
Mental Health Matters:

Progress Report on Mental Health and Psychosocial Support Activities
within the International Red Cross and Red Crescent Movement

Asia Pacific Region

October 2021



+CIFRC

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Psychosocial Centre

Executive Summary

This year's Movement-wide Mental Health and Psychosocial Support survey has been conducted to follow up on the [Mental Health and Psychosocial Support survey of 2019](#), which, for the first time, provided a dataset and baseline for mental health and psychosocial support (MHPSS) activities carried out by the components of the Movement. A total of 163 National Societies (NS), the International Federation of the Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC) participated in the survey. This report presents the results of the 2021 survey compared to the results of the survey conducted in 2019 focusing on the Asia Pacific Region.

In 2021, nearly all respondents 97% (26 NS, the IFRC and the ICRC) of the Asia Pacific region indicate that their organisation has provided MH and/or PSS activities, compared to 91% (30 NS, the IFRC and the ICRC) in 2019. When looking solely at the psychosocial support (PSS) activities, psychological first aid (PFA) was remained of the most carried out activity in 2021, yet with a slight decrease compared to 2019 data (2021: 77% (26 NS and the IFRC); 2019: 90% (25 NS and the IFRC)).

The most frequent mental health (MH) activity is psychological support (63%: 16 NS and the ICRC in 2021, compared to only 6%: one NS and ICRC in 2019). This type of activity has risen significantly in the last two years. As in the global trend, the main target group of PSS activities are volunteers

(62%: 17 NS and the IFRC) and staff (48%: 13 NS and the IFRC). Volunteers and staff have risen as the most significant groups for MH in the Asia Pacific region.

As in 2019, 15 NS, the IFRC and the ICRC stated that they make referral(s) to more specialized mental health services (2019: 46%; 2021: 59%). In 2021, a rise in focal points is noted with 83% of respondents (22 NS, the IFRC and the ICRC) having appointed one or more focal points.

Among the 27 NS who answered the survey question, the IFRC and the ICRC, around 12.600 staff and volunteers are reported to have been trained in basic psychosocial support in the last year constituting a small increase. The number of staff and volunteers trained in PFA was around 9.000 in 2021 compared to around 15.400 staff and volunteers being trained in PFA in 2019.

66% (19 NS, the IFRC and the ICRC) state that they have a system in place to monitor the MH and/or PSS activities of their organisation. 41% of respondents in 2021 (12 NS) report having no budget dedicated for MHPSS activities, while budget constraints or limited budget availability are identified as the major obstacle for delivering MH and/or PSS activities in 2021 (63%: 18 NS and the IFRC). Another obstacle constitutes a lack of or limited technical expertise i.e., manuals, trainings, specialists (48%: 14 NS).

Around half of the respondents (13 NS, the IFRC and the ICRC) plan to expand their activities within this area, while no NS intends to reduce its MHPSS activities. 45% (13 NS) also wish to integrate or mainstream their MHPSS activities, which means including MHPSS in other programme activities. 7% (2 NS) plan to maintain their level of activities in relation to MHPSS.

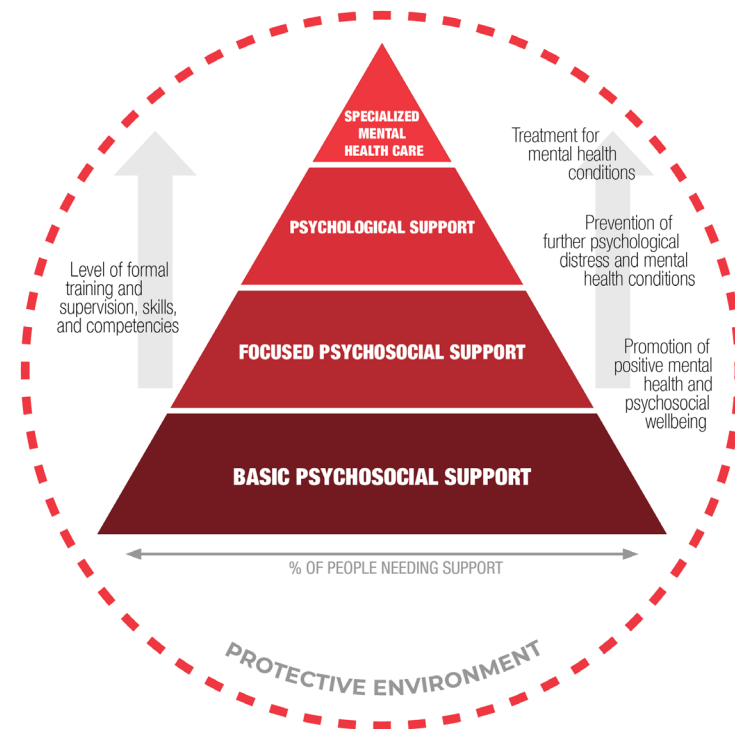
Finally, this report does not include specific information about the delivery of MH and/or PSS activities in relation to the COVID-19 pandemic. We acknowledge that the pandemic possibly has had an impact on the services provided. However, to maintain validity, the survey questions informing the report remained essentially the same as in 2019, apart from the questions introduced by the Working Groups of the MHPSS Roadmap implementation (please see the annex).

Introduction

Throughout the world, every day the International Red Cross and Red Crescent Movement (the Movement) witness the extensive unmet mental health and psychosocial support needs that populations endure. Needs that increase dramatically during armed conflicts, natural disasters, and other emergencies. One of the most prominent examples is the COVID-19 health emergency, which sheds light on how crucial mental health and psychosocial support (MHPSS) is.

In the Movement, MHPSS continues to be high on the agenda. The different components of the Movement - the 192 National Societies (NS), the International Federation of Red Cross and Red Crescent Societies (IFRC), and the International Committee of the Red Cross (ICRC) - respond to mental health and psychosocial needs through a variety of activities. These activities cover the spectrum of MHPSS from basic psychosocial support, to focused psychosocial support, psychological support, and specialized mental health care. Psychosocial wellbeing and mental health support exist on a continuum, and therefore different people need different levels of care, from prevention and promotion of positive mental health to treatment of mental disorders.

The Mental Health and Psychosocial Support survey was conducted by the International Red Cross and Red Crescent Movement in 2021 to assess and monitor areas of improvement as well as areas that need further strengthening in regard to the activities addressing mental health and psychosocial needs.



The Movement's mental health and psychosocial support framework. Read more: <https://pscentre.org/what-we-do/the-mhpss-framework/>

The survey also provides a method of tracking progress in implementing the Movement’s policy of addressing mental health and psychosocial needs and [resolution 2](#) of the 33rd International Conference “Addressing mental health and psychosocial needs of people affected by armed conflicts, natural disasters and other emergencies”

This report, therefore, includes questions specifically related to the six Priority Action Areas, as defined in the [Roadmap for Implementation 2020-2023](#). This Roadmap specifies the Movement’s collective commitments and ambitions in responding to the mental health and psychosocial needs of the populations we serve, by translating those into activities and outputs that both the Movement as a whole and NS, the IFRC and the ICRC individually should work towards. The Priority Action Areas have guided the creation of working groups (WG) that facilitate the roll-out of the specific commitments, as defined in the Roadmap. Each WG contributed to the survey by providing additional questions or amendments to past questions, to ensure an efficient follow-up of the progress on the Priority Action Areas. (Please see the annex for the WGs’ focus and Priority Action Areas and a detailed list of the questions which were added or edited.)

The additional questions provided by the WGs are the only significant change compared to the [survey conducted in 2019](#). The survey in 2019 established a dataset and a baseline of MHPSS activities carried out by NS, the IFRC and the ICRC. This report presents results from the 2021 survey and compares them with those from the previous report to document developments over the past two years.

To summarize, this report contains an overview of the survey results in 2021 compared to the results from the 2019 survey. It presents what respondents– made up of 27 NS, the IFRC Asia Pacific region and the ICRC in the Asia Pacific region – have done in the last 12 months and what they continue to do in the field of MHPSS. The focus is on the development in the delivery of MHPSS activities by respondents as well as the challenges encountered when delivering MHPSS activities

The survey represents a snapshot of current activities but does not provide information about the quality of services being provided or about potential variation in approaches used across the Asia Pacific region. For the global Movement-wide survey report and the reports of the other regions, please consult the IFRC Psychosocial Support Centre Website under this [link](#).

Key terminology

Mental health activities: counselling, group therapy, psychiatric or psychological assessments and treatments, often delivered by persons with professional training in mental health or psychology, or highly skilled, trained and supervised volunteers.

Psychosocial support activities: e.g. psychological first aid, psycho-education, awareness-raising, community-based activities and other activities usually delivered by trained volunteers but often supervised by someone with a more advanced background in psychology/social work/health.

Source: Movement-wide MHPSS survey 2021

Methods: How was the survey conducted?

The survey was shared in Arabic, English, French and Spanish and disseminated to all 192 NS, the IFRC and the ICRC in June 2021. Follow-up on submissions took place between June and August 2021.

The survey requested each component of the Movement to provide information on their mental health (MH) and/or psychosocial support (PSS) activities related to both national and international work. Only one response was accepted per NS. In cases where more than one answer was submitted from the same NS, the respondents were given the opportunity either to consolidate their response and resubmit a joint answer or choose which of the already submitted responses should be considered.

