2010). *INEE Minimum Standards for Education: Preparedness, Response, Recovery*.

56 Social and Emotional Learning (SEL) is the process of acquiring core competencies to recognize and manage emotions, set and achieve goals, appreciate the perspectives of others, establish and maintain positive relationships, make responsible decisions and handle interpersonal situations constructively. The qualities that SEL aims to foster include self-awareness, emotional literacy, cognitive flexibility, improved memory, resilience, persistence, motivation, empathy, social and relationship skills, effective communication, listening skills, self-esteem, self-confidence, respect and self-regulation. SEL is an important component of MHPSS that educators should address continually, especially in crisis contexts, since it contributes to better learning and to children's improved mental health and psychosocial well-being. INEE (2016). *Background Paper on Psychosocial Support and Social & Emotional Learning for Children & Youth*.

Additional actions for consideration (depending on context and available resources)

- ✓ Provide **social and emotional learning** opportunities for **teachers** and other education personnel so they can strengthen their own social and emotional competencies, interact positively with children and serve as role models for them to follow.
- ✓ Provide **social and emotional learning for children** through formal and non-formal school curricula.⁵⁷
- ✓ Take steps to promote the **inclusion of MHPSS elements**, including SEL, in **pre- and in-service training**.
- ✓ Advocate for the **revision of national teacher competency frameworks** to promote the integration of MHPSS elements, including SEL.
- ✓ Create and/or support structures and practices that promote **teacher-parent communication** about children's well-being (e.g. fostering teacher-parent cooperation processes by organizing pre-planned teacher-parent meetings at regular intervals, conducting awareness-raising and skills-building sessions for caregivers and for teachers).
- ✓ Support or reactivate **collective activities around learning spaces** to maximize exchanges and cooperation between education personnel, caregivers and the community (e.g. through parent-teacher associations, mothers' groups, community education committees; by creating opportunities for older community members to impart cultural and traditional knowledge to younger generations; by organizing learning and recreational events facilitated jointly by education personnel, students, caregivers and community groups; *see MSP activity* → 3.4).
- ✓ Build the **capacity of school leaders** to better support their own mental health and psychosocial well-being and that of other education personnel.
- ✓ Advocate for **policies and professional development activities** that promote the mental health and psychosocial well-being of education personnel.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

Key consideration 26: MHPSS focal points for learning spaces



Learning spaces should have a designated MHPSS focal point who is aware of the MHPSS services available and referral mechanisms in place. This may be a school counsellor, where available.

Alternatively, a high-capacity individual (such as a teacher or a head teacher) can be trained and supported to fulfil the role of MHPSS focal point, identifying needs and referring as appropriate. Taking on this role may require a review and adjustment of their existing workload and responsibilities.

Key consideration 27: Support the recruitment and retention of female teachers



There is a shortage of female teachers in many crisis-affected countries. This deprives girls of positive female role models and of teachers who understand their needs. It also further restricts options for girls' education. It is important to ensure that there are women in learning spaces (teachers and other female personnel) who can act as **mentors, role models or resource persons** for girls.

Where no female teachers or candidates are available for training, consider approaching women from the community to work as **classroom assistants**. Inexperienced or underqualified **volunteers** can teach effectively with adequate training. Whenever possible, provide ongoing training and opportunities for female volunteers to complete their own education, and support their transition into a full teaching role.

⁵⁷ See WHO (2020). *Helping Adolescents Thrive: Guidelines on mental health promotive and preventive interventions for adolescents*.



3.9 Provide MHPSS through women and girls safe spaces

Women and girls safe spaces (WGSS)⁵⁸ in emergencies are places where support activities are implemented for **all women and adolescent girls, including survivors of GBV**.^{59,60}

The objectives of WGSS are to:

- ▶ **facilitate access** for all women and adolescent girls to knowledge, skills and a range of relevant services;
- ▶ Support the **mental health and psychosocial well-being** of women and adolescent girls and the creation of **social networks**;
- ▶ Serve as a place where women and adolescent girls can organize and **access information** and resources to **reduce risks of violence**;
- ▶ Serve as a key **entry point** for specialized services for GBV survivors; and
- ▶ Provide a place where women and adolescent girls are **safe** and are encouraged to use their voice and collectively **advocate** for their rights and needs.



WGSS may also host **case management** services and include **MHPSS tailored to GBV survivors** (which may be implemented by the organization running the WGSS, if the required training, competencies and technical oversight are in place, or implemented in collaboration with other service providers).

58 'Safe spaces' may be called different names (e.g. Safe spaces, women's centre, women's shelter, women's and girls' safe spaces, women-friendly spaces, adolescent girls' safe spaces) across different countries and implementation locations as appropriate to the community.

59 GBV AoR, Global Protection Cluster (2019). [The inter-agency minimum standards for Gender-Based Violence in Emergency Programming](#). See Standard 8: Women's and Girls' Safe Spaces.

60 Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty (e.g. domestic violence - economic, psychological, physical and sexual violence; sexual harassment, exploitation and abuse; human trafficking; female genital mutilation; child marriage; femicide; and online or digital violence - cyberbullying, non-consensual sexting, doxing). These acts can occur in public or in private. The term GBV is most commonly used to underscore how systemic inequality between males and females acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. The term also includes sexual violence committed with the explicit purpose of reinforcing gender inequitable norms of masculinity and femininity (see Global Protection Cluster (2021) [Gender-Based Violence and Child Protection Field Cooperation Framework](#) (p. 6); UN Women, n.d. [Frequently asked questions: Types of violence against women and girls](#)).

ACTIVITY

Provide MHPSS through women and girls safe spaces



Core actions

- ✓ Establish and/or strengthen MHPSS activities in existing **safe spaces** for women and girls.
- ✓ Identify and promote **community-based support and self-help strategies**, including by working with women and girls to strengthen support networks and to facilitate support groups, social events and recreational activities (see [MSP activity](#) ⇒ 3.4).
- ✓ **Develop/select, ⇒ adapt and translate structured activities** for women and girls that promote their mental health and psychosocial well-being, based on needs identified in relevant participatory assessments and discussions with women and girls (see [MSP activity](#) ⇒ 2.1).
- ✓ **Train and support facilitators** to deliver the selected structured activities.
- ✓ Orient all workers at WGSS (e.g. GBV workers, outreach teams) on **basic psychosocial support, supporting survivors and managing disclosure**, including how to recognize signs that women and girls may benefit from additional support (e.g. GBV case management, mental health services) and how to facilitate safe referrals (see the [recommended training topics on basic psychosocial support skills for frontline workers and community leaders on the MHPSS MSP web platform](#)).
- ✓ Provide **individual and/or group MHPSS activities**⁶¹ (e.g. SEL, support groups, and recreational activities) that promote the mental health and psychosocial well-being of women and girls (e.g. that strengthen social supports, self-help, and coping).⁶²
- ✓ Engage regularly with women, girls, men and boys from the affected community to explain WGSS activities, facilitate community acceptance and address barriers to women's and girls' attendance.
- ✓ Provide **information** on available services and supports and facilitate **links and referrals** to needed services e.g. GBV and child protection services such as case management (see [MSP activity](#) ⇒ 3.13), mental health care and any other needed services and supports (e.g. MHPSS, legal, health, education, ECD, nutrition, livelihoods support).
- ✓ Engage **staff with MHPSS and GBV expertise** to provide ongoing technical support and oversight of activities in their areas of expertise. This technical support should be in addition to (and in coordination with) the sector-specific technical oversight required if individuals are referred to specific forms of case management (e.g. a GBV specialist overseeing GBV case management).
- ✓ Where GBV staff are providing **psychological interventions**, ensure that they are trained in evidence-based MHPSS approaches and receive appropriate supervision (see [MSP activity](#) ⇒ 3.12).

