

Guidance

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCY SETTINGS

Monitoring and Evaluation with Means of Verification: Version 2.0

IASC Reference Group on Mental Health and
Psychosocial Support in Emergency Settings

September 2021

Endorsed by the IASC Operational Policy and Advisory Group
(OPAG)

The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings

WITH MEANS OF
VERIFICATION
(VERSION 2.0)



Acknowledgements



Content of the original 2017 field test publication was developed by the IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (IASC MHPSS RG). Development of the original publication was managed by the United Nations Children's Fund (UNICEF) and produced by a thematic working group of member agencies of the Reference Group, including World Vision International, the World Health Organization (WHO), Johns Hopkins University (JHU), the Peter C. Alderman Foundation, the International Federation of Red Cross and Red Crescent Societies (IFRC), MHPSS.net and War Trauma Foundation (now ARQ National Psychotrauma Centre).

The content of the current publication, including the selection of tools and guidance for means of verification (MoV), was also developed by the IASC MHPSS RG. The update was managed by WHO and was overseen by a thematic working group of member agencies of the Reference Group, including Action Contre la Faim (ACF), Church of Sweden / ACT Alliance, Américas, ARQ National Psychotrauma Centre, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Humanity & Inclusion (HI), the IFRC Psychosocial Centre, International Medical Corps (IMC), the International Organization for Migration (IOM), Johns Hopkins University (JHU), Medair, Médecins du Monde (MdM), Médicos del Mundo (MdM), Médecins Sans Frontières (MSF), the MHPSS Collaborative, Save the Children, Terre des Hommes (TdH) and UNICEF.

Through consultation and peer review processes, valuable inputs to the common framework and its update were also received from IASC MHPSS RG agencies and from additional organisations, academic partners and other stakeholders.

The IASC MHPSS RG acknowledges and thanks Dr Alison Schafer for managing both the initial development of this framework and its revision.

For communication and to provide feedback on this publication, please email the IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings at: <mhpss.refgroup@gmail.com>.

Suggested citation:

Inter-Agency Standing Committee (IASC), The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0), IASC, Geneva, 2021.

Translations

The Reference Group itself will coordinate translation into Arabic, Chinese French, Russian, and Spanish. Contact the IASC Reference Group for Mental Health and Psychosocial Support (MHPSS) (mhpss.refgroup@gmail.com) for coordination of translations in other languages. All completed translations will be posted on the IASC Reference Group for MHPSS website. If you create a translation or an adaptation of this Work, kindly note that:

- » You are not allowed to add your logo (or that of a funding agency) to the product.
- » In case of adaptation (i.e., changes in the text or images), the use of the IASC logo is not permitted. In any use of this Work, there should be no suggestion that IASC endorses any specific organisation, products or services.
- » You should license your translation or adaptation under the same or equivalent Creative Commons license. CC BY-NC-SA 4.0 or 3.0 is suggested. This is the list of compatible licenses: <https://creativecommons.org/share-your-work/licensing-considerations/compatible-licenses>
- » You should add the following disclaimer in the language of the translation: "This translation/adaptation was not created by the Inter-Agency Standing Committee (IASC). The IASC is not responsible for the content or accuracy of this translation. The original English edition "Inter-Agency Standing Committee, The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0), Licence: CC BY-NC-SA 3.0 IGO shall be the binding and authentic edition."

©IASC, 2021. This publication was published under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO license (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>). Under the terms of this licence, you may reproduce, translate and adapt this Work for non-commercial purposes, provided the Work is appropriately cited.

Contents

.....		ANNEX 2	Systematic process for the selection of means of verification.....	55
CHAPTER 1	Introduction.....	ANNEX 3	Adapting an existing MoV.....	57
CHAPTER 2	Why is monitoring and evaluation important?.....	NOTES ON ANNEXES 4-7.....		60
CHAPTER 3	Using a shared language.....	ANNEX 4	Sample framework for providing emergency supplies in response to an earthquake.....	61
CHAPTER 4	The common framework goal and outcomes.....	ANNEX 5	Sample framework for a programme to protect and support women affected by or at risk of sexual violence.....	62
CHAPTER 5	A description of the framework outcomes and indicators.....	ANNEX 6	Sample framework for children's informal education programme.....	63
CHAPTER 6	Practical guidance for using the common framework.....	ANNEX 7	Sample framework for a health programme to provide care for people with mental health conditions in primary health clinics.....	64
CHAPTER 7	Reviewing programme design with the common framework.....	ANNEX 8	Summary of recommended quantitative MoV.....	65
CHAPTER 8	Selecting a means of verification (MoV).....	ANNEX 9	Summary of recommended qualitative MoV approaches.....	106
CHAPTER 9	Establishing plans and procedures for data collection.....	ANNEX 10	Sample adaptation/translation monitoring form.....	118
CHAPTER 10	Reporting data.....	ANNEX 11	Glossary of terms used in monitoring and evaluation.....	119
CHAPTER 11	Sharing results and lessons learned.....	ANNEX 12	Quantitative measurement gaps and limitations warranting further research.....	121
CHAPTER 12	Conclusion.....	REFERENCES		122
ANNEX 1	Academic reviews to support development of the common framework.....			

Introduction

This document provides guidance on the assessment, research, design, implementation and monitoring and evaluation of mental health and psychosocial support (MHPSS) programmes in emergency settings. Although designed specifically for emergency contexts (including protracted crises), the framework may also be applicable for the transition phases from emergency to development (including disaster risk reduction initiatives). The framework assumes familiarity with the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings¹ and an understanding of programming in humanitarian relief and/or development.

Mental health and psychosocial support refers to any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. Therefore, the common framework described in this publication is important for any emergency or development personnel who are directly or indirectly engaged in programmes that aim to influence the mental health and psychosocial well-being of others. This may include (but is not limited to) mental health professionals, child protection actors or educators, health providers, nutritionists, faith communities or programme managers and practitioners engaged in initiatives such as peacebuilding, life skills or vocational learning.

The field of mental health and psychosocial support in humanitarian settings is advancing rapidly, with various MHPSS activities now forming part of standard humanitarian responses. In 2007, the Inter-Agency Standing Committee released the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, which have been widely used to guide MHPSS programmes in many humanitarian contexts. At the same time, rigorous research that evaluates the effectiveness of specific MHPSS activities is increasingly being published.

However, the wide variation of goals, outcomes, indicators and means of verification (MoV) for the many MHPSS projects being implemented in different humanitarian

settings has led to difficulties in demonstrating their value or impact.² To address this challenge, a common monitoring and evaluation (M&E) framework was developed in 2017, to supplement the IASC guidelines. This revised version of the M&E framework now includes guidance and tools to support measurement of the six goal impact indicators previously identified.



HOW THE COMMON FRAMEWORK WAS DEVELOPED

The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings was developed through a process of academic, expert and regional- and country-level reviews. These included a literature review on frequently measured MHPSS constructs;³ an expert panel and consultation on a draft framework and key terms; regional- and country-level consultations in humanitarian settings in Africa, Asia and the Middle East; an in-depth review of commonly used indicators and measurement tools;⁴ and multiple peer reviews to establish consensus. Annex 1 provides details about the academic reviews undertaken and how these were applied to initial drafts of the framework.

Means of verification for the six goal impact indicators were established after literature and expert reviews. For quantitative measures, criteria relating to their accessibility, contextual relevance, ease of use, reliability and validity were assessed. Common practices and expert guidance informed the qualitative approaches included. Annex 2 provides details about the process undertaken to select the MoV cited in this framework.

The common framework does not cover every possible MHPSS initiative or every available means of verification, but it will be relevant to most MHPSS work in emergency settings.

Six core principles

All MHPSS actions undertaken during emergency response must work towards meeting six core principles outlined in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings:

01

Human rights and equity for all affected persons ensured, particularly protecting those at heightened risk of human rights violations.

02

Participation of local affected populations in all aspects of humanitarian response.

03

Do no harm in relation to physical, social, emotional, mental and spiritual well-being and being mindful to ensure that actions respond to assessed needs, are committed to evaluation and scrutiny, support culturally appropriate responses and acknowledge the assorted power relations between groups participating in emergency responses.

04

Building on available resources and capacities by working with local groups, supporting self-help and strengthening existing resources.