Regarding the IFRC, a response was received from each of the five IFRC Regions - Africa, Americas, Asia Pacific, Europe and Central Asia (CA), and the Middle East and North Africa (MENA) - together with a response from the IFRC Reference Centre for Psychosocial Support (PS Centre). For the global report, these separate responses were merged into one response covering all the work undertaken by the IFRC. Like the IFRC, the ICRC also provided regional breakdowns for the regions - Americas, Africa, Eurasia, North Africa and Middle East (NAME) and Asia Pacific in addition to information on their MHPSS activities worldwide. This report, however, focusses on the performance of the Asia Pacific region solely.

region solely.

The [MHPSS baseline survey in 2019](#) included 27 questions, whereas this year's survey contained 33 questions. The additional questions stem from the Roadmap for Implementation 2020-2023 working groups' (WG) specific interest in their Priority Action Areas. Each WG contributed with amendments to the existing questions or added one to two questions. The survey was divided into two sections: existing MH and/or PSS activities, and MH and/or PSS activities moving forward.

Although the COVID-19 pandemic has significantly affected the context of MHPSS activities in the past year it was decided because of reasons of validity to not further modify the initial survey of 2019. As the goal of the Movement-wide MHPSS surveys is to deliver coherent information from the commencement of resolution 2 in 2019 until the end of the Roadmap for Implementation in 2023, the survey needs to remain comparable. The impact of COVID-19 on MH and/or PSS activities and services will be reported on in other appeal reports and publications.

A total of 27 NS out of 38 NS in the Asia Pacific region, the IFRC Asia Pacific, and the ICRC Asia Pacific responded to this survey. This accounts for a total response rate of 71%, compared to the 90% response rate (33 NS, the IFRC and the ICRC) in 2019.

Year	Asia Pacific	Movement-wide
2019	90%	85%
2021	71%	84%

Table 1: Percentages of respondents in Asia Pacific and Movement-wide

Results

Mental health (MH) and/or psychosocial support (PSS) activities

The delivery of MH and/or PSS activities has remained high since 2019. In 2021, nearly all respondents 97% (26 NS, the IFRC and the ICRC) indicate that their organisation has provided MH and/or PSS activities, as shown on the map (figure 1), compared to 91% (30 NS, the IFRC and the ICRC) in 2019.

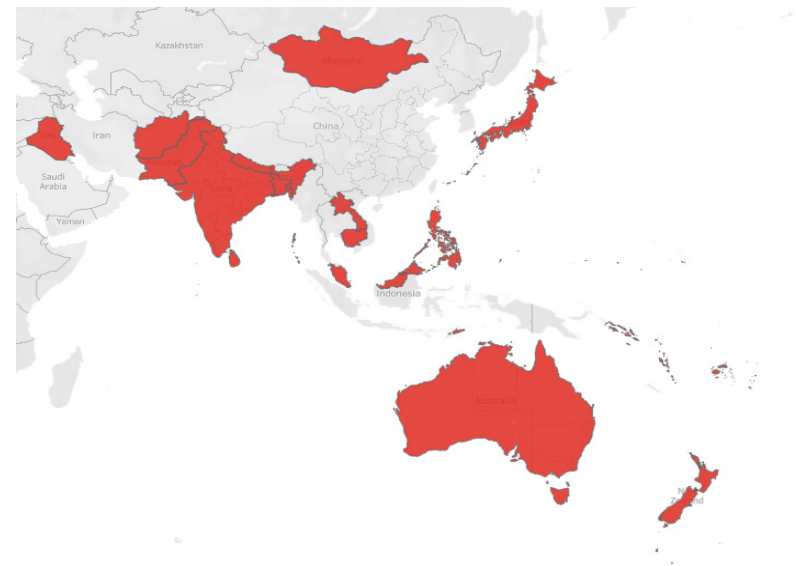
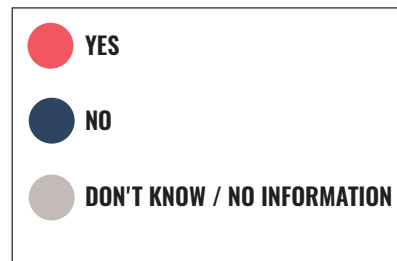


Figure 1: NS providing mental health and/or psychosocial support services

A rise in the number of NS having a MH and/or PSS focus in their organisation strategy is observable from 54% (17 NS, the IFRC and the ICRC) in 2019 to 81% (20 NS, the IFRC and the ICRC) in 2021 (figure 2).

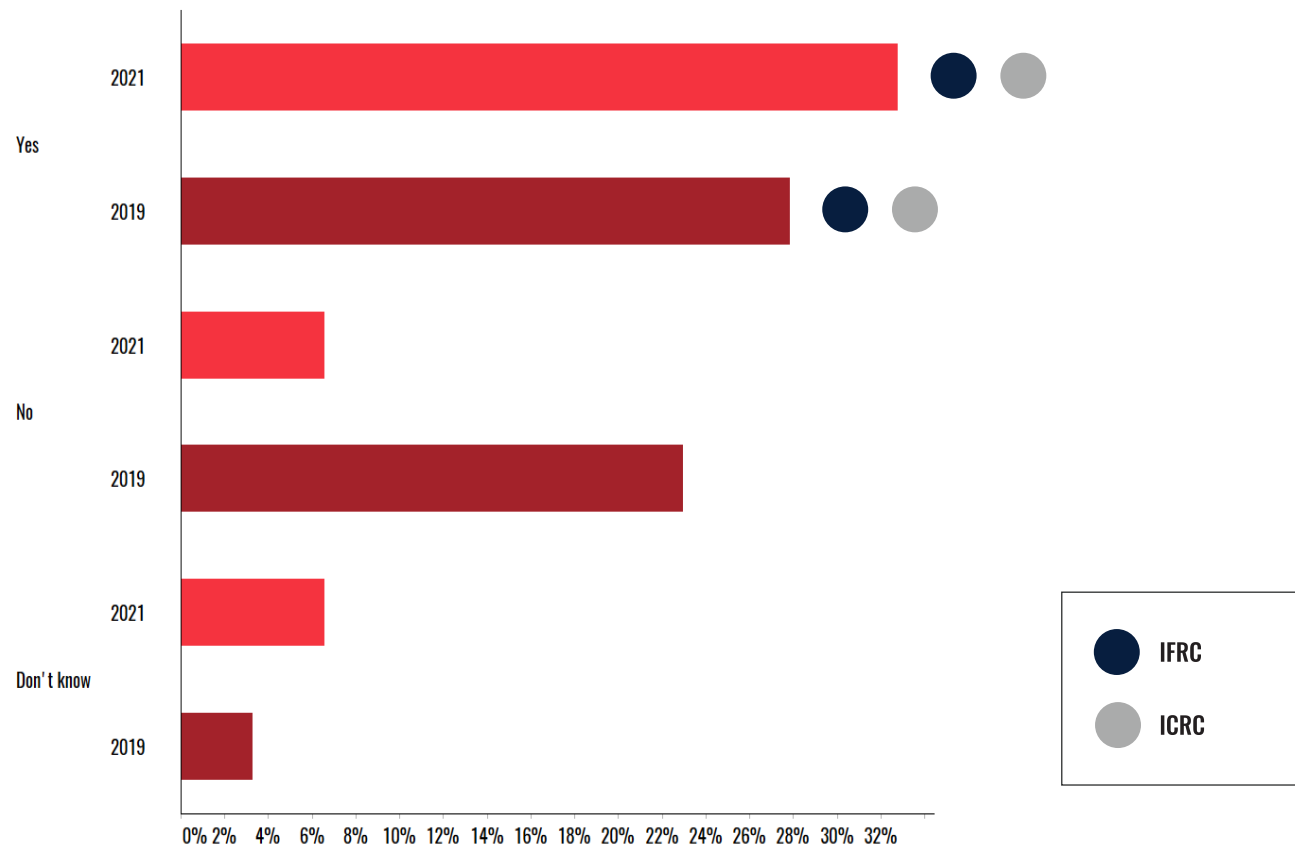


Figure 2: Provision of mental health and/or psychosocial support is a focus in the strategy

Provision of psychosocial support (PSS) activities

When looking solely at PSS activities, close to every respondent (97%) that participated in the survey (26 NS, the IFRC and the ICRC) reported having carried out at least one activity defined as psychosocial support in the last year. In 2019, 94% of respondents (31 NS, the IFRC and the ICRC) carried out PSS activities.

The different PSS activities are shown in figure 3. Figure 3 includes a comparison of the activities carried out by the NS, the IFRC and the ICRC in 2019 and 2021. The top three activities in 2019 were the following:

- psychological first aid (PFA) (77%: 26 NS and the IFRC)
- activities linked to restoring family links (69%: 23 NS and the ICRC)
- community events (66%: 22 NS and the IFRC)

In 2021, the three most utilized activity approaches were:

- psychological first aid (PFA) (90%: 25 NS and the IFRC)
- caring for staff and volunteers (79%: 22 NS and the IFRC)
- awareness campaigns (79%: 16 NS, the IFRC and the ICRC)

Figure 4 shows a comparison of the target groups for these activities for 2019 and 2021. Most respondents have focused on supporting volunteers in 2019 and 2021 (79%: 22 NS and the IFRC). The second most and third most targeted groups are staff (62%: 17 NS and the IFRC) and adolescence (65%: 16 NS and the IFRC).