Additional actions for consideration (depending on context and available resources)

- ✓ Provide **additional** structured skills- and knowledge-building opportunities for women and girls to improve their mental health and psychosocial well-being.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

61 Please note that group-based interventions targeting only GBV survivors are not recommended. It is important to ensure that GBV survivors are safely integrated into any group-based intervention. This includes: inviting survivors of GBV to join supportive groups (e.g. focused on accomplishing a shared goal or learning a new skill) without compromising confidentiality; having all group participants agree to maintain confidentiality if and when survivors choose to freely talk about their experiences; preparing group facilitators to assist both the survivor and other group members should survivors wish to share their experiences, to ensure that negative emotions associated with either sharing or hearing the experience are addressed (see p-42, UNFPA (2019). [The inter-agency minimum standards for Gender-Based Violence in Emergency Programming](#)).

62 These MHPSS activities may also be appropriate for other survivors, such as LGBTIQ+ survivors. It is important to note that such activities may need to be provided in a different space. For example, providing support to other survivors in spaces for women and girls may make them less safe and acceptable for women and girls. Case management and MHPSS services for male survivors should not be provided at WGSS. The only exception to this is where it may be appropriate for very young male survivors of sexual violence (e.g. infants or pre-school aged boys) to receive support at WGSS, particularly if their mothers are survivors who are also accessing services at WGSS. Consultation with women from the community is crucial in deciding whether or not to provide services to boys at WGSS (see GBV AoR (n.d.) [Guidance to Gender-Based Violence Coordinators Addressing the Needs of Male Survivors of Sexual Violence in GBV Coordination](#), p.9).

Key consideration 28: Gender-based violence (GBV)



Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.⁶³ GBV is a manifestation of gender inequality. Discrimination and violence against women and girls have deep impacts on their mental health and psychosocial well-being.

In times of crisis, rates of GBV increase. Intimate partner violence, including against adolescent girls, is one of the most common forms of GBV in humanitarian settings. Groups of women and girls who may be at greater risk of GBV include: women and girls with disabilities; ethnic and religious minorities; older women; adolescent girls; women and girls living with HIV and AIDS; women and girls engaged in commercial sexual exploitation; and lesbian, bisexual and transgender women.⁶⁴

All GBV-related MHPSS activities should be underpinned by **rights-based, community-based, survivor-centred approaches** based on safety, confidentiality, respect and non-discrimination.



For child survivors of GBV and sexual violence, the best interests of the child must be paramount (see key consideration [34](#)).

GBV survivors may disclose their experiences to anyone; therefore, all actors (e.g. primary health care, child protection, education personnel) should have an understanding of these principles and should be trained in basic psychosocial support skills, including supporting survivors, managing disclosure⁶⁵ and facilitating safe referrals. Developing referral pathways between relevant actors, including trained and supervised mental health care providers, GBV specialists and child protection actors is fundamental. Where GBV case management services are available, survivors should be offered this service to help ensure that they receive coordinated, holistic and survivor-centred care (see MSP activity [3.13](#)). Where GBV case management services are not available, frontline actors should be trained on the [GBV Pocket Guide: How to support survivors of gender-based violence when a GBV actor is not available in your area](#).

Note: Men and boys who experience violence are generally not considered survivors of GBV because the violence they experience is not based on systemic gender inequality as it often is with women and girls. However, anyone can be a survivor of sexual violence (see key consideration [25](#)).

Key consideration 29: Male survivors of sexual violence



Male survivors of sexual violence are frequently overlooked in emergencies. Although GBV programming focuses primarily on violence against women and girls, GBV programme actors should understand that additional services may be required to meet the needs of male survivors, including men and boys with disabilities; those with diverse sexual orientations or gender identities; and young and adolescent boys, particularly those who are unaccompanied, separated, engaged in child labour or in detention. It is important that GBV actors coordinate with health, protection (including child protection), LGBTIQ+, and disability actors to ensure access to lifesaving support.

Most services developed for women and girls will not be appropriate for male survivors (e.g. WGSS), and providing support for male survivors through such services may make them less safe and acceptable for women and girls. Male survivors of sexual violence require a range of entry points to services and staff with specialized skills. In each context, it is important to understand how and when men and boys tend to disclose their experiences of sexual violence, how they seek help and what their preferences are for service delivery. Entry points for men and boys include MHPSS services, protection services, health facilities, community centres, disability support centres, facilities with services offered to or run by LGBTIQ+ organizations and, for young and adolescent boys, child and youth protection services^{66,67} (see key consideration [34](#), and [Resources on MHPSS for at-risk groups on the MHPSS MSP web platform](#)).

63 IASC (2018). [Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#).

64 UNFPA (2019). [The Inter-Agency Minimum Standards for GBV in Emergencies Programming](#). P.15.

65 See, for example, [this video by the Shelter Cluster on managing disclosure of GBV](#).

66 UNFPA (2019). [The Inter-Agency Minimum Standards for GBV in Emergencies Programming](#).

67 GBV AoR (n.d.) [Guidance to Gender-Based Violence Coordinators Addressing the Needs of Male Survivors of Sexual Violence in GBV Coordination](#).



Provide focused support for people impaired by distress or mental health conditions

3.10 Provide mental health care as part of general health services

During humanitarian emergencies, **health facilities may be damaged**, the availability of health staff may be limited and health needs, including the need for mental health services of the affected population are high. Furthermore, there is usually already a **shortage of qualified specialized mental health workers**.

Providing clinical mental health care (including psychological and pharmacological interventions and supporting rehabilitation) as part of general health services (including primary health care) can ensure that such care is **more widely available**, acceptable, **accessible**, **cost-effective**, and **non-stigmatizing**.

General health care providers who work in non-specialized health care settings should be trained and supervised in evidence-based protocols such as the [WHO-UNHCR mhGAP Humanitarian Intervention Guide \(mhGAP-HIG\)](#) or the [WHO mhGAP Intervention Guide \(mhGAP-IG\)](#).