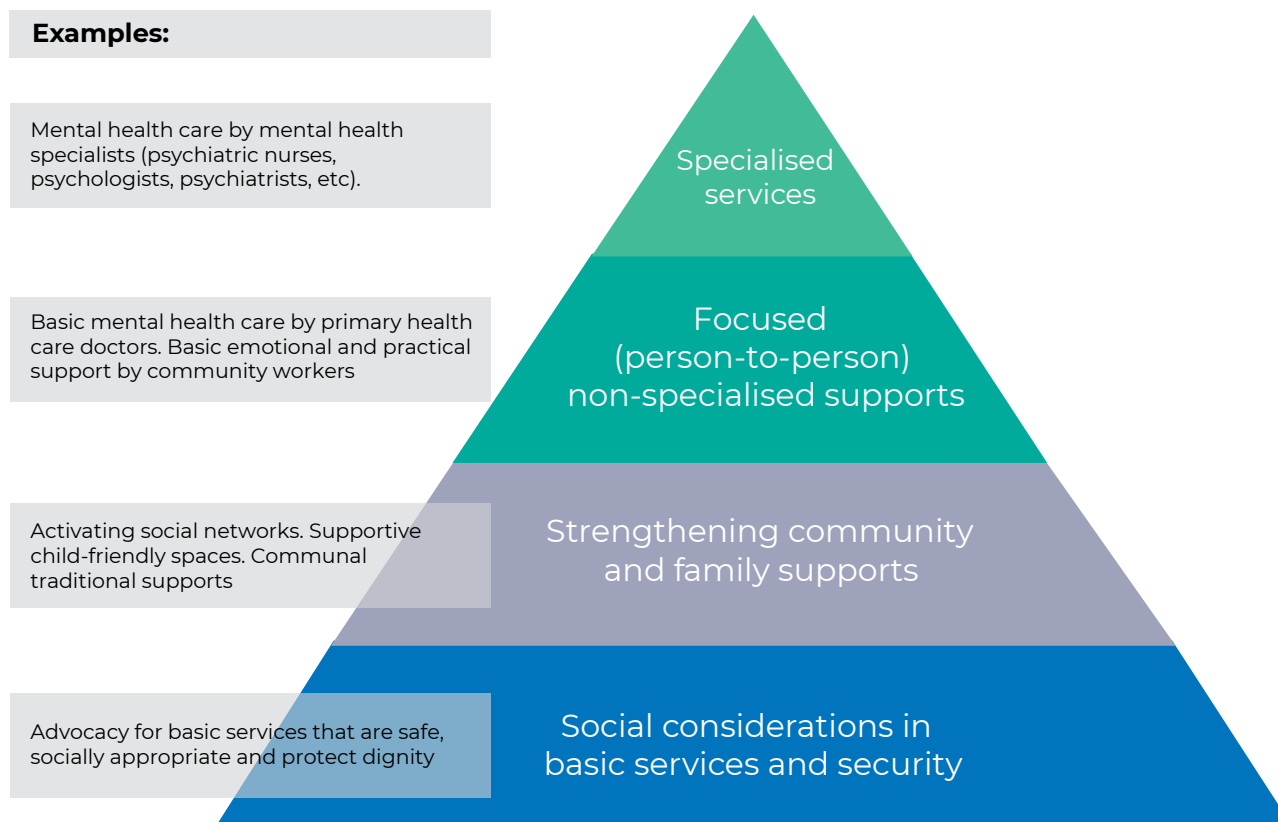
05

Integrated support systems so that MHPSS is not a stand-alone programme operating outside other emergency response measures or systems (including health systems).

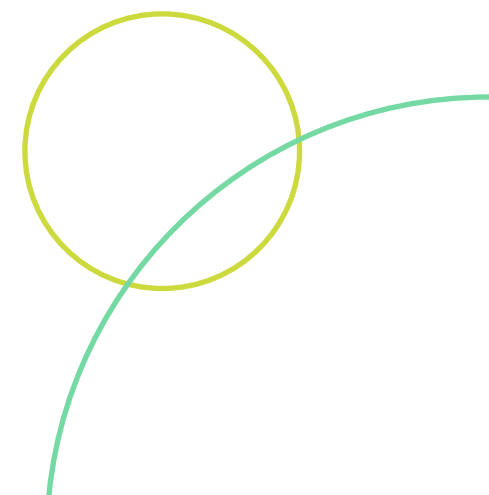
06

Multilayered supports, acknowledging that people are affected by crises in different ways and require different kinds of support. Multilayered supports are ideally implemented concurrently (though all layers will not necessarily be implemented by the same organisation). These are commonly represented by the “intervention pyramid” shown in Figure 1.

FIGURE 1
Intervention pyramid for mental health and psychosocial support in emergencies



The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings further describe a series of minimum MHPSS actions for critical work that affect the mental and psychosocial health of affected groups. The guidelines include 25 action sheets organised into 11 domains of core MHPSS activities and areas of work that require psychosocial considerations. Nearly all of these domains and action sheets are represented in this common framework. The only two areas NOT covered by this framework are the minimum responses for (1) coordination and (2) human resources. These two areas represent actions with indirect rather than direct impacts on emergency-affected populations. However, they are critical for ensuring quality MHPSS.



CHAPTER 2

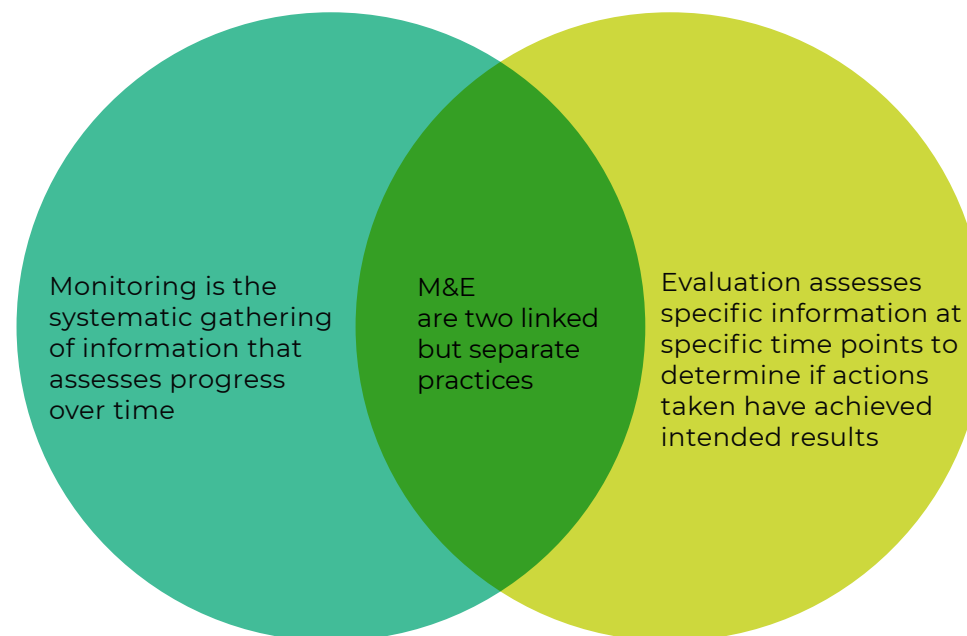
Why is monitoring and evaluation important?

Monitoring and evaluation is necessary to assess whether or not a programme, project or intervention is achieving its desired results. When done correctly, M&E uses information to demonstrate positive or negative, direct or indirect changes that have occurred and targets reached or not reached, while providing lessons for consideration in future work. M&E is also necessary for learning, contextualisation, adapting programmes and accountability. It is important that M&E information, in accessible and acceptable formats, is shared with the individuals and communities involved in the work and with others who may benefit from reviewing the results (such as other organisations, donors and national or regional government authorities). M&E is part of good humanitarian and programming practice and further contributes to meeting the core principles of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

For M&E to effectively measure status before, during and after a project, it must be built into the activities of a programme from the very beginning. An M&E framework should be included as part of any good programme design.

FIGURE 2

The differences and links between monitoring and evaluation⁵



For our purposes, “**monitoring**” refers to the visits, observations and questions we ask while a programme is being implemented to see if it is progressing as expected. One of the key issues, for example, in monitoring MHPSS programmes is to ensure that the programme is doing no harm. Monitoring can help to whether this is the case.

Similarly, “**evaluation**”, as used here, refers to examining a programme at the beginning, middle (if timing allows) and after it has been completed to see if it has achieved the desired results. Obviously, it is important to know what the desired results are in order to evaluate them.

For example, a project might aim to reduce symptoms among people with specific mental health conditions. The severity of symptoms, along with other indicators in the project (such as the number of personnel involved, risk and protective factors, or number of people in at-risk groups accessing livelihood opportunities) could be **monitored** throughout the life of the project.

Severity of symptoms may also be **evaluated** when people are first seen by service providers (baseline), at points during the project (mid-line) and at the end of the project (end-line evaluation). Additional measures are also likely at these different data collection stages.

BOX 1

USING MONITORING AND EVALUATION TO ASSESS COST-EFFECTIVENESS⁶

Currently, the field of MHPSS is underfunded. How should limited resources be spent? Decision-makers increasingly seek information on cost-effectiveness as one of various considerations when deciding how to invest scarce resources for MHPSS. “Cost-effectiveness” refers here to comparisons of (a) the financial costs of different programmes with (b) the resulting impacts of the programmes as measured by common indicators of well-being (such as changes in functioning, health or subjective well-being). It thus gives information on value for money. Currently, there is limited evidence and very little comparative work on the cost-effectiveness of any humanitarian action, including of MHPSS programmes in emergency settings. This is an important gap. Agencies are encouraged to work with welfare economists and health economists to start collecting data on cost-effectiveness, using the goal-level indicators outlined in the common framework.



CHAPTER 3

Using a shared language

Many organisations have their own M&E approaches, terminology and techniques. The language used to describe components of an M&E framework also varies. Some organisations begin their designs with an overarching “vision” or “ultimate goal”. From there, additional terms used may include “project goal” or “primary objective”, while others may use the term “project aim”. Similarly, some organisations refer to “outcomes” as “objectives”, “outputs”, “deliverables” or “activities”. “Indicators” may be called “targets”, “measures of success” or “means of verification”. These can then be divided into “impact indicators”, “outcome indicators” or even “process indicators”. Adding to the complexity of M&E in the humanitarian sector, organisations and donors also use different project design frameworks (such as various logical frameworks or theories of change) and different “levels” of detail in their designs. Organisations also differ in what elements of a project they will actually monitor or evaluate.