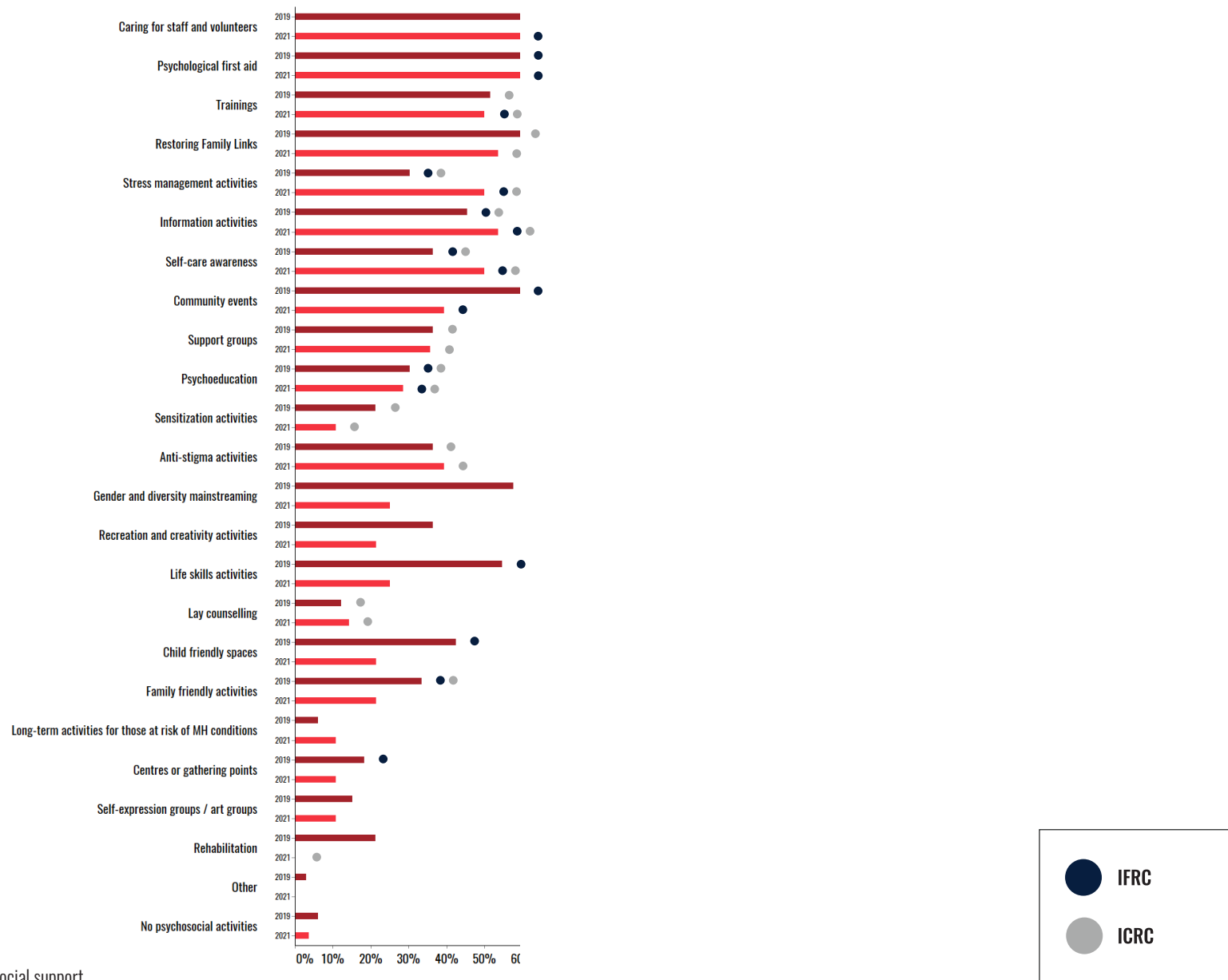


Figure 3: Provision of psychosocial support

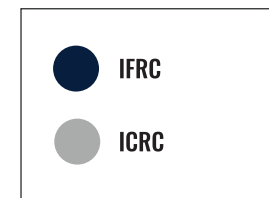


Figure 4: Groups targeted for psychosocial support activities

Provision of mental health (MH) activities

Turning to MH activities carried out in the past year, 83% of respondents (22 NS, the IFRC, and the ICRC) in comparison to 74% of respondents (24 NS, the IFRC and the ICRC) in 2019, report that they have provided at least one activity defined as a MH activity.

The different MH activities are shown in figure 5. The most frequent activity is psychological support (63%: 16 NS and the ICRC in 2021, compared to only 6%: one NS and the ICRC in 2019). This type of activity has risen significantly in the last two years. The second most frequent type of mental health activity in 2021 is the provision of training of community actors and of health staff in basic psychological support (48%: 12 NS, the IFRC and the ICRC). This is followed by 42% of respondents providing counseling (10 NS and the ICRC), following the global ranking of the provision of MH activities.

Volunteers (62%: 17 NS and the IFRC) by 70% and staff by 30% (48%: 13 NS and the IFRC) rose significantly as a target group of MH services in the Asia Pacific region in 2021. In 2019, however, respondents targeted mostly adolescents (46%: 14 NS, the IFRC and the ICRC), older persons (40%: 14 NS) and children (31%: 9 NS, the IFRC and the ICRC). Please see figure 6 for more detailed information about targeted groups of MH activities.

As in 2019, 15 NS, the IFRC and the ICRC stated that they make referral(s) to more specialized mental health services such as psychiatrists and

psychologists (2019: 46%; 2021: 59%). This number includes one NS which had not carried out any mental health activities in the past year and therefore relied on referrals to other specialized MH care.



Figure 5: Provision of mental health activities in the past year

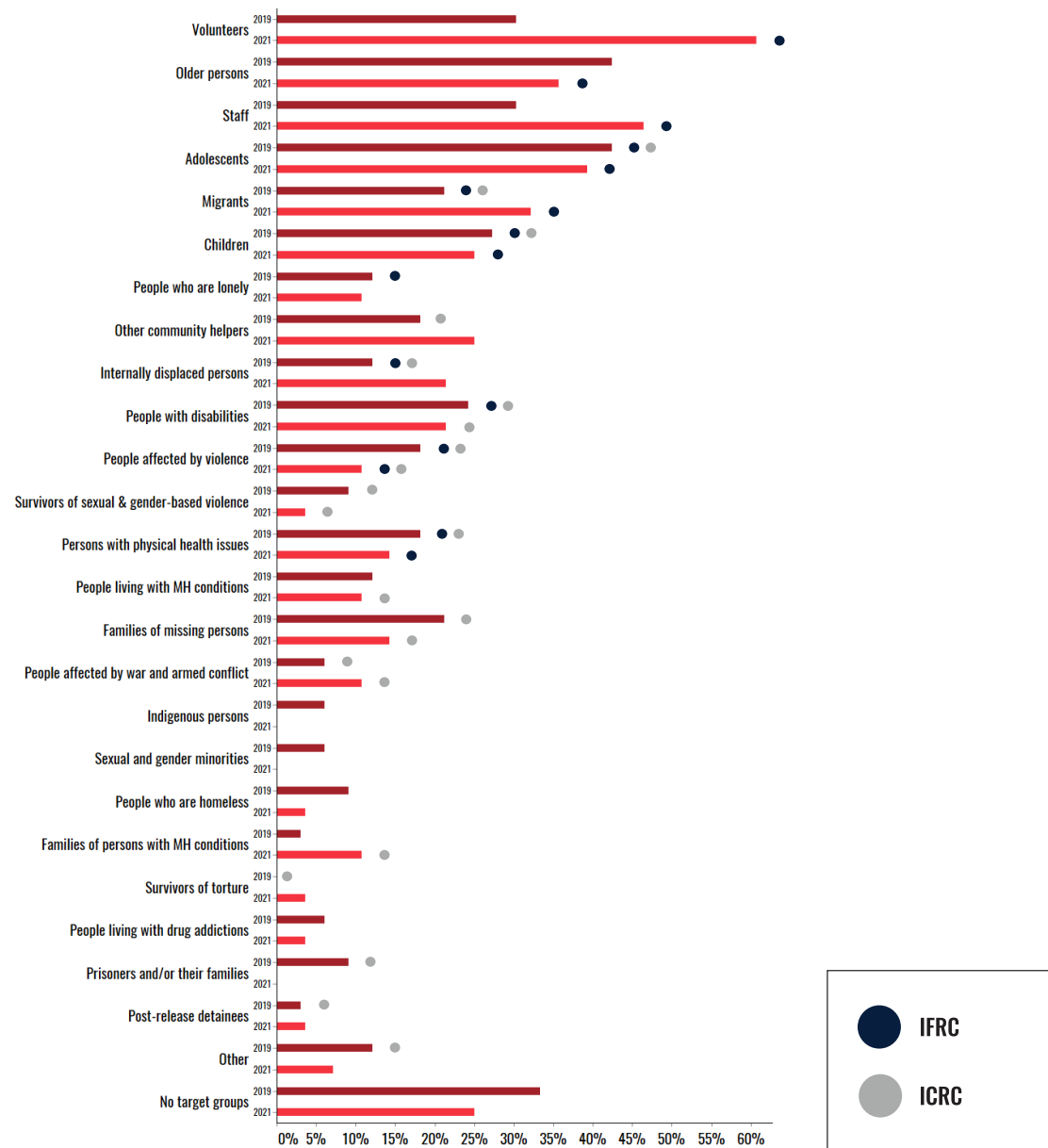


Figure 6: Groups targeted for mental health activities

Approach used when delivering MH and/or PSS services

The components of the Movement use different approaches when they deliver MH and/or PSS services: a stand-alone approach, an integrated or mainstreaming approach, or a combination of both. The survey results indicate that the Movement respondents deliver MH and/or PSS activities using all these approaches.