General health care providers include **general physicians**, nurses, and **clinical officers**, as well as **physicians** specialized in areas other than psychiatry, neurology, or addiction medicine.



Women seeking sexual and reproductive health care may have accompanying specific MHPSS needs (e.g. prenatal or postpartum depression). **Maternal mental health** is of particular concern because of its impact on the care for and the development of children (antenatal care, infants, and young children).

ACTIVITY

Provide mental health care as part of general health services



Core actions

- ✓ Establish an **operations team** responsible for overseeing the integration of care for mental, neurological, and substance use (MNS) disorders into general health care, raising awareness about the need for mental health care with key stakeholders and participating in coordination mechanisms (*see MSP activity* → [1.1](#)).
- ✓ Decide **which health service points** (e.g. general health services, SRH services, types of health facilities) and which providers will be engaged to provide mental health care.
- ✓ Develop/select, → [adapt](#) and translate **training manuals and materials** where needed.
- ✓ **Train health care providers** (at least one per facility) and **community health workers** in evidence-based protocols (e.g. for the assessment and management of a range of conditions in adults and children: these may include acute stress, grief reactions, depression, post-traumatic stress disorder (PTSD), suicide, psychosomatic conditions, psychosis, harmful use of alcohol and drugs, intellectual disability and epilepsy).
- ✓ **Engage service providers** in reorganizing clinical schedules to provide dedicated time for mental health consultations (e.g. one afternoon per week with longer appointment-based consultations).
- ✓ Orient all health care providers and community health workers on **basic psychosocial support skills** (including those who are not trained in the assessment and management of MNS conditions, *see MSP activity* → [3.2](#)).
- ✓ Orient clinical and non-clinical health staff to appropriately respond to a **disclosure of sexual violence** or GBV and safely refer survivors to care, using the first-line support (LIVES) approach.
- ✓ Set up a **private space** to ensure confidentiality while providing mental health services (e.g. arrange private space for consultations).
- ✓ Engage a **technically qualified mental health specialist** to provide ongoing supervision, refresher trainings and follow-up to trained staff.
- ✓ Identify, treat and care for people with **MNS conditions** in the general health system. Provide translators (who have been oriented on their role, including MHPSS considerations) if needed.
- ✓ Support the establishment of an appropriate filing system (e.g. allowing for follow-up), integrate mental health categories into the **health management information system** (*see Sphere Appendix 2 for a* → [sample HMIS form](#) and → [UNHCR case definitions](#)) and regularly report this information to relevant clusters (e.g. Health, Protection, Education).
- ✓ Organize an uninterrupted **supply of essential psychotropic medicines** with at least one from each therapeutic category (antipsychotic, antidepressant, anxiolytic, antiepileptic and medicines to counter side-effects of antipsychotics (*see the* → [Inter-Agency Emergency Health Kit](#)).
- ✓ Strengthen or establish **links and referral mechanisms** to and from: mental health specialists, general health care providers, protection (e.g. GBV case management services), education actors, food security and livelihoods, community-based support and other services (e.g. nutrition), as well as traditional healers and faith leaders (where appropriate).
- ✓ Organize **community mental health outreach** to disseminate key mental health promotion messages (*see MSP activity* → [3.3](#)) and to **identify people** with possible MNS conditions and link them to services (e.g. provided by trained community health workers). Engage community members in the identification of people with severe mental health conditions who may be physically restrained, hidden away, or not accessing care for various reasons.
- ✓ Address **discrimination and neglect** of people with severe and chronic mental health conditions in the humanitarian response. For example, **advocate** for children, adults and older persons with MNS conditions to have access to basic services (nutrition, shelter), learning opportunities, livelihoods and recreational activities; and **facilitate referral** to such services and supports as needed. Address the use of physical restraint (which is often used because of lack of alternative support/medication).

Additional actions for consideration (depending on context and available resources)

- ✓ Initiate, support or engage in **strategic longer-term planning processes** for the integration of mental health into general health care (e.g. as part of MHPSS TWGs with humanitarian and development donors and government actors such as national mental health steering groups or commissions, and in strategic reviews of policies, guidance or plans at the national level).
- ✓ Facilitate **peer support groups** for mental health service users and their family members/carers, including people with psychosocial and intellectual disabilities or cognitive impairments.
- ✓ Build the capacity of and support **family members/carers** of persons with mental health conditions, psychosocial and intellectual disabilities or cognitive impairments (e.g. strengthening coping skills, self-care).
- ✓ Engage community members, including persons with lived experience of mental health conditions, in larger-scale **activities that address stigma and negative perceptions about mental health conditions** (e.g. community discussions and events, World Mental Health Day events).
- ✓ Add a **mental health professional** (e.g. psychiatrist, psychiatric nurse, psychiatric clinical officer, psychologist) to referral health care facilities (e.g. one per geographic area or region), who can provide specialized mental health care and engage in training, supporting and supervising general health care providers.
- ✓ Hire, train, and supervise workers to provide more comprehensive services such as **mental health case management** (e.g. advocating for persons with mental health conditions; supporting coordination and navigation of services; facilitating access to various services and supports; helping to address urgent practical problems (e.g. housing, protection, medical needs) and providing strengths-based and recovery-oriented support, *see also MSP activity* → [3.13](#)).
- ✓ Regularly obtain **feedback** from mental health service users about available care (e.g. accessibility, perceived quality).
- ✓ Build **longer-term capacity** in delivering clinical mental health care through academic and other training institutions (e.g. inclusion in curricula of diploma and degree programmes for health care professionals, continued professional education).
- ✓ **Integrate mental health care** into **disease-specific programmes and services**, such as those for HIV/AIDS, tuberculosis and noncommunicable diseases (NCDs) and into **population-specific** programmes and services, such as maternal, sexual and reproductive health, child and adolescent health, and family health and well-being programmes and services.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.




3.11

Provide MHPSS as part of clinical care for survivors of sexual violence and intimate partner violence

Sexual violence and intimate partner violence (IPV)⁶⁸ are global problems, occurring in every society. In humanitarian settings, **rates** of sexual violence and IPV are **especially high** due to the breakdown of social protections. Certain groups of people may be at heightened risk because of their specific circumstances (e.g. children, women, IDPs, refugees, migrants, ethnic minorities, people deprived of their freedom, persons with disabilities and LGBTIQ+ persons).

Sexual violence and IPV are usually severely distressing experiences that can have serious short- and long-term physical, psychological, personal and social **consequences for survivors**. Survivors can suffer injuries, unintended pregnancy, pregnancy complications, sexually transmitted infections (including HIV) and other health conditions. The **mental health impacts** may include acute stress reactions, depression, PTSD, anxiety, sleep disturbances, substance abuse, self-harm, and suicidal behaviour. Survivors may also face **stigma and rejection** from their families and communities.