The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings, described in this publication, is not intended to replace existing or preferred M&E structures or approaches. Rather, the framework is organised in a simple way that will allow individuals and organisations to use its overall goal and outcomes to complement their own M&E frameworks and project-specific designs. This framework may also be viewed as a supplementary approach towards achieving more global goals, such as those outlined in the Sustainable Development Goals (SDGs) and/or the Comprehensive Mental Health Action Plan 2013–2030. **Practical information about how this common framework can be applied is outlined in Chapter 6.**

KEY TERMINOLOGY

For the purposes of this common framework, the meaning of key M&E terms can be understood as follows:⁷

Overall goal: The specific end result desired or expected to occur as a consequence, at least in part, of relevant project outcomes being achieved. Results at the level of a goal are commonly referred to as **impacts**. A portfolio of multiple programmes may be necessary to achieve an overall goal. Example: Reduced suffering in target area.

Outcomes: The changes that occur as a consequence of a specific project’s activities. Results at this level are commonly referred to as project **outcomes**. Example: People with mental health and psychosocial problems use appropriate focused care.

Activities: The actual work implemented. The common framework does not recommend specific activities. However, the activities of each organisation will need to be considered in relation to how they work towards the likely achievement of the outcome and, ultimately, the goal. **Results at the level of an activity are often referred to as outputs.** Example: Social services staff are trained in the correct procedures for MHPSS referral.

Indicators: A unit of measurement that specifies what is to be measured; indicators are intended to answer whether or not the desired impact, outcomes or outputs have been achieved. Indicators may be quantitative (for example, percentages or numbers of people) or qualitative (such as perceptions, quality, type, knowledge, capacity).

THE COMMON FRAMEWORK’S OVERALL GOAL:

Reduced suffering and improved mental health and psychosocial well-being.

KEY TERMINOLOGY CONT...

- » **Goal impact indicator:** In this framework, impact indicators are aligned with the goal statement and aim to reflect the result (or impact) of actions on a broader social, institutional (or organisational) scale. Example: Improved functioning. There are different methods of measuring impact that involve both quantitative and qualitative indicators. In this framework, impact is recognised as a change at the level of the individual and that of the collective or group.
- » **Outcome indicator:** In this framework, outcome indicators are aligned with the outcome statements and aim to reflect the changes for individuals or groups of people that have occurred as a consequence of a particular MHPSS programme or intervention. Example: Number of people who receive clinical management of mental, neurological or substance use (MNS) disorders through medical services (primary, secondary or tertiary health care).
- » **Output indicator:** In this framework, output indicators are aligned with the activity plan and aim to reflect whether the planned activity was carried out as intended. Given that output indicators are tied to specific activities, they are not covered in this overall framework. Example: Number of social services staff trained in MHPSS referral procedures.

Typically, a project will develop a logical framework (logframe) or theory of change for one or a few outcomes. However, change may be necessary across multiple projects in order to observe change in impact indicators and achieve the overall goal.

Means of verification (MoV): The tool used to measure the indicator. This might also be called a “measure” or a “measurement/assessment tool” or “data collection tool”. An MoV may result in quantitative or qualitative data. In their simplest form, quantitative measures provide numerical data, while qualitative data result in descriptive information. Both approaches are important and can provide valuable learning. Some indicators may be measured more appropriately through qualitative MoV while others may require quantitative tools. **A good M&E system should include a combination of quantitative and qualitative approaches** so that different types of information can be compared, verified and triangulated (that is, making sure that your results are telling a similar story) or so that unique results can be highlighted.

The goal and outcomes of the common framework use many other terms that could have different meanings for diverse humanitarian or development practitioners, MHPSS professionals or other implementers. For reference and to confirm the meaning of these terms as they relate to this framework, see Chapter 5. However, at the outset, it is important to confirm key terms used in the goal of the common framework, including:

Suffering:* A state of undergoing pain, distress or hardship.^{8,9}

Mental health: A state of (psychological) well-being (not merely the absence of mental disorder) in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.¹⁰

Psychosocial well-being: The psychosocial dimension of well-being. Although there is no widely agreed definition, practitioners often use the adjective “psychosocial” to describe the interaction between social aspects (such as interpersonal relationships and social connections, social resources, social norms, social values, social roles, community life, spiritual and religious life) and psychological aspects (such as emotions, thoughts, behaviours, knowledge and coping strategies) that contribute to overall well-being.

The term “mental health” is often mistakenly used merely to mean the absence of mental illness. However, the terms “mental health” and “psychosocial well-being” overlap. Mental health cannot be attained without psychosocial well-being, and vice versa. The combined term “mental health and psychosocial well-being” is often used to reflect the combined goal across diverse agencies and practitioners working on MHPSS.

* Suffering may be individual and/or collective (Kleinman, A, Das V, Lock MM, eds. Social Suffering. University of California Press, Berkeley; 1997). Individuals may suffer in unique ways and as a result of a variety of experiences, but this is usually in a wider social (or global) context that informs what suffering is; therefore, individuals may also suffer collectively in the face of certain events and social structures (for example, social, political, economic and humanitarian structures).

CHAPTER 4

The common framework goal and outcomes

Every MHPSS programme, project or activity will require its own unique M&E framework that is appropriate and relevant to its design. However, to build evidence for MHPSS globally and to demonstrate its effectiveness in emergency settings, it will be necessary for diverse MHPSS interventions to measure some common impact and outcome indicators. The goal, outcomes and related indicators in the Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings (see pages 19-22) reflect the need for further shared learning and improved MHPSS programmes in emergency responses.

It is not expected that every MHPSS initiative implemented by every organisation will report against every goal, impact or outcome indicator in the common framework. However, as use of the common framework grows, the field of MHPSS will begin building a shared language and understanding about the most appropriate practices in emergency settings.

THE FRAMEWORK'S OVERALL GOAL

The common framework's overall goal is: **Reduced suffering and improved mental health and psychosocial well-being.**

The goal comprises two important elements:

- » First, the goal to reduce suffering, which is aligned with the Humanitarian Charter's imperative "that action should be taken to prevent or alleviate human suffering arising out of disaster or conflict".¹¹
- » Second, the goal focuses on MHPSS by asserting that the aim is to improve people's mental health and psychosocial well-being.

Following core principles in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, helping to meet people's basic needs or targeting the reduction of symptoms of mental health conditions are all actions that will likely improve mental health and psychosocial well-being and/or reduce suffering. Ultimately, the goal suggests that any MHPSS programme ought to aim for improvements in mental health and psychosocial well-being of a population affected by a humanitarian crisis or reduce the ways in which they experience suffering.

GOAL IMPACT INDICATORS

- » **Functioning:** For example, the ability to carry out essential activities for daily living, which will differ according to factors such as culture, gender and age.
- » **Subjective well-being:** Aspects of subjective well-being that could be measured include feeling calm, safe, strong, hopeful, capable, rested, interested or happy, and not feeling helpless, depressed, fearful or angry.*
- » Extent of prolonged **disabling distress and/or presence of MNS disorder** (or symptoms thereof).
- » **Ability of people with mental health and psychosocial problems to cope** with problems (for example, through skills in communication, stress management, problem-solving, conflict management or vocational skills).
- » **Social behaviour:** For example, helping others, aggressive behaviour, use of violence or discriminatory actions.
- » **Social connectedness:** Referring to the quality and number of connections an individual has (or perceives to have) with other people in their social circles of family, friends and acquaintances. Social connections may also go beyond one's immediate social circle and extend, for example, to other communities.¹³

MEANS OF VERIFICATION (MOV) FOR GOAL IMPACT INDICATORS

Based on definitions of the six goal impact indicators, MoV were determined through a systematic review process and across different age ranges. Table 1 provides a summary of the recommended quantitative MoV for these indicators, while Tables 2 and 3 summarise the recommended qualitative MoV. However, selecting an MoV requires a range of important and careful considerations. Information about these steps is provided in Chapter 8. MoV-specific information, including references, links, copyright restrictions and other tips for their use is provided in Annexes 8–9.

MoV for outcome indicators are not provided or recommended in this guide, although some MoV included here may still be useful for measuring these indicators. Outcome indicators will vary depending on programme design. Information is provided in this guide about selecting appropriate MoV and adapting MoV (see Chapter 8). Many MHPSS outcome indicators do not require MHPSS-specific tools but may require access to certain kinds of information. For example, the MoV for assessing the outcome “Percentage of medical facilities, social services facilities and community programmes which have staff trained to identify mental health conditions and to support people with mental health and psychosocial problems” (O5.1) would not require specific MHPSS tools, but would require access to records that list numbers of staff for each facility with the relevant training.

THE PURPOSE OF THIS FRAMEWORK

The purpose of the common framework is to encourage the use of a select number of outcomes and indicators and the use of common tools as MoV to build the MHPSS evidence base and better inform those working in this area about important goals and impacts. To achieve this, it is recommended that each MHPSS programme or project use:

- » the overall goal of this framework;
- » at least ONE goal impact indicator; plus
- » at least ONE recommended MoV related to that goal impact indicator; plus
- » at least ONE outcome indicator from the common framework.

* “Subjective well-being” refers to all of the various types of evaluation, both positive and negative, that people make of their lives. It includes reflective cognitive evaluations, such as life satisfaction and work satisfaction, interest and engagement, and emotional reactions to life events, such as feelings of joy or sadness.¹² Various aspects of subjective well-being may be measured to reflect this goal indicator.