However, we can identify a higher preference for the integrated or mainstreaming approach in 2019 and 2021 (2019: 49% (15 NS, the IFRC and the ICRC); 2021: 38% (10 NS and the ICRC)) or a combination of that with stand-alone programmes, over the stand-alone approach on its own, as shown in figure 7.

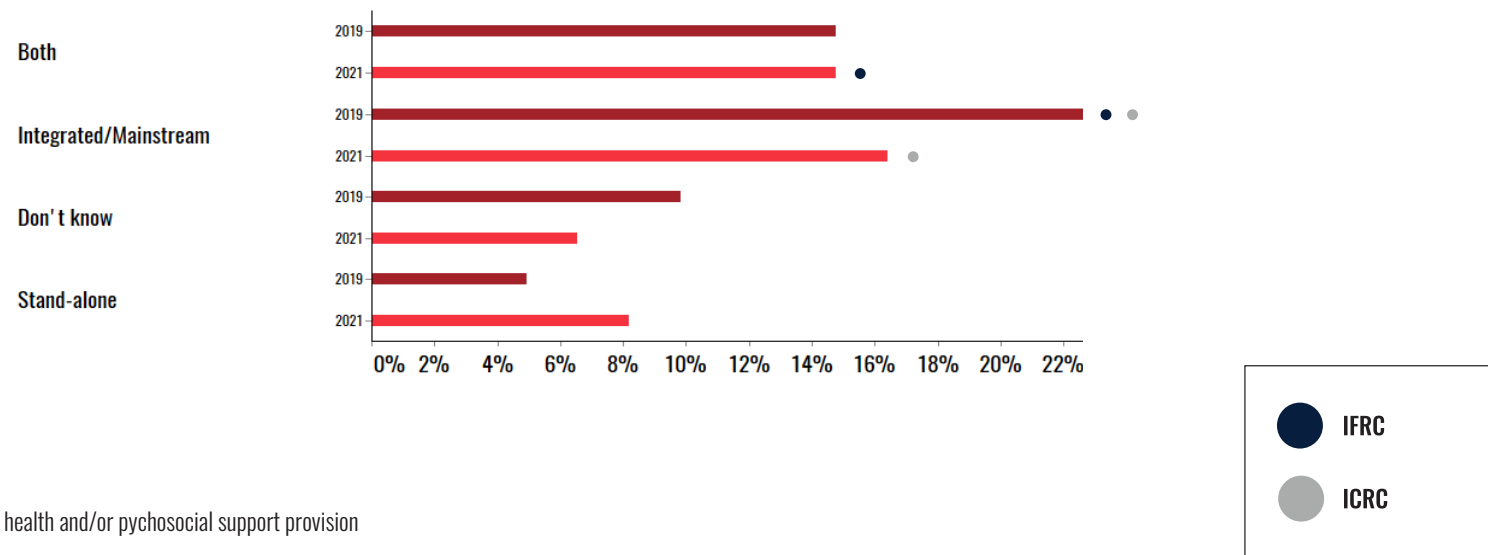


Figure 7: Approaches used in mental health and/or psychosocial support provision

Systems in place to ensure quality

The Movement invests in ensuring that quality support is provided. 48% (12 NS, the IFRC and the ICRC) of respondents, in contrast to 31% of respondents (9 NS, the IFRC and the ICRC) in 2019 have supervision mechanisms in place to ensure the quality of the MHPSS activities they provide. This is a positive development.

66% (19 NS, the IFRC and the ICRC) state that they have a system in place to monitor the MH and/or PSS activities of their organisation which

is lower than the Movement-wide average. Figure 8 shows the tools used in the Movement to monitor MH and/or PSS activities in comparison to the tools used two years ago. As in 2019 (51%: 16 NS, the IFRC and the ICRC), documenting the number of beneficiaries engaged in an activity was the most used tool in 2021 (69%: 18 NS, the IFRC and the ICRC).

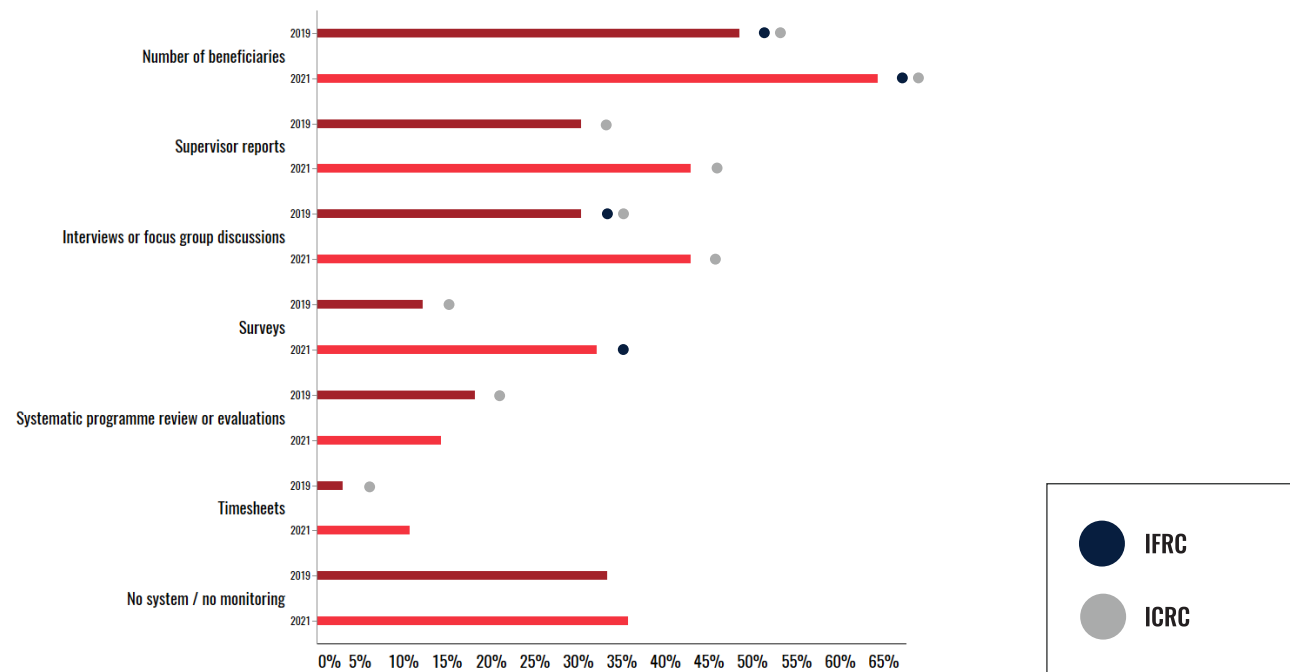


Figure 8: Type of tools/guidance used for mental health and/or psychosocial activities monitoring.

Mental health and psychosocial wellbeing of staff and volunteers

The mental health and wellbeing of staff and volunteers is critically important to the Movement. Staff and volunteers are therefore of particular focus when it comes to MHPSS activities. 80% of respondents (21 NS, the IFRC and the ICRC) indicate having systems in place to support staff and volunteers' mental health and psychosocial wellbeing (figure 10).

Most of NS and the IFRC (60%: 17 NS and the IFRC) offer staff and volun-

teers psychological support (internal and/or external) and (52%: 16 NS and the IFRC) conduct self-care activities, such as, for instance, awareness sessions, group activities, mediation practices, sports, or recreational activities.

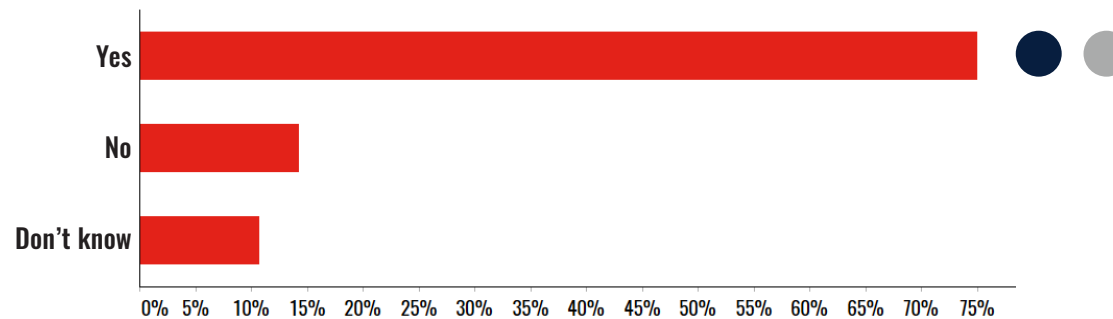
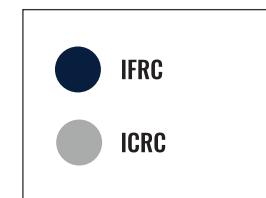


Figure 10: Components having systems in place to support staff and volunteers' mental health and psychosocial well-being



Human resources for MHPSS

The Movement has both staff and volunteers involved in MH and/or PSS activities. In 2019, 60% (19 NS, the IFRC and the ICRC) reported that they had at least one focal point for MH and/or PSS in their organisation. In 2021, however, a rise in focal points is noted with 83% of respondents (22 NS, the IFRC and the ICRC) having appointed one or more focal points. As an amendment to the survey of 2019, this year's survey more clearly defined 'focal point' as a representative of the NS which is responsible for MH and/or PSS within their NS (either alone or in collaboration with another/others) and should be appropriately resourced and enabled by the NS/Movement component that they represent.