 **Health care providers** offering **sexual and reproductive services** (e.g. clinic and outpatient services or hospitals offering antenatal or prenatal care; basic delivery care; post-abortion care; management of STIs; etc.) as well as maternal and general health care providers are often the **first contact points** for survivors seeking assistance. It is therefore essential that they can offer appropriate **first-line support**, including **MHPSS**, and referral to other services, including to more specialized mental health service providers as appropriate.⁶⁹

68 IPV may be physical, sexual and/or emotional/psychological. With IPV, the impact on mental health can be more gradual since IPV may occur repeatedly and over a long period, at times escalating and potentially involving high levels of emotional abuse.

69 GBV AoR, Global Protection Cluster (2019). [The inter-agency minimum standards for Gender-Based Violence in Emergency Programming](#). See Standard 4: Health care for GBV survivors.

ACTIVITY

Provide MHPSS as part of clinical care for survivors of sexual violence and intimate partner violence



Core actions

- ✓ **Identify health care settings** where MHPSS can be provided or strengthened as part of clinical care for survivors of sexual and intimate partner violence.
- ✓ **Develop/select, ↗ adapt and translate MHPSS training materials** where needed, based on needs and priorities identified in the assessment and through participatory discussions (e.g. adaptation to the context, understanding laws and policies, awareness of available resources and services).
- ✓ **Train health care providers** (e.g. physicians, nurses, midwives, medical assistants and others providing SRH services) on aspects of **MHPSS specific to sexual violence and IPV**, e.g. providing first-line support to survivors (LIVES)⁷⁰, including basic psychosocial support; the impact of sexual violence and IPV on mental health; gender-sensitive care; how to inquire about suspected violence; managing disclosure; assessing and managing mental health conditions; providing regular follow-up; monitoring mental health needs; and facilitating **links and referrals** to additional services, such as specialized mental health services and GBV case management services, and supports (e.g. legal, food security and livelihoods).
- ✓ Integrate MHPSS into **facility-level protocols, job aids and tools** (e.g. medical algorithms for health care; treatment checklists; assessment guidance; locally adapted procedures; medical history and examination forms; referral forms and protocols).
- ✓ Strengthen the capacity of **community health providers**, traditional birth attendants and other community-based health actors who are important entry points for referrals and first-line support to survivors (e.g. by providing training on first-line support to survivors, managing disclosure and facilitating links and referrals).
- ✓ Engage **staff with MHPSS and GBV technical expertise** to provide training, ongoing support and supervision.
- ✓ Coordinate with other service providers and **develop, strengthen, and/or maintain referral systems and pathways** (e.g. to GBV services; to additional or specialized mental health care; to education, livelihoods and community-based support), including procedures for confidentiality and privacy.
- ✓ Where health, SRH, or GBV staff are providing **psychological interventions**, ensure that they are equipped with evidence-based approaches and appropriate supervision (see MSP activity ↗ 3.12).

Additional actions for consideration (depending on context and available resources)

- ✓ Build **longer-term capacity** in delivering clinical care for survivors through academic and other training institutions (e.g. inclusion in curricula of diploma and degree programmes for health care professionals, continued professional education).

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

70 WHO (2014). *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook*.



Key consideration 30: Providing MHPSS to survivors of sexual violence and IPV through health services



Health service providers should consider that persons presenting with psychological distress or mental health conditions may be survivors of sexual violence and IPV. They may be reluctant or fearful to talk about these experiences and may face stigma and rejection from their families and communities. Survivors often experience common psychological reactions, such as fear, anxiety, sadness, anger, guilt, shame, self-blame, dissociation (e.g. feeling disconnected, dazed or numb), nightmares or problems sleeping, as well as social isolation and withdrawal. These reactions are normal and will most often improve over time, particularly if the affected person feels safe and has the emotional support they need. However, some people experience prolonged distress, particularly if exposed to an ongoing situation of violence, as is often the case with IPV. In addition, some groups may face additional barriers to accessing support (e.g. LGBTIQ+ persons).

Providing **first-line support (e.g. LIVES), which includes basic psychosocial support**, is a first step that all health-care staff should be prepared to take when supporting survivors of sexual violence and IPV. In an emergency setting where a health care provider may see a survivor only once, first-line support may be the only help that can be offered. Health care providers should understand how to provide survivor-centred support and facilitate referrals to needed services (see [↔ “General principles and considerations” on informed consent/assent, safe information-sharing practices, confidentiality and mandatory reporting](#) and [key consideration 28](#)). It is also important to support service providers in examining their own beliefs about gender roles (e.g. harmful beliefs about women’s and men’s rights, roles and power in society, or about persons of diverse SOGIESC) and in addressing any discriminatory attitudes that may lead to them contributing to or even causing harm in their work (e.g. re-victimisation, increased distress).⁷¹ The GBV guiding principles and survivor-centered attitude scale are foundational for working with survivors.⁷²

Some survivors of sexual violence and IPV may develop **mental health conditions** such as depression, suicidal ideation, self-harm or PTSD or may have medically unexplained somatic complaints or ongoing problems with sleep. Health care providers (e.g. physicians, nurses, midwives, medical assistants and others providing SRH services) should be able to **identify, assess and manage** such conditions, using evidence-based clinical guidelines such as the mhGAP-HIG (see [MSP activity 3.10](#)).

Further specific actions can be found in [MSP activity 3.11](#). See also [key consideration 28](#) and [key consideration 29](#).

71 Re-victimisation of survivors can occur at the provider level (e.g. via responses to disclosure that are victim-blaming or judgemental), the team level (e.g. service users having to retell their story to multiple team members), and the systems level (e.g. triage systems in which service users are asked in front of other service users about their reasons for seeking care, restraining practices on inpatient wards). Mental health services that are predicated upon power imbalances and conditions of coercion and control can result in dynamics that resemble those of abusive relationships and cause increased distress to survivors. For example, through the use of coercive treatment, such as seclusion, restraint, and forced medication in inpatient settings. Oram et al. (2022). [The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy](#). *Lancet Psychiatry*, 9(6), pp.487-524.

72 Please see the Survivor-Centred Attitude Scale in the [interagency GBV Case Management Guidelines](#), p.193.



3.12 Initiate or strengthen the provision of psychological interventions

Prolonged **psychological distress** and **mental health conditions** (such as depression, anxiety and PTSD) are common in humanitarian settings. Mental health conditions impair day-to-day functioning and the ability to access needed services and supports.

People without a professional licence or qualification in mental health care (sometimes known as **para-professionals** or **non-specialized staff**) can deliver scalable psychological interventions⁷³ to address these problems if they are **well trained, supervised** and **supported**.

For example, staff in **health, social, nutrition** and **other sectors** can be trained in structured scalable evidence-based psychological interventions (*see key consideration* [↻ 31](#)).