TABLE 1. SUMMARY OF QUANTITATIVE MEANS OF VERIFICATION (MOV)* FOR GOAL IMPACT INDICATORS BY AGE RANGE

For full details of each MoV, refer to Annex 8.**

Age range	Functioning	Subjective well-being	Disabling distress/symptoms	Coping	Social behaviour	Social connectedness
0–5	Malawi Development Assessment Tool (MDAT)		MSF PSYCa (6–36 months)		Malawi Development Assessment Tool (MDAT)	Malawi Development Assessment Tool (MDAT)
	Early Child Development Index and Family Care Indicators in MICS		MSF PSYCa (3–6 years)		Early Child Development Index and Family Care Indicators in MICS	
	Impairment Rating Scale (IRS)					
6–11	Impairment Rating Scale (IRS)	Stirling Children's Wellbeing Scale (SCWBS)	Child Psychosocial Distress Screener (CPDS)	Child Hope Scale (CHS)	Strengths and Difficulties Questionnaire (SDQ)	Social Connectedness Scale – Revised (SCS-R)
			Strengths and Difficulties Questionnaire (SDQ)	Child Youth Resilience Measure (CYRM)	Concern for Others Scale	Social Support Inventory Scheme (SSIS)
			Revised Child Anxiety and Depression Scale-25 (RCADS-25)***			

* The majority of developers of the measures included in this framework were contacted and asked 1) to give their permission and approval for the inclusion of the measure and 2) to provide guidance on descriptions of its use. However, despite genuine and repeated attempts, in some instances the original developer(s) could not be reached and permission and guidance were not obtained. In these instances, measures are included here and described in line with published guidance on their use.

** Means of verification (MoV) included in this table were identified and evaluated through consultations with content experts as well as reviews of relevant literature. These measures may not represent the entirety of appropriate assessment tools available across each domain and also may not be relevant in every context. Organisations are not required to use only these specific MoV; rather, these are presented as options. Users are also encouraged to use locally validated MoV where available or to adapt existing MoV.

*** Some of the MoV recommended in this framework (e.g., PHQ-9, GAD-7, PCL-5, RCADS-25, AUDIT, ASSIST) are self-report measures of clinical constructs. These measures are not recommended as a way to estimate exact prevalence of mental health conditions (i.e. how many people have a condition in a population). Studies have shown that self-report measures commonly overestimate rates of mental health conditions.^{14,15,16} They are included here because they may be useful for giving an approximate indication of an MHPSS programme's or project's impact on distress, such as depressive, anxiety and post-traumatic stress symptoms. As mentioned elsewhere in this guide, users of these MoV should give due attention to evidence for validity in the local or in similar contexts before using these measures.

The RCADS-25 was developed for use with children and adolescents 8 years and older.

Age range	Functioning	Subjective well-being	Disabling distress/symptoms	Coping	Social behaviour	Social connectedness
12–17	Impairment Rating Scale (IRS)	Stirling Children's Wellbeing Scale (SCWBS)	Child Psychosocial Distress Screener (CPDS)	Child Hope Scale (CHS)	Strengths and Difficulties Questionnaire (SDQ)	Social Connectedness Scale – Revised (SCS-R)
		Short Warwick–Edinburgh Mental Well-Being Scale (SCWBS)	Strengths and Difficulties Questionnaire (SDQ)	IFRC-PIA Resilience Questionnaire	Concern for Others Scale	Social Support Inventory Scheme (SSIS)
		Basic Psychological Need Satisfaction and Frustration Scale	Alcohol Use Disorders Identification Test (AUDIT)			
			Revised Child Anxiety and Depression Scale-25 (RCADS-25)*			
18–25 26–59 60+	WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)	Basic Psychological Need and Frustration Scale (BPNFS)	Patient Health Questionnaire (PHQ-9)	Brief COPE Inventory	Aggression Questionnaire (AQ)	WHOQOL Social Relationships Subscale
	Psychological Outcome Profiles (PSYCHLOPS)	WHOQOL-BREF	Generalized Anxiety Disorder (GAD-7)	Brief Resilience Scale (BRS)	Postpartum Bonding Questionnaire (PBQ)	Multidimensional Scale for Perceived Social Support (MSPSS)
		World Health Organization Five (WHO-5) Well-Being Index	PTSD Checklist for the DSM-5 (PCL-5)**	Adult Hope Scale (AHS)	Reported and Intended Behaviour Scale (RIBS)	Neighborhood Cohesion Instrument (NCI)
		Discrimination and Stigma Scale (DISC-12)	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)		Mental Illness: Clinician's Attitudes Scale (MICA-4)	Short Adapted Social Capital Assessment Tool (SASCAT)
		Barriers to Accessing Care Evaluation (BACE)	Drug Abuse Screening Test (DAST)			Oslo 3 Social Support Scale (OSSS-3)
		Psychological Outcome Profiles (PSYCHLOPS)	Barriers to Accessing Care Evaluation (BACE)			Discrimination and Stigma Scale (DISC-12)
			Psychological Outcome Profiles (PSYCHLOPS)			

* The RCADS-25 was developed for use with children and adolescents 8 years and older.

** The PCL-5 is used to assess for symptoms of post-traumatic stress disorder (PTSD). While PTSD is included in the World Health Assembly-approved ICD-11 and is thus supported globally by governments, it is a clinical construct that captures only some aspects of the distress that emergency-affected populations experience. There tends to be an inappropriately narrow focus on PTSD in many humanitarian crises, and the concept of PTSD is often a topic of debate among humanitarian agencies, academic communities and clinicians.

TABLE 2. SUMMARY OF QUALITATIVE MOV APPROACHES AND EXAMPLE METHODS*

For full details of each MoV, refer to Annex 9.

Means of verification	Description	Example methods*
Mapping	Mapping involves drawing some aspect of an individual (e.g. a body map to identify locations of pain or distress), their community (e.g. identifying locations where children feel safe and unsafe) or their social connections (e.g. identifying social supports)	Risk and resource mapping asks participants to create maps of risks and resources in their community
		Social mapping asks participants to map their social relationships with various people in their lives
		Transect walks involve walking with participants through their location to identify areas of importance
		Body mapping includes outlining the body and identifying important areas (e.g. of pain or distress)
		Lifeline asks participants to draw a lifeline of important events and to discuss the impact of MHPSS actions
Group discussions	Community or group members are gathered together to discuss the benefit and impacts of specific interventions or projects. Specific approaches or prompts can be used to initiate conversations and collect data	Classic focus group discussions (FGDs) involve engaging group members in open-ended or semi-structured interactive conversations about topics of interest, such as projects, interventions, outcomes or indicators
		Cards/visual prompting can be used to prompt discussion around outcomes and indicators
		Ranking asks groups to rank issues or topics of interest by priority
		Free listing asks groups to identify the issues that affect them

* Multiple methods listed in Table 2 may be relevant to more than one MoV. For example, cards/visual prompting can be used in both focus group discussions and individual interviews. This is also true for many of the other example methods listed. Appendix 9 includes brief guidance and links to resources for implementing these methods. Many qualitative MoV can also be used to further investigate and contextualise quantitative MoV results.

Means of verification	Description	Example methods*
Interviews	These approaches involve interviewing participants and can be conducted using a number of different approaches	Brief ethnographic interviews can be conducted to collect and assess indicators of well-being
		Key informant interviews (KIIs) can be conducted after an MHPSS activity to assess outcomes
		Most significant change (MSC) is a systematic method of collecting stories about outcomes
		PSYCHLOPS is a structured mixed-methods tool that asks participants to rate their individual problems before, during and after an intervention
		Free listing asks participants to identify and rank issues or problems by priority
		Cards/visual prompting can be used to prompt discussion around outcomes and indicators
Observation and documentation	These approaches involve observing individuals or groups in various settings and reviewing relevant project documentation. Observation may also be used to assess implementation and adherence to intervention protocols. Structured approaches and checklists are advised to support reliability	Observation during sessions of an activity can be used to assess relevant outcomes
		Observation in the community can also be used to evaluate relevant outcomes
		Documentation analysis involves a review of project data or information to evaluate impact
Creative data-generating methods	These approaches provide unique and innovative ways to engage participants in providing information and to collect qualitative data. Interpretation of these data will require structured approaches to maximise validity and reliability	Diary entries ask participants to document their experiences in a diary that can later be analysed
		Story telling/crafting asks participants to tell a story about their experience
		Photovoice involves asking participants to document their lives through pictures

* Multiple methods listed in Table 2 may be relevant to more than one MoV. For example, cards/visual prompting can be used in both focus group discussions and individual interviews. This is also true for many of the other example methods listed. Appendix 9 includes brief guidance and links to resources for implementing these methods. Many qualitative MoV can also be used to further investigate and contextualise quantitative MoV results.