If the NS/Movement component indicated that they had one or more focal points, they were asked which focus this person had (programming or human resources related) as an additional question in this year's survey. The result is that the majority of the focal points (59%: 13 NS, the IFRC and the ICRC), focus on both staff and volunteers' mental health and psychosocial wellbeing and MHPSS

activities and programmes, whereas 27% (6 NS) focus only on staff and volunteers' mental health and psychosocial wellbeing, and 13% (3 NS) only on MHPSS activities and programmes.

As shown in figure 11 below, 55% of respondents (15 NS and the IFRC) have less than five staff members involved in MH and/or PSS activities, while 21% (6 NS) have between 5-19, 21% (5 NS and the ICRC) have between 20-49 staff, 10% (3 NS) have between 50-99, and 3% (1 NS) have more than 100 staff involved in these activities. ICRC staff provides MHPSS specifically to conflict-affected populations.

Taking the profile and numbers of staff as a whole, the Movement has collectively close to 190 social workers, 15 psychologists, 4 psychiatrists, and more than 4.400 community health workers working in this field.

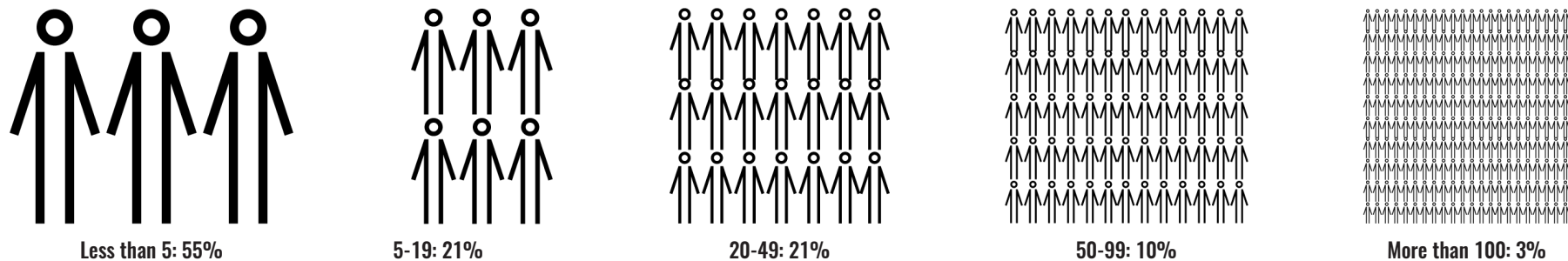


Figure 11: Staff involved in mental health and/or psychosocial support activities

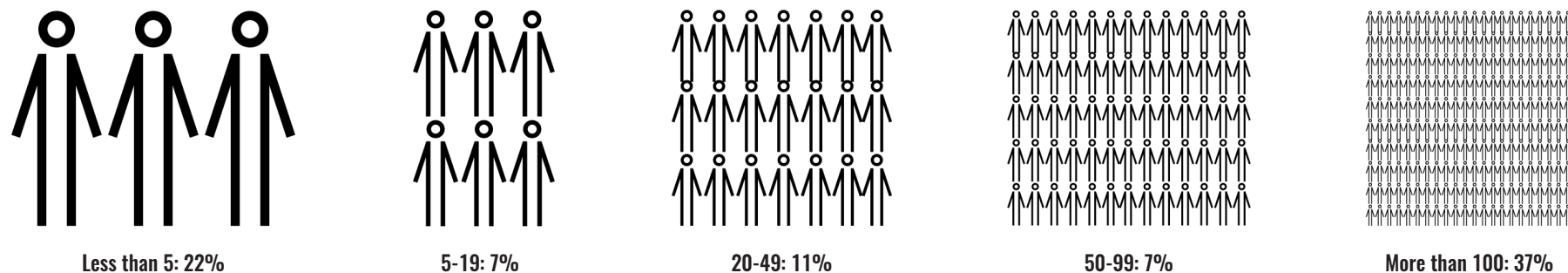


Figure 12: Volunteers involved in mental health and/or psychosocial support activities

As shown in figure 12, 22% (6 NS) have less than five volunteers involved in MH and/or PSS activities, while 7% (2 NS) have between 5-19, 11% (3 NS) have between 20-49, 7% (2 NS) have between 50-99, while the majority, 37% of respondents (10 NS), have more than 100 volunteers. The IFRC and the ICRC often collaborate with volunteers recruited through the hosting NS. In some cases, however, the IFRC and the ICRC work directly with volunteers.

The 27 NS indicated that around 3.000 social workers, 25 psychologists, 8 psychiatrists and close to 25.000 community workers work as volunteers in this field.

Collectively, among the 27 NS respondents, the IFRC and the ICRC, around 12.600 staff and volunteers are reported to having been trained in basic psychosocial support in the last year, compared to almost 11.400 staff and volunteers in 2019. As explained in the Movement's MHPSS Policy, the survey refers to basic psychosocial support as the first layer of the MHPSS

Framework, addressed through activities that promote positive mental health and psychosocial wellbeing, resilience, social interaction, and social cohesion activities within communities. Activities in this layer are often integrated into health, protection, and education sectors and should be accessible to the affected population. More information about the International Red Cross and Red Crescent Movement's MHPSS Framework can be found in the [resource library of the IFRC Psychosocial Centre](#).

Furthermore, the number of staff and volunteers trained in PFA decreased, from more than 15.400 staff and volunteers in 2019 to around 9.000 in 2021.

It should be noted that all specific numbers regarding staff and volunteers are likely to be higher than reported, as respondents typed zero in cases where the actual numbers were unknown. In the last 12 months, 59% (15 NS, the IFRC, and the ICRC) of respondents answered 'yes' to the question

whether the management and other leaders in the Movement's components (e.g. board, branches) received training focused on the importance and benefits of mental health and psychosocial wellbeing of staff and volunteers. Cited training topics included PFA, PSS during emergencies, Caring for Staff and Volunteers (some specifically mentioned in relation to COVID-19), Stress Management.

Learning resources and needs for training staff and volunteers

The Movement has developed a range of learning resources such as manuals and courses for training staff and volunteers. As seen in figure 13, more NS used generally more the learning resources developed by the IFRC Reference Centre for Psychosocial Support. The [IFRC Reference Centre for Psychosocial Support \(PS Centre\)](#) works under the framework of the IFRC and supports NS in promoting and enabling the psychosocial well-being of beneficiaries, staff and volunteers. 59% of respondents (16 NS and the IFRC) use adapted materials from the IFRC Reference Centre for Psychosocial Support. 48% (13 NS and the IFRC) indicate that they use PS Centre learning. The ICRC and 8 NS (31%) use other Movement learning resources.

There is a strong request for more technical support regarding trainings and programme/ activity guidance. 80% (22 NS, the IFRC and the ICRC) express a need for this. More than half the respondents (57%: 15 NS, the IFRC and the ICRC) indicate new trainings or tools are required to tackle specific aspects of the MHPSS activities within their organisations, especially context specific tools.

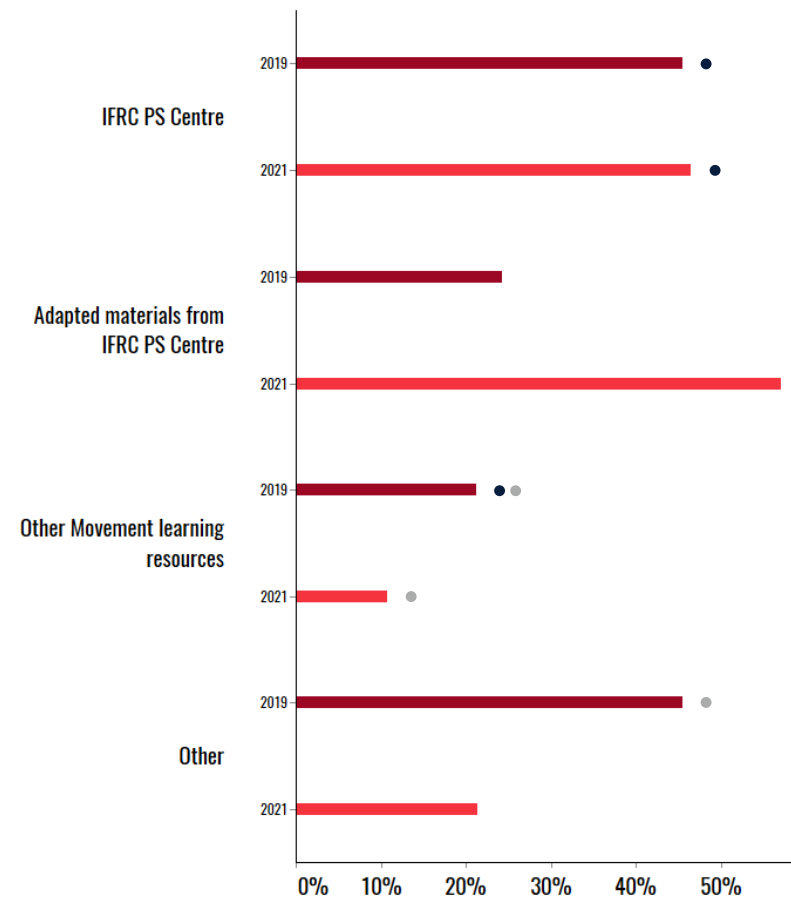
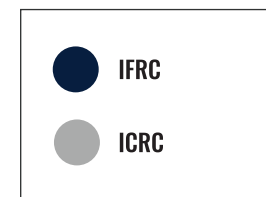


Figure 13: Learning resources used for training staff and volunteers



Budget dedicated to MHPSS

Each component of the Movement is fully independent and responsible for its own budget plan. The budget for MHPSS is therefore very diverse. 41% of respondents in 2021 (12 NS), compared to 31% of respondents (11 NS) in 2019, have no budget dedicated to MHPSS activities, representing most respondents. This may be because many activities are delivered as an integrated approach and therefore the budget is not captured specifically under MHPSS but is included in other sectors. Only one NS (3%) has a budget between 1-50.000 CHF, 7% (2 NS) have a budget between 50.001-100.000 CHF and 10% (3 NS) have a budget between 100.001-150.000 CHF. Two NS (7%; compared no NS in 2019) state that they have the largest budget indicated, CHF 150.001-200.000.