Workforce development and **systems strengthening** for delivery of psychological interventions is a longer-term process but should be initiated and planned from the beginning.

⁷³ Scalable psychological interventions are typically characterized by reduced reliance on specialists (e.g. non-specialized staff can be trained and supervised), include interventions that address multiple problems, may not require diagnostic assessment and focus on skills for self-management.

ACTIVITY

Initiate or strengthen the provision of psychological interventions



Core actions

- ✓ Decide which **platform or setting** (e.g. general health services, SRH services, rehabilitation centres, social services, protection services or settings such as safe spaces, education, or nutrition services) and which providers will be engaged to deliver psychological interventions.
- ✓ Facilitate access to **appropriate space(s)** for the delivery of psychological interventions (e.g. considering confidentiality and having a safe space for accompanying children).
- ✓ Develop/select, ⇨ **adapt** and translate evidence-based psychological **intervention manuals and materials**, if needed.
- ✓ Assess **training needs and capacities**, including supportive attitudes and beliefs, of potential training participants.
- ✓ Provide **competency-based training** and **supervision** in psychological interventions.
- ✓ Provide **psychological interventions** in the selected setting.
- ✓ Facilitate **referrals** to other services as needed (e.g. specialized mental health care providers, general health care providers, protection and education actors, livelihoods and community-based support).
- ✓ **Engage qualified MHPSS staff** to provide ongoing follow-up, supervision and support to trained workers.

Additional actions for consideration (depending on context and available resources)

- ✓ Expand the **availability of competent, supervised staff** who can provide psychological interventions in additional settings and geographical areas.
- ✓ Build **longer-term capacity** in delivering psychological interventions through **academic institutions** (e.g. diploma and degree programmes, continued professional education). This includes mapping existing educational programmes and curricula on psychotherapy, including at academic and professional national associations and licensing bodies (e.g. national cognitive behavioural therapy societies).

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.



Key consideration 31: Evidence-based psychological interventions and delivery methods to manage prolonged psychological distress and common mental health conditions



Evidence-based approaches:^{*}

- ▶ Cognitive behavioural therapy (CBT) in various forms, such as behavioural activation, cognitive processing therapy, exposure-based approaches (e.g. narrative exposure therapy) and third-wave approaches (e.g. acceptance and commitment therapy; ACT);
- ▶ Stress management/relaxation training;
- ▶ Problem-solving counselling/problem-solving therapy;
- ▶ Interpersonal therapy/interpersonal psychotherapy;
- ▶ Eye movement desensitization and reprocessing (EMDR).



Delivery methods:

- ▶ Individual and group interventions;
- ▶ Guided and unguided self-help approaches;
- ▶ Digital and face-to-face methods.



Examples of evidence-based psychological intervention manuals developed for humanitarian settings are listed in the [relevant guidelines, standards and tools section on the MHPSS MSP web platform](#).

*** Please note** that this is not an exhaustive list of psychological interventions; it is based on those recommended in the [mhGAP Intervention Guide and other WHO guidelines](#). Please refer to national guidelines for information on other psychological treatments. Note that there are relatively few publicly available evidence-based manuals on psychological interventions and other focused MHPSS interventions for children, including adolescents, in humanitarian settings.⁷⁴



Key consideration 32: Do not offer psychological debriefing



Do not provide one-off, single-session psychological debriefing⁷⁵ as an early intervention after exposure to an adverse, terrifying, or life-threatening event, including conflict or natural disaster.⁷⁶ Evidence shows no effectiveness of psychological debriefing and suggests that it may be harmful to some people.^{77,78} Basic psychosocial support (e.g. PFA, [see MSP activity ↗ 3.2](#)), rather than psychological debriefing, should be offered to people in severe distress who have recently been exposed to an adverse event.⁷⁹

74 Global Protection Cluster (2020). [Guidance for MHPSS Aspects of Child Protection in the HNO/NRP 2021](#).

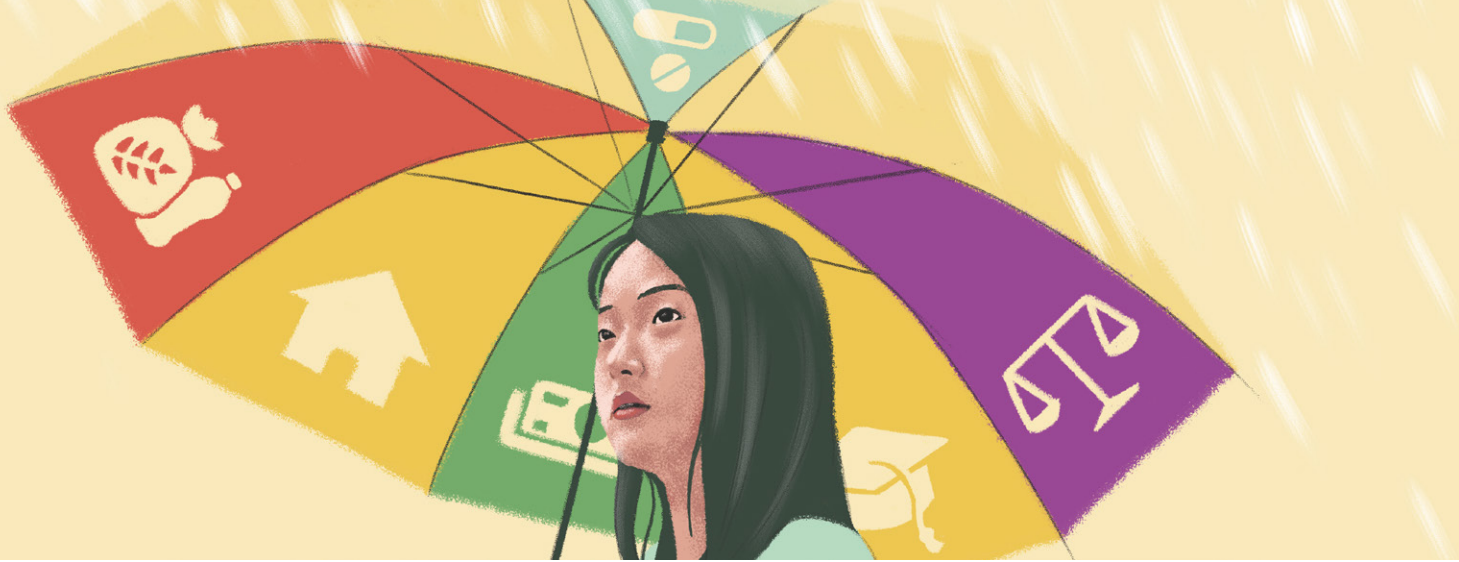
75 Psychological debriefing as an intervention typically consists of a single session only, and involves some form of emotional processing/ventilation, by encouraging recollection/reworking of the traumatic event, accompanied by normalisation of emotional reaction to the event.