TABLE 3. SUMMARY OF QUALITATIVE MOV APPROACHES FOR GOAL IMPACT INDICATORS, BY AGE RANGE*

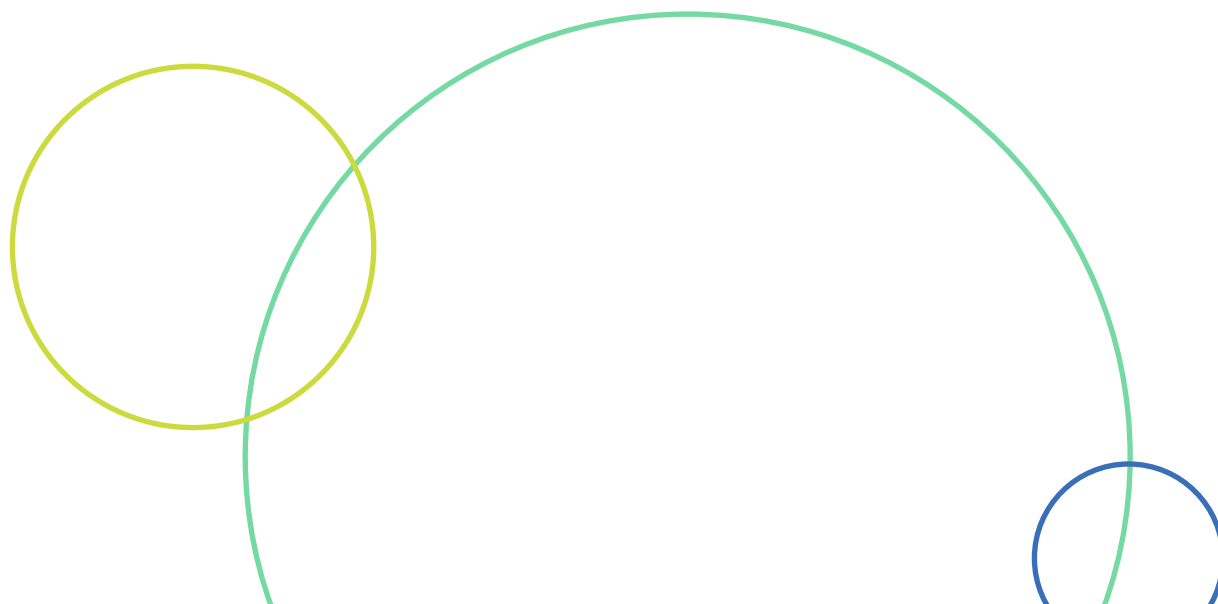
Age range	Functioning	Subjective well-being	Disabling distress/ symptoms	Coping		Social behaviour	Social connectedness	
0–5	Observations/ documentation	Storytelling	Observations/documentation	Storytelling		Observations/ documentation	Observations/documentation	
						Storytelling		
6–11	Classic FGDs	Body mapping**	PSYCHLOPS KIDS	Classic FGDs		Social mapping	Body mapping**	
	Key informant interviews	Risk and resource mapping		PSYCHLOPS KIDS	Classic FGDs	Social mapping		
		Social mapping				Transect walks		
	PSYCHLOPS KIDS	Key informant interviews		Storytelling	PSYCHLOPS KIDS	Classic FGDs		
		PSYCHLOPS KIDS	Key informant interviews					
	Observations/ documentation	PSYCHLOPS	Observations/ documentation			PSYCHLOPS KIDS	PSYCHLOPS KIDS	
		Storytelling					Observations/ documentation	Observations/ documentation
						Storytelling		
		Classic FGDs	Body mapping	Lifeline	Cards/visual prompts	Ranking		Body mapping**
	Risk and resource mapping		Free listing			Risk and resource mapping		
Brief ethnographic interviews	Social mapping				Ranking	Social mapping		
	Lifeline		Classic FGDs		Classic FGDs	Transect walks		
12–17	Most significant change	Free listing	Most significant change	Free listing		Most significant change	Free listing	
		Cards/visual prompts		PSYCHLOPS TEEN	Ranking			
		Brief ethnographic interviews			Brief ethnographic interviews	Cards/visual prompts		
		Classic FGDs		Brief ethnographic interviews	Classic FGDs			
	PSYCHLOPS TEEN	Most significant change	PSYCHLOPS TEEN	Most significant change	Observations/ documentation	PSYCHLOPS TEEN		
		PSYCHLOPS		PSYCHLOPS		Most significant change		
		Observations/ documentation		Storytelling	Observations/ documentation	Diary entries	Photovoice	Observations/documentation
				Diary entries				Diary entries
		Observations/ documentation	Storytelling	Photovoice	Photovoice	Storytelling		
						Photovoice	Photovoice	

* Qualitative MoV are shown for each goal impact indicator (as listed in Table 1) and colour-coded in line with their description in Table 2. For full details of each MoV, refer to Annex 9.

** Body mapping may also be applicable with participants aged 18+ depending on culture and context.

Age range	Functioning	Subjective well-being	Disabling distress/symptoms	Coping	Social behaviour	Social connectedness
18–25 26–59 60+	Classic FGDs	Lifeline	Lifeline	Free listing	Free listing	Free listing
				Ranking		Ranking
				Classic FGDs		Classic FGDs
	PSYCHLOPS	Ranking	Most significant change		Ranking	Brief ethnographic interviews
		Free listing		Cards/visual prompts		
					Classic FGDs	
	Most significant change			Most significant change	Brief ethnographic interviews	PSYCHLOPS
		Cards/visual prompts		PSYCHLOPS	Most significant change	Most significant change
		Brief ethnographic interviews		Brief ethnographic interviews		Diary entries
	Observations/ documentation	Most significant change	PSYCHLOPS	Observations	PSYCHLOPS	Storytelling
		PSYCHLOPS		Diary entries	Observations/ documentation	Photovoice
		Diary entries		Storytelling		Observations/documentation
		Storytelling		Photovoice	Photovoice	

Note on accessing MoV: Information for using and accessing all qualitative and quantitative tools described in Tables 1, 2, and 3 and throughout this document is provided in Annexes 8 and 9. These annexes, the accompanying tools and other guidance materials are also available on MHPSS. net at the following webpage: <https://mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit>



FRAMEWORK OUTCOMES

The common framework has identified five outcomes that would likely contribute towards realisation of the goal statement. These five outcomes can be further divided across the two levels at which MHPSS programmes are commonly implemented:

- » **Community-focused**, where MHPSS activities centre on social considerations for the provision of safety, human rights, dignity and basic needs, building community and family supports, which includes work to nurture the optimal development of children and youth, and fostering a social environment to help individuals, families and communities realise their potential. Community-focused MHPSS initiatives usually engage larger groups of children or adults, or link with systems or social or legal structures in community-based approaches.
- » **Person-focused**, where MHPSS activities centre on individuals and families who may require targeted assistance by way of specialised or non-specialised focused support. People may be receiving MHPSS interventions on an individual, family or small group basis, where implementers working on such person-focused MHPSS initiatives track service users' individual progress in some way.

The common framework is summarised in Table 4. Table 5 presents the whole framework, including the goal, outcomes and indicators. The following chapters detail how each outcome relates to one or more of the action sheets from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, provide a rationale for each outcome and offer specific information about key terms used in those outcome statements and their indicators.

TABLE 4. SUMMARY OF THE COMMON FRAMEWORK

Goal: Reduced suffering and improved mental health and psychosocial well-being			
Outcomes:			
Community-focused	1. Emergency responses do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable	2. People are safe and protected, and human rights violations are addressed	3. Family, community and social structures promote the well-being and development of all their members
Person-focused	4. Communities and families support people with mental health and psychosocial problems	5. People with mental health and psychosocial problems use appropriate focused care	
Underlying core principles: 1. Human rights and equity; 2. Participation; 3. Do no harm; 4. Integrated services and supports; 5. Building on available resources and capacities; 6. Multilayered supports			

TABLE 5.

THE COMMON MONITORING AND EVALUATION FRAMEWORK FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN EMERGENCY SETTINGS*

Overall goal	Key goal impact indicators (Gi)
Reduced suffering and improved mental health and psychosocial well-being (G)	<ul style="list-style-type: none"> Gi.1. Functioning (for example, the ability to carry out essential activities for daily living, which will differ according to factors such as culture, gender and age) Gi.2. Subjective well-being (aspects of subjective well-being that could be measured include feeling calm, safe, strong, hopeful, capable, rested, interested or happy, and not feeling helpless, depressed, anxious or angry) Gi.3. Extent of prolonged disabling distress and/or presence of mental, neurological and substance use (MNS) disorder (or symptoms thereof) Gi.4. Ability of people with mental health and psychosocial problems to cope with problems (for example, through skills in communication, stress management, problem-solving, conflict management or vocational skills) Gi.5. Social behaviour (for example, helping others, aggressive behaviour, use of violence, discriminatory actions) Gi.6. Social connectedness: refers to the quality and number of connections an individual has (or perceives to have) with other people in their social circles of family, friends and acquaintances. Social connections may also go beyond one's immediate social circle and extend, for example, to other communities. <p>Note that some of these six indicators may serve as outcome indicators depending on the logic of the programme (theory of change).</p>
Outcomes	Key outcome indicators (O)
1. Emergency responses do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable (O1)	<ul style="list-style-type: none"> O1.1. Percentage of affected people who report that emergency responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully O1.2. Percentage of affected people who report being actively involved in different phases of emergency response (for example, participation in needs assessment, programme design, implementation and M&E activities) O1.3. Percentage of target communities where local people have been enabled to design, organise and implement emergency responses themselves O1.4. Percentage of staff trained and following guidance (for example, the IASC Guidelines) on how to avoid harm O1.5. Number of negative events perceived by beneficiaries to be caused by humanitarian and/or MHPSS interventions O1.6. Number of affected people who know codes of conduct for humanitarian workers and how to raise concerns about violations O1.7. Programmatic changes made after comments were filed through feedback mechanisms O1.8. Perceptions of needs addressed (that is, needs perceived as serious problems by affected people themselves, such as perceived problems with shelter or livelihoods) O1.9. Percentage of affected people who report receiving accessible information in a timely manner about (i) the emergency, (ii) the emergency response and (iii) self-help approaches for positive coping/well-being

* Disaggregation by sex and age is encouraged for all relevant indicators. The indicators presented here are not exhaustive. In addition to selecting at least one impact and one outcome indicator, MHPSS practitioners should feel free to create additional indicators that match other elements of the goals and outcomes of their specific projects.