Moreover, 21% of respondents (5 NS and the ICRC), have budgets different from the indicated intervals or have budgets which are included or based on other budgets. 17% (4 NS and the IFRC) of respondents reported that they do not know what budget is held for MHPSS activities in their organisations.

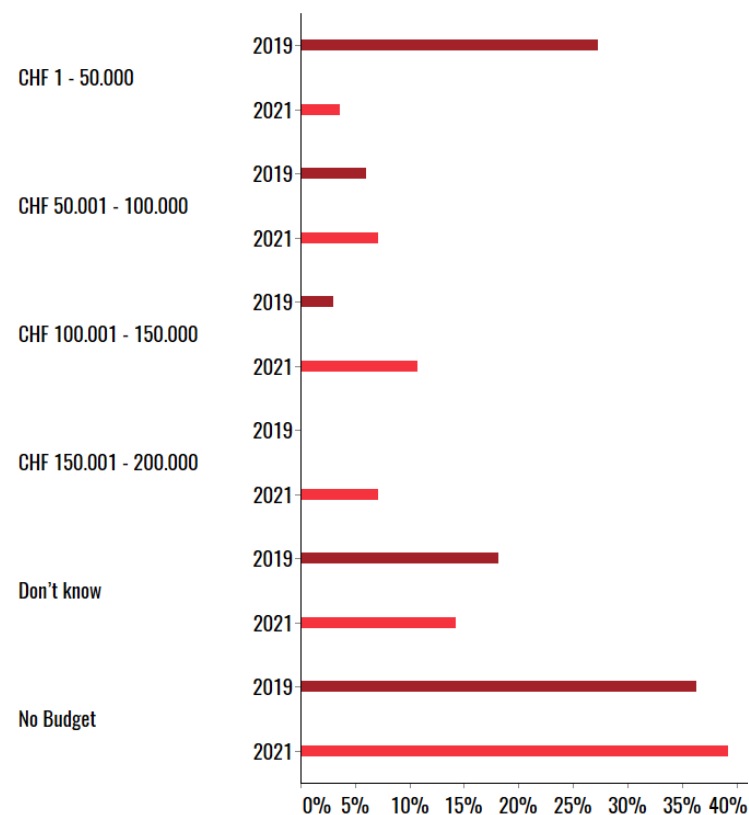


Figure 14: Annual budgets dedicated to mental health and/or psychosocial support activities

Collaboration regarding MH and/or PSS

The Movement receives support from various stakeholders and of different kind. Survey data indicate that the support received by the Movement components is mostly of a technical kind, provided particularly by the IFRC (67%), Partner National Societies (PNS) (47%), respective governments (42%) and the ICRC (39%). The second most frequent type of support is funding. NS report that the IFRC (53%), PNS (42%) and the ICRC (31%)

contribute funding to their MHPSS service delivery and programming. However, collaboration is very limited in relation to individual donors, the private sector, United Nations agencies and universities.

	Funding	Human Resources	Technical	No collaboration
ICRC	45% (13 NS)	10% (3 NS)	34% (10 NS)	28% (8 NS)
IFRC	69% (20 NS)	17% (5 NS)	72% (21 NS)	7% (1 NS, ICRC)
Partner National Societies	24% (7 NS)	3% (1 NS)	34% (10 NS)	41% (10 NS, ICRC, IFRC)
Government (e.g. ministry of social affairs, ministry of health)	17% (5 NS)	14% (4 NS)	48% (13 NS, ICRC)	28% (7 NS, IFRC)
Individual donors	17% (5 NS)	3% (1 NS)	7% (2 NS)	72% (19 NS, IFRC, ICRC)
Private sector	21% (56NS)	0% (0 NS)	7% (2 NS)	69% (18 NS, IFRC, ICRC)
United Nations Agencies	21% (6 NS)	7% (2 NS)	14% (4 NS)	62% (16 NS, IFRC, ICRC)
Universities	3% (1 NS)	17% (5 NS)	28% (7 NS, ICRC)	55% (15 NS, IFRC)

Table 2: Number of Movement components receiving support (such as funding, human resources, technical support) from various partners (such as ICRC, IFRC, Partner National Societies, Governments, individual donors, private sector, United Nations Agencies, and universities).

Challenges that hinder or have already hindered collaboration between Movement partners are reported to be the lack of funding even when an agreement is reached (48%: 14 NS), the turnover in staff involved partnerships (28%: 9 NS). Figure 15 illustrates the respondents' evaluation

of the challenges experienced and encountered when exploring collaboration possibilities.

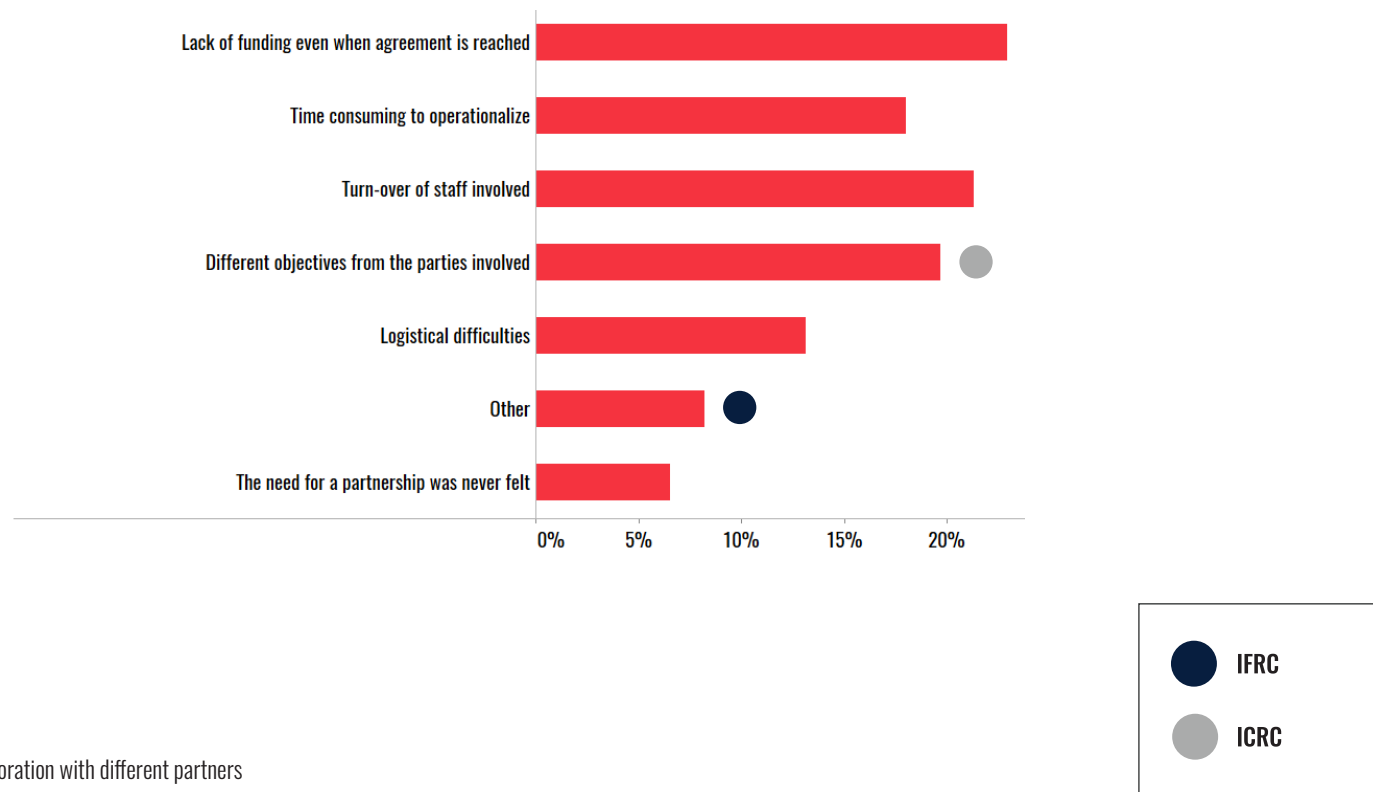


Figure 15: Type of challenges presented by collaboration with different partners

Challenges and gaps in delivering MH and/or PSS services

Budget constraints or limited budget availability are the year’s major obstacle for delivering MH and/or PSS activities in 2021, as they were in 2019. 63% of respondents (18 NS and the IFRC) in 2021, compared to 83% of respondents (28 NS and the IFRC) in 2019, indicated these as challenges, although it can be observed a decline in the number of NS stating this as a major problem. This is followed by a lack of or limited technical expertise i.e., manuals, trainings, specialists, which were also signalled as difficulties in the delivery of MH and/or PSS activities (48%: 14 NS). An overview of the different challenges can be seen in figure 16.