76 Inter-Agency Standing Committee (2007). [IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#).

77 Rose SC, Bisson J, Churchill R, Wessely S. [Psychological debriefing for preventing post traumatic stress disorder \(PTSD\)](#). Cochrane Database Syst Rev.

78 World Health Organization (2011). [Single-Session Psychological Debriefing: Not Recommended](#).

79 Inter-Agency Standing Committee (2007). [IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#).




3.13 Provide MHPSS through case management services

Case management is a way of providing services to individuals or families who require individualized support due to their needs or circumstances. **Different types of case management** are used in the fields of protection, GBV, child protection, refugee protection, disability, mental health and victim assistance for survivors of explosions.

While the format, frequency of contact and goals vary depending on the area of work, a common feature is that a case worker works jointly with each individual or family to **assess** their situation, **develop** and **implement** an **assistance plan** and regularly **review progress** towards goals.

The case worker serves as a consistent source of support over time, providing **direct care** to the person or family, **advocating** for them and **facilitating their access** to other services as needed (e.g. shelter, legal assistance, mental health care).

 Each form of case management requires specific expertise and technical supervision. Dedicated training packages, guidance documents and minimum standards are available for different types of case management. Regardless of the sector, however, case management must be delivered in a way that is **sensitive to mental health needs**, promotes **safety** and **psychological well-being**, builds on a person's **abilities and strengths** and promotes **family and community support**.⁸⁰ The actions below apply to all forms of case management, and should be used in conjunction with the sector-specific guidance documents ([see !\[\]\(0f31ebba7abcd47777e178db26f29705_img.jpg\) *relevant guidelines, standards and tools on the MHPSS MSP web platform*](#)).

⁸⁰ Some guidelines consider general child protection case management and GBV case management to be de facto MHPSS services, aligning with Level 3 of the IASC MHPSS Intervention Pyramid i.e. focused non-specialized support (e.g. UNICEF (2019). [Operational Guidelines for Community-based MHPSS](#); GBVIMS Steering Committee (2017). [Interagency GBV Case Management Guidelines](#)).

ACTIVITY

Provide MHPSS through case management services



Core actions

- ✓ ⇒ **Adapt** case management training curricula to include key MHPSS topics appropriate to the capacity of the available workforce (see the [recommended MHPSS training topics for case workers supporting adults and children on the MHPSS MSP web platform](#)).
- ✓ **Train case workers** and supervisors on the relevant MHPSS topics and skills.
- ✓ ⇒ **Adapt** case management tools, templates and referral protocols to include MHPSS (e.g. assessment and review of MHPSS needs, MHPSS considerations in care planning, criteria for MHPSS referrals, SOPs for MHPSS crisis management).
- ✓ **Work with caregivers, family members and close contacts** where safe and appropriate, to build their capacity to support the person in-need (e.g. through responsive caregiving practices and education on development, mental health and psychosocial well-being).
- ✓ Engage **staff with MHPSS technical expertise to provide ongoing technical oversight and supervision** to case workers providing MHPSS, through care planning meetings and individual sessions (e.g. to ensure that activities promote well-being and do not cause harm). This technical support should be in addition to (and in coordination with) the sector-specific technical oversight required by the specific form of case management (e.g. a GBV specialist overseeing GBV case management).
- ✓ **Identify safe location(s)** to provide case management services. For GBV case management, consider utilizing safe spaces for women and girls and mobile options to provide non-stigmatizing access points to services. For LGBTIQ+, expand contacts with local LGBTIQ+ organizations where available, who may be able to offer safe and welcoming environments.

Additional actions for consideration (depending on context and available resources)

- ✓ Train case workers in evidence-based **psychological interventions** and provide technical supervision (see [MSP activity](#) ⇒ 3.12).
- ✓ ⇒ **Adapt** case management M&E tools and care and treatment plans to include an assessment of the impact of services on the client's mental health and psychosocial well-being (if this is not already included).

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

Key consideration 33: Ensure clarity of roles



Where multiple roles within an organization contribute to MHPSS outcomes, it is crucial that staff and volunteers have a clear understanding of the remit of each role and how it contributes towards shared objectives. For example, programmes sometimes include both general child protection workers and dedicated MHPSS workers within child protection teams (e.g. MHPSS officers or psychosocial support officers), with both offering forms of emotional and psychological support. If the unique contribution of each of these roles is not clearly defined, it can be confusing for both staff and service users and can lead to **tension, duplication of work** and **data protection risks**.

When the roles and criteria for referral between different roles are clearly defined and well understood (e.g. a child protection worker providing case management and an MHPSS worker providing a specific psychological intervention), they can offer **effective and complementary supports** as part of a comprehensive package of care.

Where a person has **needs relevant to multiple case management teams** (e.g. GBV; protection), to avoid subjecting them to duplicative procedures and assessments, one case worker should assume primary responsibility and serve as their point of contact, while receiving technical input from other sectors/AoRs. The team best positioned to assume primary responsibility should be determined based on the client's preference as well as the technical expertise needed to manage the primary or most urgent concern.

See also [key consideration 34](#).

Key consideration 34: Child and adolescent survivors of sexual violence



Both GBV and child protection services can support child survivors of sexual violence, as long as workers have the necessary competencies and appropriate organizational procedures are in place. It is good practice to establish inter-agency SOPs that **clarify roles and responsibilities** for providing case management to child survivors based on the capacities and expertise available.

A child should have only **one case worker** at any one time, and the case worker should coordinate with other providers as needed to ensure that the child does not have to endure duplicative assessments or assessment questions. A range of factors should be considered when determining the **most appropriate service provider** for any given child or adolescent, including the child's wishes; the availability, training and competencies of staff; existing referral pathways and local agreements; and the service to which the child was first referred. Case workers and others working with survivors should **seek further support** from technical experts and supervisors with relevant expertise.

Children should have a choice about what services they receive and from whom, recognizing that child survivors are not a homogeneous group. For example, adolescent girls may feel more comfortable accessing services through GBV services and spaces focused on women and girls, while adolescent boys may prefer to access support through protection or health services.

See also [key consideration 25](#).



3.14 Protect and care for people in psychiatric hospitals and other institutions

During humanitarian crises, people with **mental, neurological and substance use (MNS) conditions** or with **intellectual, developmental and psychosocial disabilities or cognitive impairments** who are living in psychiatric hospitals and institutions are at high risk of **human rights violations** such as physical and sexual abuse; punishment; neglect; abandonment; and lack of shelter, food or medical care.

Although **community-based mental health care** is **recommended**, many countries affected by humanitarian crises rely mainly on institutional care (e.g. psychiatric hospitals, social care homes, residential homes, substance use rehabilitation clinics).

These **institutions** are typically limited to main cities and are **often not accessible** to crisis-affected populations. The care in such institutions is **often grossly inadequate** even before the onset of a crisis.