Overall goal	Key goal impact indicators (Gi)
<p>2. People are safe and protected, and human rights violations are addressed (O2)</p>	<ul style="list-style-type: none"> • O2.1. Number of reported human rights violations • O2.2. Percentage of target communities (that is, villages, neighbourhoods or institutions, such as mental hospitals or orphanages) with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women, people with severe mental disorders) • O2.3. Percentage of target communities where representatives of target groups are included in decision-making processes on their safety • O2.4. Percentage of target group members who, after training, use new skills and knowledge for prevention of risks and referral • O2.5. Number of members of at-risk groups (such as children or survivors of sexual violence) who use safe spaces • O2.6. Percentage of target group members (such as the general population or at-risk groups) who feel safe • O2.7. Number of protection mechanisms (such as social services or community protection networks) and/or number of people who receive help from formal or informal protection mechanisms • O2.8. Number of people who have reported human rights violations and their perceptions about the responses of institutions addressing their case
<p>3. Family, community and social structures promote the well-being and development of all their members (O3)</p>	<ul style="list-style-type: none"> • O3.1. Number of children reunified with family members or who are in other appropriate care arrangements according to their specific needs and best interests • O3.2. Extent of parenting and child development knowledge and skills among caregivers • O3.3. Quality of caregiver–child interactions • O3.4. Level of family connectedness or cohesion • O3.5. Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups) • O3.6. Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development • O3.7. Percentage of target communities where communal rituals for the dead have been organised • O3.8. Percentage of formal and informal social structures that include specific mental health and psychosocial activities or supports • O3.9. Number of affected people who use different formal and informal social structures (such as schools or informal education for children of all ages, health care, social services, early child development programmes, women's groups and youth clubs) • O3.10. Number of people in at-risk groups engaged in livelihood opportunities • O3.11. Number of children with opportunities to engage in learning developmentally appropriate socio-emotional skills

Overall goal	Key goal impact indicators (Gi)
4. Communities and families support people with mental health and psychosocial problems (O4)	<ul style="list-style-type: none"> • O4.1. Number of people with mental health and psychosocial problems who report receiving adequate support from family members • O4.2. Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information and resources needed to access care) • O4.3. Level of social capital of individuals with mental health and psychosocial problems (both cognitive and structural) • O4.4. Perceptions, knowledge, attitudes (including stigma) and behaviours of community members, families and/or service providers towards people with mental health and psychosocial problems
5. People with mental health and psychosocial problems use appropriate focused care (O5)	<ul style="list-style-type: none"> • O5.1. Percentages of medical facilities, social services facilities and community programmes that have staff trained to identify mental health conditions and to support people with mental health and psychosocial problems • O5.2. Percentages of medical facilities, social services facilities and community programmes that have staff receiving supervision to identify mental health conditions and to support people with mental health and psychosocial problems • O5.3. Percentages of medical facilities, social services facilities and community programmes that have and apply procedures for referral of people with mental health and psychosocial problems • O5.4. Number of women, men, girls and boys who receive focused psychosocial and psychological care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or other psychological interventions) • O5.5. Number of women, men, girls and boys who receive clinical management of MNS disorders through medical services (primary, secondary or tertiary health care) • O5.6. Number of people per at-risk group (for example, unaccompanied or separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental health conditions) • O5.7. Percentage of available focused MHPSS programmes that offer evidence-based care relevant to the culture, context and age of target group • O5.8. Level of satisfaction of people with mental health and psychosocial problems and/or their families regarding the care they received

CHAPTER 5

A description of the framework outcomes and indicators

The common framework's outcomes relate to specific aspects and action sheets from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings; therefore each outcome has a rationale to help explain its intent.

Also, the outcomes and corresponding outcome indicators use a range of important terms that could have different meanings for different people. This chapter provides details on how the outcomes relate to the guidelines and the ideas behind the key terms used, for both outcomes and indicators.



© Claire Marie Whitney

OUTCOME



EMERGENCY RESPONSES DO NOT CAUSE HARM AND ARE DIGNIFIED, PARTICIPATORY, COMMUNITY-OWNED AND SOCIALLY AND CULTURALLY ACCEPTABLE

Related to outcomes included in IASC Guidelines action sheets: 3.3, 5.1, 6.1, 6.4, 7.1, 8.1, 9.1, 10.1, 11.1

Rationale: Addressing stressors and preventing harm from inappropriate emergency responses is essential to promote and protect psychosocial well-being, prevent distress and, possibly, to prevent disorders, and to ensure that community ownership and protective safeguarding mechanisms are in place.

Key terms and descriptions related to Outcome 1:

- » **Emergency responses** include all international, domestic and community emergency response activities in any sector (such as nutrition, water and sanitation, health).
- » **Not causing harm** is about ensuring that emergency responses do not put people at risk (including physically, mentally, socially, materially, emotionally or legally) or cause any further harm to affected populations, including potential harm by humanitarian personnel, violations of human rights (including violations of privacy and dignity) or the reproduction of harmful power imbalances (new or existing) in decision-making processes.
- » **Dignified** refers to the expected Outcome of emergency responses that value the concerns of affected people, treat those people with respect as subjects rather than objects, and allow segments of affected communities to guide and inform the emergency response, including individuals or groups who may require special attention.
- » **Participatory** refers to the involvement of community members in the emergency response, but further implies that community participation is voluntary, does not add to their burdens and is sensitive to the capacities and circumstances of the affected population.

- » **Community-owned** refers to actions that ensure that people – including members of marginalised groups – contribute towards prioritising, planning and implementing the work intended to improve their circumstances. Community ownership is experienced when communities have power to make key decisions related to what aid is delivered and how it is provided. It includes mobilising communities and recognising and/or strengthening the capacities of existing formal and informal community structures.
- » **Social and cultural acceptability** describes emergency responses that are sensitive to the norms and values of the affected population and to these being respected in how emergency response actions are carried out. It describes consideration of diversity of cultural and social values within the affected population, as well as acknowledgement that emergency situations often lead to changes in practices that may be supported by some community members but may cause concern to others.*
- » **Accessible information** refers to information that can be accessed equally by all people in ways that they can understand this information, and that the information is culturally appropriate, respectful, accurate and useful. This may mean that information needs to be adapted for different age groups, language groups, genders or people with different abilities (for example, accessible to people with disabilities and/or low literacy) and potentially shared in different ways (such as in writing, illustrations) and/or across multiple platforms (for example, posters, radio, leaflets, disability services). Information should not be distributed or include material that may pose risks to certain individuals or groups (for example, containing politically sensitive information).

* Because some local practices cause harm, humanitarian workers should think critically and support local practices only if they align with international standards of human rights.

OUTCOME 1 INDICATORS

- » **01.1.** Percentage of affected people who report that emergency responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully
- » **01.2.** Percentage of affected people who report being actively involved in different phases of emergency response (for example, participation in needs assessment, programme design, implementation and M&E activities)
- » **01.3.** Percentage of target communities where local people have been enabled to design, organise and implement emergency responses themselves
- » **01.4.** Percentage of staff trained and following guidance (for example, the IASC Guidelines) on how to avoid harm
- » **01.5.** Number of negative events perceived by recipients to be caused by humanitarian and/or MHPSS interventions
- » **01.6.** Number of affected people who know codes of conduct for humanitarian workers and how to raise concerns about violations
- » **01.7.** Programmatic changes made after comments were filed through feedback mechanisms
- » **01.8.** Perceptions of needs addressed (that is, needs perceived as serious problems by affected people themselves, such as perceived problems with shelter or livelihoods)
- » **01.9.** Percentage of affected people who report receiving accessible information in a timely manner about (i) the emergency, (ii) the emergency response and (iii) self-help approaches for positive coping/well-being.



OUTCOME

2

PEOPLE ARE SAFE AND PROTECTED, AND HUMAN RIGHTS VIOLATIONS ARE ADDRESSED

Related to outcomes included in IASC Guidelines action sheets: 3.1, 3.2, 3.3, 6.2, 6.3, 8.1

Rationale: Feeling safe and being protected can reduce mental health and psychosocial problems, or prevent such issues from arising or becoming worse. Providing opportunities for justice following acts or causes of violations may support affected people's social and psychological recovery, including people impaired by mental illness and living with formal or informal carers.

Key terms and descriptions related to Outcome 2:

In coordination with existing protection mechanisms, MHPSS actors have a role to play in contributing to the creation of conditions for community members to safely deal with threats and human rights violations.

» **Being safe** may result from: (i) enabling community members to acknowledge, prevent and respond to hazards or threats; (ii) responding to the ways that these hazards or threats impact emotional, social and psychological well-being; (iii) supporting individuals affected by rights violations, including those living in formal or informal care situations, to address risks, threats or ongoing harm; (iv) building functional referral systems, accountability measures and networks; (v) undertaking advocacy regarding the ways that threats and human rights violations impact people; (vi) assisting communities to access processes for justice; (vii) strengthening community capacity and state capacity (that is, duty-bearers) to identify, mitigate and respond to possible risks; or (viii) addressing underlying conditions that may result in violence at individual, family, peer/school and community levels. Supporting individuals who are experiencing distress or illness may also enhance their protection and help them feel safer. Where people experience safety and well-being they are less likely to fall victim to or perpetrate abuses, which may further help reduce the cyclic harm of others.