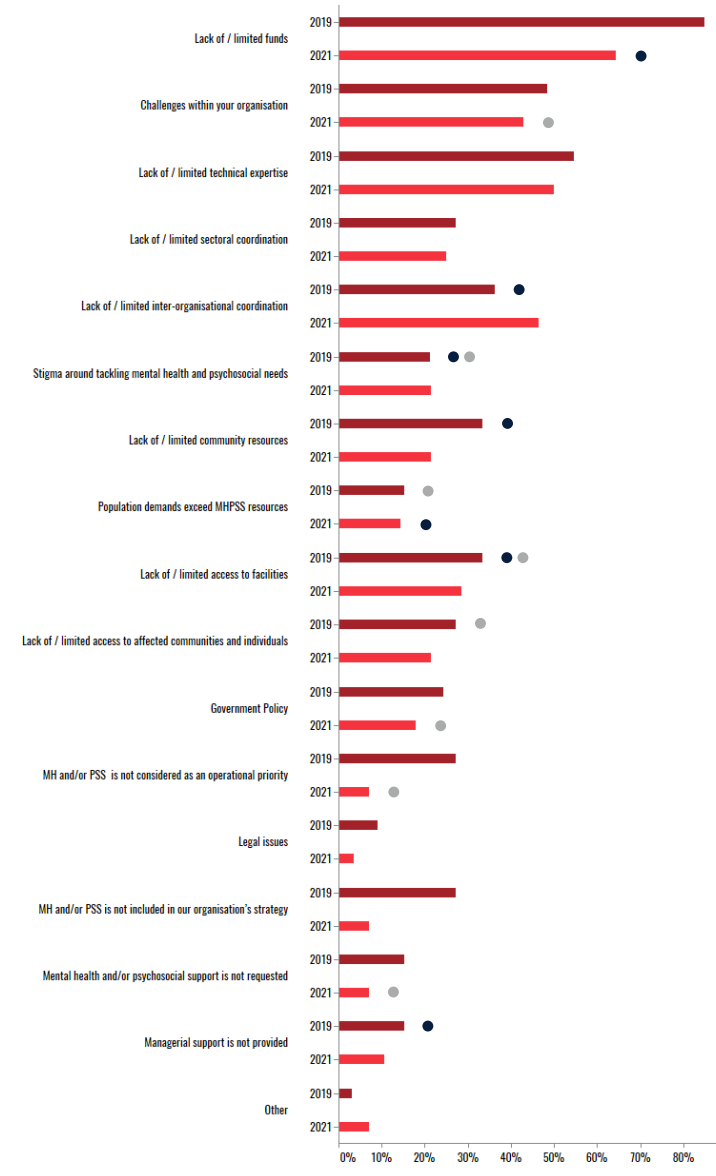
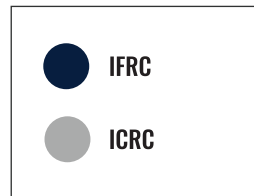


Figure 16: Perceived gaps in delivering mental health and/or psychosocial support activities

MHPSS research, advocacy and the national role

The Movement is involved in humanitarian diplomacy and research, generating awareness and funding for mental health and psychosocial support services and documenting our work to inform the development of innovative approaches.

69% of respondents (18 NS, the IFRC and the ICRC), work with humanitarian diplomacy on MHPSS related topics or issues.

In 2019, four NS and the ICRC reported that they were involved or had previously been involved in MH and/or PSS research, while in 2021, just one

NS, the IFRC and the ICRC reported engaging in MH and/or PSS research. This is lower than the global average.

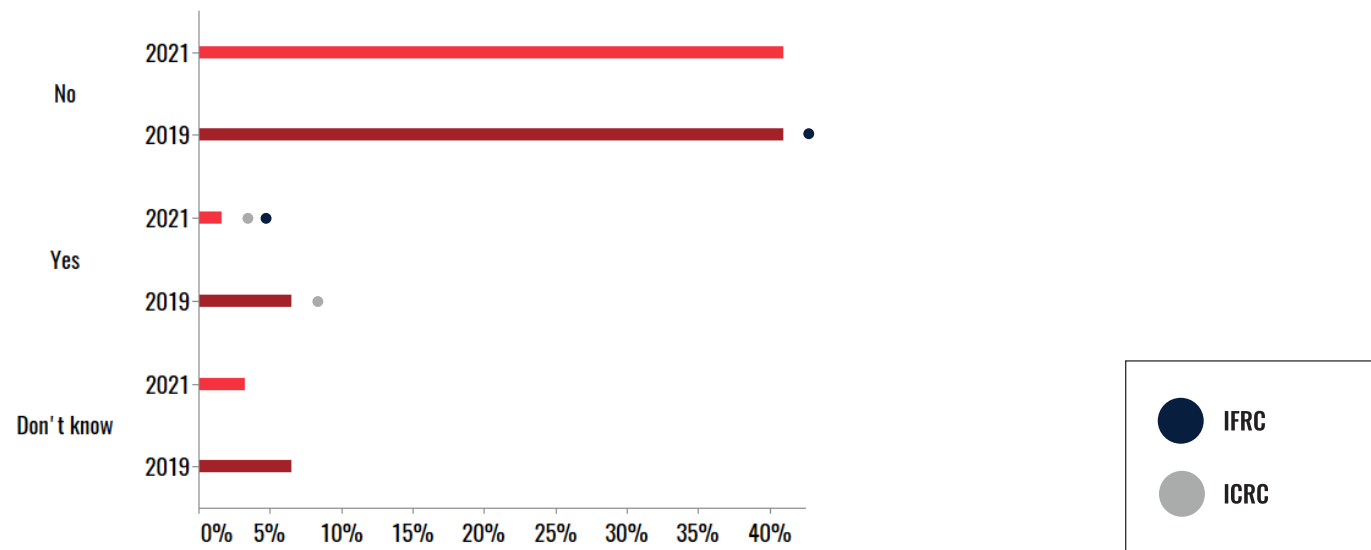


Figure 17: Involvement in mental health and/or psychosocial support research

19% of NS (5 NS) indicate that their role in providing MH and/or PSS services is mentioned in national public health laws and policies and that they have specific agreements with the public authorities (19%: 5 NS). 41% of respondent NS (11 NS) are mentioned in the national public health or disaster management plans. Most NS (52%: 14 NS) are included in inter-ministerial/departmental committees and (44%: 12 NS) are included as participants in relevant humanitarian inter-agency mechanisms.

As the NS work as auxiliaries to public authorities, it is key to understand if the public authorities recognize MHPSS as a component of their responses to disasters and emergencies. MHPSS is mentioned in pandemic preparedness and response laws, policies or plans by 11 (41% NS) governments. MHPSS is also referred to in disaster risk management laws, policies or plans by 12 (44% NS) governments, while 11 (41% NS) governments point out MHPSS in plans for response to conflicts or violence. As the IFRC and the ICRC do not have auxiliary status, this is not applicable to them.

Future plans

MHPSS activities appear to be on the rise. Around half of the respondents (13 NS, the IFRC and the ICRC) plan to expand their activities within this area, while no NS intends to reduce its MHPSS activities. 45% (13 NS) also wish to integrate or mainstream their activities, which means including MHPSS in other programme activities. This includes an increase in the number of staff and volunteers who have a basic understanding of PSS and know how to integrate the approach in their activities. 7% (2 NS) plan to maintain their level of activities in relation to MHPSS.

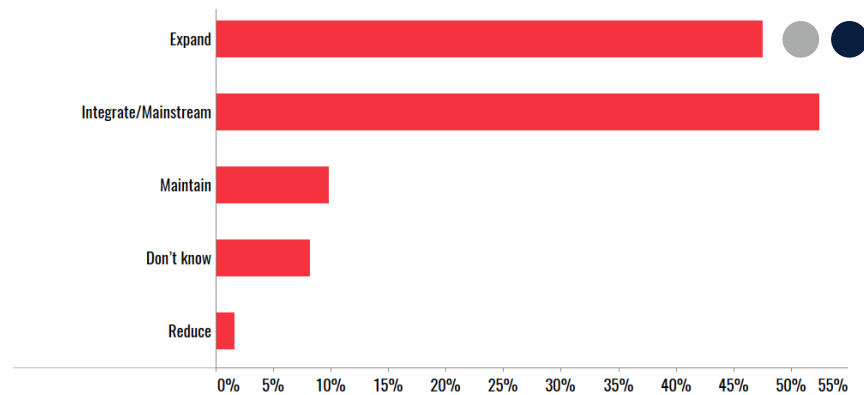
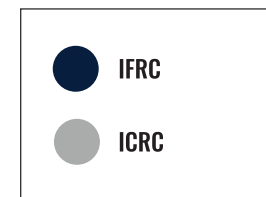


Figure 18: Future plans to expand, integrate, maintain or reduce mental health and/or psychosocial activities



Concluding remarks

Despite often limited resources and funds, the components of the Movement in Asia Pacific region are delivering a wide range of MHPSS services and activities in accordance with their respective mandates, commitments, and auxiliary roles.