Humanitarian emergencies can **damage physical structures** and **diminish staff numbers**. People in psychiatric hospitals and institutions may be abandoned by staff and **left unprotected** from the effects of natural disaster or armed conflict. Living in an institution also **isolates** people from potential **family protection** and **support**, which may be essential for survival in emergencies.



Furthermore, **sudden discontinuation** of **psychotropic medications** can be harmful and even **life-threatening**.

ACTIVITY

Protect and care for people in psychiatric hospitals and other institutions



Core actions

- ✓ **Visit psychiatric hospitals and other institutions** on a regular basis from the beginning of the crisis to assess needs (in coordination with relevant government authorities such as ministries of health and social affairs).
- ✓ Support efforts to ensure the **physical security** of persons in institutions and staff as needed (e.g. protection of civilians and health facilities as per international humanitarian law, protection from infectious disease outbreaks or diseases endemic in the country).
- ✓ Implement or strengthen **human rights monitoring and surveillance** by external review bodies (if available), human rights organizations or protection specialists.
- ✓ Address **protection concerns** of men, women and children in institutions (e.g. protection from neglect, abuse, GBV or coercive treatment by others, including by staff or other institutionalized persons). Facilitate links to additional supports and service providers as needed (e.g. GBV specialists).
- ✓ Ensure that the **basic physical needs** of people in institutions are met in coordination with other sectors (e.g. potable water, adequate food, shelter, clothing and sanitation), as well as their physical health needs (e.g. access to treatment for physical disease and injury).
- ✓ Facilitate **family tracing and communication** with families for people living in institutions.
- ✓ Support authorities in ensuring that proper evacuation, disaster response and **emergency plans** are in place (e.g. drafted, disseminated and tested).
- ✓ Ensure the provision of **basic mental health care** throughout the emergency (i.e. essential psychotropic medications and psychosocial support).
- ✓ **Facilitate discharge** whenever possible (e.g. if there is availability of family support, community-based mental health care and access to basic needs including shelter, food and physical health care).
- ✓ Provide an uninterrupted supply of **psychotropic medications** and other essential medical supplies and equipment (based on a needs assessment of the facility), if needed.
- ✓ If the crisis creates staff shortages, **mobilize trusted human resources** from the family, the community and the health system to assist with care (e.g. helping ensure adequate provision of food and other basic needs).
- ✓ Support authorities in providing basic **training and continued support and supervision** to staff as needed (e.g. human rights in mental health; managing crises without using coercive practices such as physical, mechanical or chemical restraints and seclusion; ongoing care and ways to improve patients' self-management; staff self-care). Include service provider staff (e.g. doctors, nurses) as well as other relevant staff (e.g. security).

Additional actions for consideration (depending on context and available resources)

- ✓ Conduct a more **comprehensive assessment** of the facility, involving various stakeholders including service users (e.g. using the [WHO QualityRights assessment and transformation toolkit](#)).
- ✓ Engage in **community awareness-raising and education** to reduce discrimination and stigma and promote community support, social inclusion and human rights (while actively involving people with lived experience of mental health conditions).
- ✓ Support the development of individualized **person-centred recovery plans**, involving **multidisciplinary teams**.
- ✓ Support and ensure access for residents to a **wide range of services and supports** (e.g. rehabilitation, recreation and spiritual services).
- ✓ Provide **additional training and supervision** to staff (based on a training needs assessment).
- ✓ Support steps towards **deinstitutionalization** processes and the replacement of long-stay residential institutions (for children and adults) and psychiatric hospitals with human rights-oriented and **community-based services** (e.g. acute psychiatric units in general hospitals, provision of clinical mental health care as part of general health facilities, case management, community support and social inclusion). Consult with and meaningfully involve persons with lived experience of mental health conditions during this process.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

SECTION 4



ACTIVITIES AND CONSIDERATIONS FOR SPECIFIC SETTINGS



4.1

Integrate MHPSS considerations and support into clinical case management for infectious diseases

Outbreaks of infectious disease (e.g. COVID-19, Ebola virus disease, Zika virus disease) have major impacts on mental health and psychosocial well-being. **Stressors** resulting from such outbreaks include social isolation, economic hardship, disrupted daily routines (education, employment) and disrupted access to services, including mental health care.

Persons admitted to **health care facilities** can experience fear, uncertainty and social isolation. Those who lose loved ones often have limited opportunities to mourn or to access support. There are often **discrimination** and **social stigma** towards people with the disease and their carers, including health workers. Fear, depression and worry are common, and rates of mental health conditions are likely to increase. It is therefore important to integrate MHPSS considerations and support into clinical case management for infectious diseases and also to integrate relevant MHPSS actions into the **broader public health emergency response** ([see key consideration 35](#)).

ACTIVITY

Integrate MHPSS considerations and support into clinical case management for infectious diseases



Core actions

- ✓ Develop/select, [↪ adapt and translate](#) materials where needed (e.g. orientation materials for staff, information, education and communication (IEC) materials aimed at affected populations).
- ✓ Identify **MHPSS focal points** to provide and coordinate services for MHPSS in **all health facilities**.
- ✓ Ensure that every health facility has **at least one person trained and a system in place** to identify and provide care for people with common and severe mental health conditions.
- ✓ Orient **health care workers** who are tasked with the management of persons with infectious diseases in **basic psychosocial support skills, assessment** and first-line **clinical interventions** and on drug-drug interactions (e.g. between medications for managing infectious diseases and psychotropic medication).
- ✓ **Provide MHPSS** to persons with infectious diseases and their **family** members, including children. This includes support for coping with **acute and severe illness** (e.g. acknowledging and addressing distress, facilitating communication, ensuring respect and dignity).
- ✓ Identify, manage and, as appropriate, refer infected people with new or pre-existing **MNS conditions** to mental health services as needed.⁸¹
- ✓ Ensure that health facilities are equipped with needed supplies of **essential psychotropic medications**.
- ✓ Integrate **data on comorbid mental health conditions** in clinical forms and health information systems.⁸²
- ✓ Include **MHPSS considerations** to mitigate protection risks and reduce psychological distress for infected persons who are hospitalized (e.g. ensuring access to accurate and easily understood information about the condition and the treatment; facilitating communication with family members remotely via phones or protective screens; facilitating visits from religious leaders if desired; facilitating daily activities, e.g. by providing books and games, especially for children).
- ✓ Establish links and **referral mechanisms** for affected people and their family members to access mental health care providers, food security and livelihoods support, education, social services (including housing) and other relevant services and supports.
- ✓ Establish opportunities for those who are **bereaved** to mourn and follow cultural traditions for **safe and dignified** burials, based on their preferences and to the extent possible.
- ✓ Protect the **mental health of all responders** and ensure that they can access mental health and psychosocial care.