» **Being protected** relates to ensuring that systems are in place to help prevent or reduce the impacts of threats or human rights violations. This is an outcome that may result from work in relation to rights protection and the building of protective environments. This may require acknowledgement (and action) on matters of justice, reparation or legal rights. It includes understanding the context and approaches that support affected people in addressing the structural factors that influence their well-being and recovery.

» **Addressing human rights violations** refers to aspects of monitoring, reporting, documenting, accompanying or supporting people of all ages to seek justice for human rights violations, where local conditions allow. Many considerations are important when addressing human rights violations, including but not limited to the following:

- ▶ Local conditions may result in the need to create or strengthen processes to address human rights violations within the frameworks of local laws and customs.
- ▶ Actions to address violations may be undertaken before (that is, prevention), during or after rights violations are experienced.
- ▶ Certain groups may be especially at risk of rights violations and harm, often due to vulnerabilities or discrimination that existed before an emergency (such as persons with severe mental illness, children and adults in institutional settings, etc.).
- ▶ MHPSS actors may work with structures or mechanisms that are responding to issues of safety, protection and justice, or with communities, families and individuals who are seeking to access or engage them.
- ▶ Technical support may be necessary for documenting human rights violations, including ensuring the safety, protection and ethical management of personal information.



OUTCOME 2 INDICATORS

- » **O2.1.** Number of reported human rights violations
- » **O2.2.** Percentage of target communities (that is, villages, neighbourhoods or institutions such as mental hospitals or orphanages) with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women, people with severe mental disorders)
- » **O2.3.** Percentage of target communities where representatives of target groups are included in decision-making processes on their safety
- » **O2.4.** Percentage of target group members who, after training, use new skills and knowledge for prevention of risks and referral
- » **O2.5.** Number of members of at-risk groups (such as children or survivors of sexual violence) who use safe spaces
- » **O2.6.** Percentage of target group members (such as the general population or at-risk groups) who feel safe
- » **O2.7.** Number of protection mechanisms (such as social services or community protection networks) and/or number of people who receive help from formal or informal protection mechanisms
- » **O2.8.** Number of people who have reported human rights violations and their perceptions about the responses of institutions addressing their case.

OUTCOME

3

FAMILY, COMMUNITY AND SOCIAL STRUCTURES PROMOTE THE WELL-BEING AND DEVELOPMENT OF ALL THEIR MEMBERS

Related to outcomes included in IASC Guidelines action sheets: 5.2, 5.3, 5.4, 7.1, 8.2

Rationale: Human development, mental health and psychosocial well-being occur in the context of social relations and connections, which are often disrupted in emergencies. This can negatively impact well-being. The protection, restoration and positive transformation of family and community structures can create a supportive environment to sustain the well-being of their members and foster psychological and social recovery.

Key terms and descriptions related to Outcome 3:

- » **Family, community and social structures** (sometimes viewed as “systems”) may be formal or informal. They can provide an environment for social cohesion and building trust so that individuals can be supported in a wider social network. Social, community and family supports enable individuals to continuously learn and adapt to meet development milestones. This is especially true for children and adolescents, but can also apply to adults who may need to adjust to changed life circumstances or to take advantage of new opportunities. Examples of such structures include (but are not limited to) family tracing and reunification systems, formal education structures, religious or spiritual systems, traditional community practices, health structures, institutions or informal structures such as women’s groups, children’s or youth organisations/clubs or advocacy groups.
- » **Development**, as it relates to human development, can be described as having two dimensions:¹⁷ (i) directly enhancing human abilities, to assure a long and healthy life, knowledge and a decent standard of living, and (ii) creating conditions so that people can participate in political and community life, work towards environmental sustainability and experience human security, rights and gender equality. Human development takes place throughout the life cycle. Therefore it relates to any age group, meeting age-appropriate developmental milestones and working towards helping people, individually or collectively, to increase their life choices, opportunities and potential for a reasonable chance of leading productive, creative lives that they value.
- » **“All members”** refers to the fact that these structures should be inclusive of all community members (that is, individuals of any age or gender, education level, health status, disability, family background, religious or ethnic/social group affiliation and so forth).

OUTCOME 3 INDICATORS

- » **03.1.** Number of children reunified with family members or who are in other appropriate care arrangements, according to their specific needs and best interests
- » **03.2.** Extent of parenting and child development knowledge and skills among caregivers
- » **03.3.** Quality of caregiver–child interactions
- » **03.4.** Level of family connectedness or cohesion*
- » **03.5.** Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups)
- » **03.6.** Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development
- » **03.7.** Percentage of target communities where communal rituals for the dead have been organised
- » **03.8.** Percentage of formal and informal social structures that include specific mental health and psychosocial activities or supports
- » **03.9.** Number of affected people who use different formal and informal social structures (such as schools or informal education for children of all ages, health care, social services, early child development programmes, women's groups and youth clubs)
- » **03.10.** Number of people in at-risk groups engaged in livelihood opportunities
- » **03.11.** Number of children with opportunities to engage in learning developmentally appropriate socio-emotional skills.

* While there is no widely agreed understanding of social cohesion, current definitions focus on notions such as sense of belonging, participation, level of attachment to the group and shared (equity in) social and economic outcomes.¹⁸

OUTCOME

4

COMMUNITIES AND FAMILIES SUPPORT PEOPLE WITH MENTAL HEALTH AND PSYCHOSOCIAL PROBLEMS

Related to outcomes included in IASC Guidelines action sheets: 5.2, 5.3, 5.4, 6.3, 6.4, 6.5

Rationale: Community and family supports can assist individuals or groups with mental health and psychosocial problems. Typically, these are the first support measures that people experiencing mental health and psychosocial problems receive. Families and caregivers are the most important source of protection and well-being for children. Such support may be strengthened or weakened or even become dysfunctional after an emergency. Establishing, restoring or strengthening these supports can ensure that individuals with mental health and psychosocial problems can be cared for in their families and communities, especially in the context of scarce or limited formal services.

Key terms and descriptions related to Outcome 4:

- » **Mental health and psychosocial problems** may include social problems (such as sexual violence or discrimination), psychological distress, MNS disorders, intellectual disability or any combination of these.
- » **Community** includes community members, formal and informal institutions (such as schools, health facilities, religious institutions, carer support groups and neighbourhood respite care).
- » **Community and family support** occurs when:
 - ▶ Families help meet the individual needs of people with mental health and psychosocial problems (for example, by responding to psychological distress or assisting them in challenging daily tasks).
 - ▶ Community members provide support (for example, by organising cultural or healing practices, providing employment and/or encouraging others in their community to respect and include them – for example, by preventing discrimination or actively supporting social inclusion).

- ▶ Community institutions facilitate access and inclusion of people with mental health and psychosocial problems (by, for example, including people with severe mental illness in livelihood opportunities or including children with developmental disorders in education).
- ▶ Community and family support seeks to reduce suffering by easing the burdens of stress, fear, insecurity and discrimination and helps others to increase their functional contributions to community and family life. Communities and families can be mobilised or strengthened to assist individuals and groups who do not have support networks, such as orphaned children or others requiring special protection.

It is important to recognise that communities and families themselves may contribute to the creation and perpetuation of mental health and psychosocial problems. They may also limit access to opportunities and services for people with mental health and psychosocial problems. Therefore, it may be necessary to complement MHPSS activities that focus on this outcome with additional community-focused interventions to directly support persons in need.



© IOM/Carolina Celi

OUTCOME 4 INDICATORS

- » **O4.1.** Number of people with mental health and psychosocial problems who report receiving adequate support from family members
- » **O4.2.** Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information and resources needed to access care)
- » **O4.3.** Level of social capital of individuals with mental health and psychosocial problems (both cognitive and structural)
- » **O4.4.** Perceptions, knowledge, attitudes (including stigma) and behaviours of community members, families and/or service providers towards people with mental health and psychosocial problems

OUTCOME

5

PEOPLE WITH MENTAL HEALTH AND PSYCHOSOCIAL PROBLEMS USE APPROPRIATE FOCUSED CARE

Related to outcomes included in IASC Guidelines action sheets: 6.1, 6.2, 6.3, 6.4, 8.2

Rationale: People of any age with identified mental health and psychosocial problems may require focused care beyond those supports that are available from family or community resources. In such cases, access to focused care can help to secure the mental health, well-being and recovery of affected persons.

Key terms and descriptions related to Outcome 5:

- » **Mental health and psychosocial problems** may include social problems (such as sexual violence or discrimination), psychological distress, MNS disorders, intellectual disability or any combination of these.
- » **Use of appropriate focused** care indicates that the focused care provided to the individual is accessed, utilised and helpful in one or more ways (for example, by improving functionality, coping, reducing symptoms of mental illness, increasing social supports, reducing social problems and so forth, without severe adverse effects). To enable the greatest potential benefits from focused care, feasible evidence-based approaches and interventions should be provided to address specific needs. This might also require focused care that is adapted and relevant to meet the needs of specific groups, such as children, women and girls, individuals with developmental problems or people living with other disabilities.

- **Appropriate care** means that people receive individual assistance and treatment specific to their needs, in accordance with international human rights instruments.* It underscores that “access to appropriate care” is inclusive, available, accessible, acceptable and of good quality. Appropriate access ought to be provided by duty-bearers (such as nation states), but may need to be temporarily provided by non-state actors (such as non-governmental organisations) in emergency, recovery and development contexts.
- **Focused care** may be delivered by specialised professionals (such as qualified psychiatrists, social workers, psychologists, etc.), by trained lay counsellors/helpers or by trained service providers who are not necessarily specialised in MHPSS care (such as general nurses/physicians, community health workers and classroom teachers). Focused care could range from community-based to inpatient services and from informal to formal supports.**

* Such as the International Covenant on Economic, Social and Cultural Rights (1966) General Comment No. 14, as well as the Universal Declaration of Human Rights (1948) Article 25, Convention on the Elimination of All Forms of Discrimination against Women (1979) Article 12, Convention on the Rights of the Child (1990) Article 24 and the Convention on the Rights of Persons with Disabilities (2008) Article 25.