The adoption of the policy on addressing mental health and psychosocial needs and resolution 2 of the 33rd International Conference “Addressing mental health and psychosocial needs of people affected by armed conflicts, natural disasters and other emergencies” provides the Movement and States with the framework, technical direction and political will to address unmet mental health and psychosocial needs. The data from the first Movement- wide MHPSS survey conducted in 2019 provided the critical baseline information against which we have been able to measure and track our progress in the operationalisation and implementation of the policy and the resolution. The report will also inform the Council of Delegates. A similar survey will be conducted by 2023 to monitor progress throughout the years of the Roadmap implementation from 2020-2023, drawing on the baseline set by the original survey of 2019.

Key takeaways:



52%

(13 NS, the IFRC and the ICRC) plan to expand their MHPSS activities



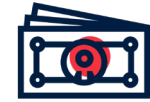
9.000

Volunteers and staff are trained in PFA



48%

(14 NS, the IFRC and the ICRC) have a system in place to ensure confidentiality and protection of personal data



63%

(123 NS, the IFRC and the ICRC) identify limited funds as a challenge



83%

(22 NS, the IFRC and the ICRC) provide MH and/or PSS activities in emergencies



59%

(15 NS, the IFRC and the ICRC) offer referral to more specialized mental health services



10%

(1 NS, the IFRC) are involved in MH and/or PSS research



66%

(19 NS, the IFRC and the ICRC) have a system in place to monitor MH and/or PSS activities



69%

(18 NS, the IFRC and the ICRC) work with MHPSS advocacy

Breakdown of Movement staff



Nearly 190 social workers



More than 25 psychologists



More than 4 psychiatrists



More than 4.400 community health workers

Breakdown of Movement volunteers



More than 3.000 social workers



More than 25 psychologists



More than 8 psychiatrists



More than 25.000 community health workers

With thanks to the following for their participation in the survey:

Afghan Red Crescent Society

Micronesia Red Cross

Vanuatu Red Cross Society

Australian Red Cross

Mongolian Red Cross Society

International Federation of the Red Cross and Red Crescent Societies (IFRC) Asia Pacific Region

Bangladesh Red Crescent Society

Nepal Red Cross Society

International Committee of the Red Cross and Red Crescent Societies (ICRC) Asia Pacific Region

Brunei Darussalam Red Crescent Society

New Zealand Red Cross

Cambodian Red Cross Society

Pakistan Red Crescent

Cook Islands Red Cross

Palau Red Cross Society

Fiji Red Cross Society

Philippine Red Cross

Indian Red Cross Society

Singapore Red Cross Society

Japanese Red Cross Society

The Solomon Islands Red Cross

Lao Red Cross

The Sri Lanka Red Cross Society

Malaysian Red Crescent Society

Timor-Leste Red Cross Society

Maldivian Red Crescent

Tonga Red Cross Society

Marshall Islands Red Cross

Tuvalu Red Cross Society

Annex

Working Groups & their Priority Action Areas	Working Group Co-Leads (status October 2021)	Changes to the survey 2021 compared to the initial survey 2019
<p>Working Group 1</p> <p>Priority Action Area 1: Guarantee a basic level of psycho-social support and integrate mental health and psychosocial support across sectors</p>	<p>British Red Cross: Sarah Davidson</p> <p>IFRC PS Centre: Sarah Harrison</p>	<p>Initial question (2019): Are there one or more focal points for mental health and/or psychosocial support within your organisation?</p> <p>Addition to initial question is a definition of ‘Focal Point’: “A Focal Point should represent the National Society and be responsible for mental health and psychosocial support within their National Society (either alone or in collaboration with another/others). The focal point should be appropriately resourced and enabled by the NS/ Movement component that they represent.”</p> <p>Question added to the survey: Please indicate their focus (and select all that apply for all of the focal points you have):</p> <ol style="list-style-type: none"> 1. MHPSS activities and programmes 2. Staff and volunteers’ mental health and psychosocial wellbeing. <p>Initial question (2019): How many volunteers and staff are trained in basic psychosocial support?</p> <p>Addition to initial question is a definition of ‘basic psychological support’: “Basic psychosocial support – the first layer of the pyramid – promotes positive mental health and psychosocial wellbeing, resilience, social interaction and social cohesion activities within communities. Activities in this layer are often integrated into health, protection and education sectors and should be accessible to 100% of the affected population, where possible. Examples of activities include psychological first aid (PFA) and recreational activities. Basic psychosocial support can be provided by trained Red Cross and Red Crescent staff and volunteers and/or trained community members.”</p>

Working Group 2

Priority Action Area 2:
Develop a holistic MHPSS approach
between Movement components and in
collaboration with other actors

Danish Red Cross:
Louise Steen Kryger

ICRC:
Douglas Khayat Araujo
Siqueira

Initial question (2019): If your mental health and/or psychosocial activities receive support, please specify from whom:

Questions added to the survey:

Does your organisation work in collaboration (this includes operational support, technical support and any form of coordination activities in the field) regarding MHPSS with other partners?

	Funding	Human Resources	Technical	Other	No collaboration
ICRC					
IFRC					
Partner National Societies					
Government (e.g. ministry of social affairs, ministry of health)					
Individual donors					
Private sector					
United Nations Agencies					
Universities					
Other					

What are the challenges that may (or have already) hinder collaboration between Movement partners (i.e. jointly develop and implement activities) – please select all that apply:

1. Time consuming to operationalize
2. Different objectives from the parties involved
3. Turnover of staff involved
4. Lack of funding even when an agreement is reached
5. Logistical difficulties
6. The need for a partnership was never felt
7. Other _____

Working Group 3

Priority Action Area 3:
Protect and promote the mental health
and psychosocial wellbeing of staff and
volunteers

Swedish Red Cross:
Maite Zamacona

IFRC HR:
Ines Hake

Questions added to the survey:

In the past 12 months, have management and other leaders in your organisation (e.g., board, branches) received training on the importance and benefits of mental health and psychosocial wellbeing of staff and volunteers? If yes, indicate what training they have received (at minimum one hour):

1. Yes _____
2. No
3. Don't know

Does your organisation have ways to support staff and volunteers' mental health and psychosocial wellbeing?

1. Yes _____
2. No
3. Don't know

Indicate which systems are in place:

1. Self-care activities (e.g., awareness sessions, group activities, meditation practices, sports or recreational activities, etc)
2. Peer-to-peer support (e.g., peer support groups, buddy systems)
3. Psychological support (e.g., it can be both internal and external)
4. Referral systems (e.g., supervision mechanisms for monitoring and/or directing staff and volunteers to the appropriate support groups/focal point)
5. Self-care trainings and capacity building (e.g., trainings or tools to tackle specific aspects of the MHPSS activities within your organisation)
6. Other _____

Working Group 4

Priority Action Area 4:
Demonstrate the impact of MHPSS interventions through research, evidence, monitoring and evaluation

Swiss Red Cross:
Monia Aebersold

IFRC PS Centre:
Michelle Engels

Questions added to the survey:

What are the reasons for why your organisation does not have a system in place to monitor your mental health and/or psychosocial support activities in your organisation? Please select all that apply:

1. Lack of / limited funds
2. Lack of planning (e.g. not including monitoring and evaluation plans at the beginning of the project/activities)
3. Lack of staff who can collect data
4. Lack of staff who can analyse data
5. Lack of suitable tools
6. Lack of / limited technical expertise (e.g. to identify manuals, trainings, specialists)
7. Monitoring mental health and psychosocial support activities is not seen as a core priority for the organisation
8. Monitoring and evaluation is not requested
9. Practical monitoring and evaluation support is not provided
10. Legal issues (e.g. data protection and information security)
11. Other _____

What resources/guidance does your organisation use to monitor mental health and psychosocial support activities?

Please select all that apply:

1. IFRC Reference Centre for Psychosocial Support 'Monitoring and Evaluation Framework for Psychosocial Support Interventions – Toolbox / Indicator Guide'
2. ICRC 'Guidelines on Mental Health and Psychosocial Support'
3. IASC 'Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings'
4. IASC 'Mental Health and Psychosocial Support Assessment Guide'
5. WHO & UNHCR 'Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings'
6. IFRC 'Project/Programme Monitoring and Evaluation Guide'
7. We do not use any of the above listed resources/guidance (please specify why not and select all that apply):
8. We use other existing guidance/resources, please specify: _____

Working Group 5

**Priority Action Area 5:
Strengthen resource mobilization for
MHPSS in humanitarian response**

and

**Priority Action Area 6:
Mobilize political support for MHPSS –
humanitarian diplomacy and advocacy**

Danish Red Cross:
Jakob Harbo

ICRC/POL
Barbara Jackson

IFRC PSK:
Joy Muller

Questions added to the survey:

Is your organisation's role in providing MH and/or PSS services expressly recognized by:

1. Mention in national public health laws or policies?
 Yes No Don't know
2. Mention in national public health or DM plans?
 Yes No Don't know
3. Specific agreements with the public authorities?
 Yes No Don't know
4. Inclusion of the NS as a participant in inter-ministerial/departmental committees of your government that handle this issue?
 Yes No Don't know
5. Inclusion of the NS as a participant in relevant humanitarian inter-agency mechanisms (e.g. clusters, technical working groups) that handle this issue?
 Yes No Don't know

Is the role of MHPSS specifically mentioned in:

1. Your government's pandemic preparedness and response laws, policies or plans?
 Yes No Don't know
2. Your government's disaster risk management laws, policies or plans?
 Yes No Don't know
3. Your government's plans for response to conflicts or violence?
 Yes No Don't know
4. Any other plans? Please specify: _____