Additional actions for consideration (depending on context and available resources)

- ✓ Add to health care facilities either a **mental health professional** (e.g. psychiatric nurse, psychiatric clinical officer, psychologist) or a trained and supervised non-specialist whose work is dedicated part-time or full-time to mental health care.
- ✓ Facilitate **community-level activities** such as support groups for those who have been affected or are recovering (if this can be done safely) ([see MSP activity ↪ 3.4](#)).
- ✓ Provide **psychological interventions** for persons who have recovered from infectious diseases and for others, including bereaved family members ([see MSP activity ↪ 3.12](#)).

81 WHO (2020). [The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment](#). Annex 3: Modifications for safe delivery of MNS services and considerations towards restoration of activities.

82 For example, see [WHO clinical characterization forms for COVID-19](#).

- ✓ Provide **follow-up** for persons with **MNS conditions** after discharge to assess their symptoms, ensure that they are doing well and facilitate access to additional support and services as needed (e.g. through telehealth, where available and appropriate).
- ✓ Organize **dedicated helplines** to provide remote support to persons recovering from infectious diseases, their families and the public.
- ✓ Organize activities and **positive messaging to reduce stigma and to honour people** affected and front-line responders.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

Key consideration 35: MHPSS as part of the public health emergency response



Mental health and psychosocial support is an integral component of the public health emergency response to infectious diseases and contributes to saving lives.

MHPSS actors have a key role to play **across several pillars of the public health emergency response**, including infectious disease case management, infection control measures, risk communication and community engagement, safe and dignified funeral rites, and maintaining safe and accessible essential health services.^{83,84} In some public health emergencies, MHPSS might also be a specific stand-alone pillar linked to other pillars as a cross-cutting issue.



MHPSS workers often play a central role in supporting people to **change their behaviours and make decisions** that prevent the transmission of disease. The support and information that MHPSS workers provide to affected individuals is often key to their decisions to enter quarantine or treatment facilities and to cooperate with restrictions and procedures (e.g. isolation, contact tracing). When a person dies in a treatment facility, MHPSS workers are often tasked with informing family members and facilitating safe and dignified burial practices. MHPSS workers also support and advocate for people who have recovered from infectious diseases, facilitating their safe reintegration into their communities and working with community members to address stigma and harmful misconceptions.



At-risk groups (e.g. older persons, persons with pre-existing MNS conditions, persons with disabilities, women and girls, people on the move, victims of trafficking, refugees, IDPs, migrants) must be considered when planning and implementing outbreak response actions and when adapting ongoing activities (e.g. appropriate targeting of these populations; developing accessible messages).

There should be **at least one person** (and where possible two persons, one male and one female) and **a system in place** to provide and coordinate services for MHPSS in **all facilities engaged** in the infectious disease outbreak response (health, education, camps, social services and others).⁸⁵

See the [additional guidance for using the MHPSS MSP in the public health emergency response to infectious disease outbreaks on the MHPSS MSP web platform, including considerations and actions relevant to each MSP activity.](#)

83 WHO (2021). [COVID-19 Strategic Preparedness and Response Plan \(SPRP 2021\)](#).

84 WHO Executive Board, [Promoting mental health preparedness and response for public health emergencies](#). 20 January 2021.

85 IASC Reference Group on MHPSS in Emergency Settings (2020). [Information Note on Updating Humanitarian and County Response Plans to Include COVID-19 Mental Health and Psychosocial Support \(MHPSS\) Activities](#).



4.2 Provide MHPSS to persons deprived of their liberty

In humanitarian crises, adults and children may be deprived of their liberty for a variety of reasons: for example, they may be held in **administrative detention** or **immigration detention** while attempting to seek safety and protection across borders and on migration routes or they may be placed in detention or internment because they are (suspected) combatants or affiliated with fighting forces.

People living with pre-existing and severe **mental health conditions** may also be held in detention or at other locations, instead of receiving appropriate mental health care. Further, people in detention may develop mental health conditions (e.g. depression, anxiety) and/or misuse substances such as drugs or alcohol as a way of coping.



Providing **access to MHPSS services** for people deprived of their liberty can be a life-saving intervention and can help to ensure that their rights are upheld.

ACTIVITY

Provide MHPSS to persons deprived of their liberty



Core actions

- ✓ **Develop/select, ⇒ adapt and translate training materials** to equip staff to provide basic psychosocial support to persons deprived of their liberty, including considerations for specific groups such as juveniles, survivors of sexual violence and survivors of torture, as relevant.
- ✓ **Train staff** visiting and monitoring institutions/detention centres to provide age- and gender-appropriate **basic psychosocial support** to people in detention.
- ✓ Advocate to managers and staff at detention facilities for **MHPSS considerations** to minimize psychological distress (e.g. maintaining family and social connections) and to ensure availability of **private spaces** for provision of confidential mental health and psychosocial support.
- ✓ **Provide basic psychosocial support** to people in detention, including facilitating communication with family, identifying and referring people for additional support (e.g. mental health services, restoring family links, specialized support for juveniles, survivors of sexual violence and survivors of torture).
- ✓ Set up a system of **referral and consultation** with mental health care providers (e.g. visits from mental health care providers who can treat MNS conditions; *see MSP activity ⇒ 3.10*) in coordination with the detaining authorities and in cooperation with line ministries.
- ✓ Engage **staff with MHPSS technical expertise** to provide ongoing support and oversight.
- ✓ Train detention/facility administrators and staff on the **identification of MHPSS needs** and referral pathways.

Additional actions for consideration (depending on context and available resources)

- ✓ Set up **additional MHPSS services and activities** to support people in detention facilities (e.g. needs assessments, peer support groups, psychological interventions) in coordination with the detaining authorities.
- ✓ Provide basic psychosocial support to family members of those in detention.

Guidelines, standards and tools



[Click here](#) to access relevant guidelines, standards and tools.

Key consideration 36: Providing services in places where people are deprived of their liberty

Providing services for people in detention is often sensitive and requires nuance. Many places where people are deprived of liberty around the world are not legally established, subject to oversight or independent detention monitoring, and individuals may be held without a legal basis. Evidence⁸⁶ shows that detention is harmful for the mental health and psychosocial well-being of adults and children. However, these situations still exist, and people who are deprived of their liberty are at higher risk for developing mental health conditions and are likely in dire need of MHPSS services. It is important to consider the political, legal and ethical aspects of providing services in places where people are deprived of their liberty. Negotiating principled conditions (e.g. confidentiality) for access to places of detention should be a priority. Confidentiality, data protection, rights, and access are typically even more important when working with people in detention.

86 WHO 2022. *Immigration detention is harmful to health – alternatives to detention should be used*; W. Gundo et al. (2022). *Improving health in immigration detention and promoting alternatives to detention*. The Lancet, 399 (10338), pp.1849-1850.



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