** For example: (i) people with social problems may need access to dedicated protection and social services, as well as more generic supportive networks (for example, recreational groups, mothers' groups, etc.) to facilitate rehabilitation and reintegration into community life; (ii) people experiencing grief and acute distress may need access to basic psychological support, social support from family and community members and culturally appropriate mourning; (iii) people with mental health conditions need access to mental health care and more generic social services/supports from the people, families and communities around them.

OUTCOME 5 INDICATORS

Some indicators within Outcome 5 reflect overlapping services and terms that can be used differently by certain professionals (for example, number of people receiving psychosocial care, psychological interventions and clinical management). However, these have been separated in the indicators to enable implementers to utilise the approach best suited to their interventions.

- » **O5.1.** Percentages of medical facilities, social services facilities and community programmes that have staff trained to identify mental health conditions and to support people with mental health and psychosocial problems
- » **O5.2.** Percentages of medical facilities, social services facilities and community programmes that have staff receiving supervision to identify mental health conditions and to support people with mental health and psychosocial problems
- » **O5.3.** Percentages of medical facilities, social services facilities and community programmes that have and apply procedures for referral of people with mental health and psychosocial problems
- » **O5.4.** Number of women, men, girls and boys who receive focused psychosocial and psychological care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or other psychological interventions)
- » **O5.5.** Number of women, men, girls and boys who receive clinical management of MNS disorders through medical services (primary, secondary or tertiary health care)
- » **O5.6.** Number of people per at-risk group (for example, unaccompanied or separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental health conditions)

- » **O5.7.** Percentage of available focused MHPSS programmes that offer evidence-based care relevant to the culture, context and age of the target group
- » **O5.8.** Level of satisfaction of people with mental health and psychosocial problems and/or their families regarding the care they have received.



CHAPTER 6

Practical guidance for using the common framework

Each MHPSS programme is unique. What MHPSS programmes and how they are implemented will depend on the context, assessed needs, the experience and capacity of the implementing organisation or partners and local resources, as well as capacity, timing, budget and other considerations. It is NOT expected that an MHPSS programme will use every outcome or indicator from this common framework. Nor is it expected that the recommended MoV will always be best suited for what you need to measure. Nonetheless, it is recommended that MHPSS programmes in emergency settings or M&E designs include:

- » the overall goal of this framework;
- » at least ONE goal impact indicator; plus
- » at least ONE recommended MoV related to that goal impact indicator; plus
- » at least ONE outcome indicator from the common framework

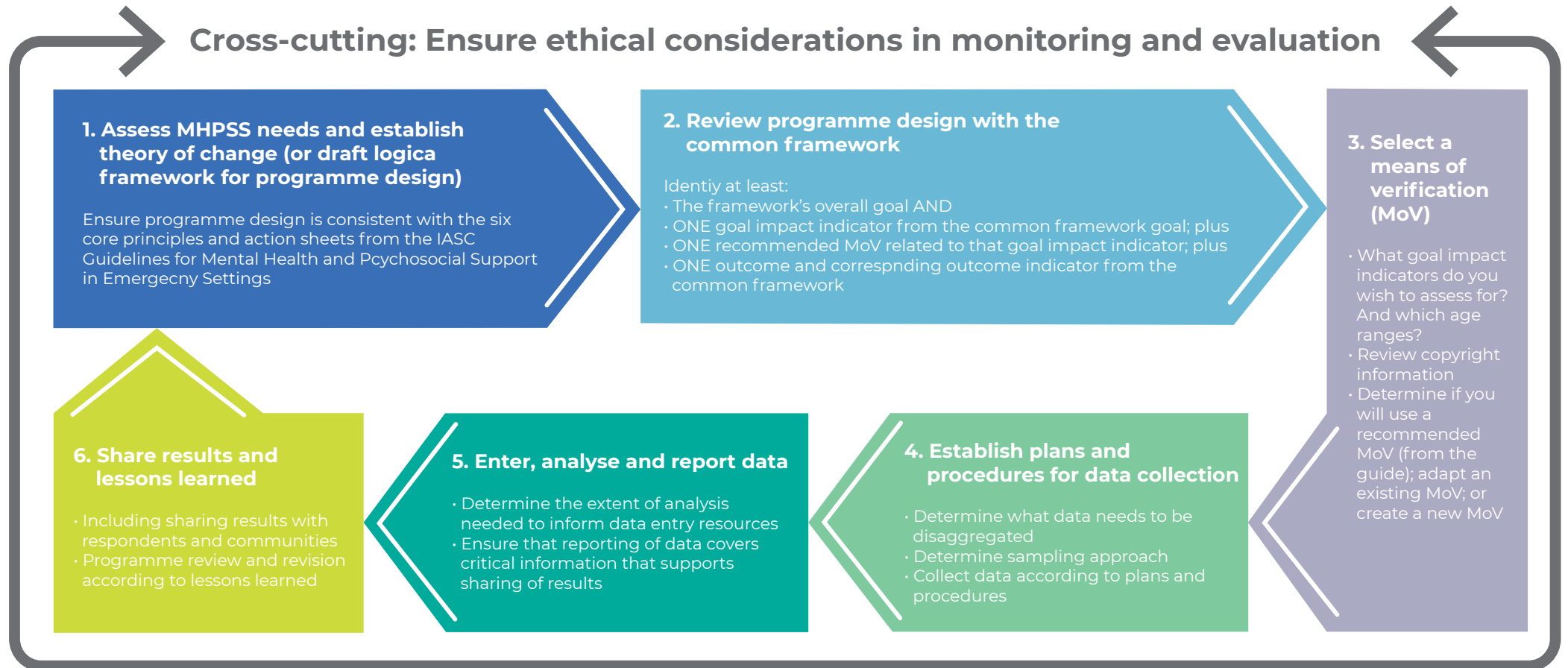
In line with emergency coordination efforts (for example, emergency response MHPSS working groups), the steps shown in Figure 3 can be followed to support the use of this common framework. **The steps should always begin with a comprehensive MHPSS assessment.** Depending on work already under way, relevant MHPSS information might also be accessible from other actors. It is important to remember that MHPSS programmes should always:

- » be designed in collaboration with affected communities;
- » be consistent with the six core principles and action sheets from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings
- » confirm the appropriateness of indicators and MoV with communities in their context.



FIGURE 3

Flowchart outlining how individual MHPSS programme designs and M&E plans can include aspects of the common framework and MoV



CHAPTER 7

Reviewing programme design with the common framework

The common framework can be used in a way that best “fits” within the intended goal, outcomes and outputs of various MHPSS programmes. The framework has been designed to be broad enough to be relevant to the majority of MHPSS initiatives known to be implemented in emergency settings. However, this may also mean that certain indicators or outcomes in the common framework could relate to a range of activities or programmes. For example, an intervention that encourages families to better care for household members living with mental health conditions might relate to Outcome 2 (“People are safe, protected and human rights violations are addressed”), since the goal of the project is to keep people living with mental health conditions safe and to ensure that their rights to protection and treatment are realised. However, the same project might also relate to Outcome 4 (“Communities and families support people with mental health and psychosocial problems”), since project activities may relate to empowering families with the knowledge and resources needed to better support family members who have mental health conditions. Similarly, some MoV may be used for different indicators at different levels.

The framework currently presents all MoV as options for assessing the goal-level key impact indicators; however, some of these same MoV may also be appropriate to use for outcome-level indicators. For example, using the Mental Illness: Clinician’s Attitudes Scale (MICA-4) measure to assess the goal impact indicator for social behaviour (Gi.5) might also be appropriate to assess the outcome-level indicator “Perceptions, knowledge, attitudes (including stigma) and behaviours of community members, families and/or service providers towards people with mental health conditions” (O4.4).

It is recommended that each MHPSS programme or project use:

- ▶ The **OVERALL GOAL** (adapted as needed); plus
- ▶ At least **ONE goal impact indicator** from the common framework goal; plus
- ▶ At least **ONE recommended MoV** related to that goal impact indicator; plus
- ▶ At least **ONE outcome and corresponding outcome indicator** from the common framework.

Ultimately, the practitioner designing the programme is empowered to match up the most suitable outcomes with the accompanying indicator(s) and MoV from the common framework. Direction may come from a practitioner’s own MHPSS programme design, programme activities, the description of the outcomes provided in this publication or the action sheets from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. MoV may include those suggested in this guide (see Chapter 8 and Annexes 8–9), locally validated measures or some combination of these. Across the M&E plan, MoV should ideally include a mix of quantitative and qualitative methods. In the final selection of goal and outcome indicators and related MoV, an MHPSS and/or M&E expert should review and confirm the proposed design, MoV, data collection and data entry procedures.

To further assist organisations in using the common framework, Annexes 4–7 provide possible case scenarios for four commonly used MHPSS interventions in emergency settings. The scenarios help demonstrate how these types of interventions and typical MHPSS programme designs may be linked back to and integrated with the common framework and their recommended MoV. Although the case scenarios are abbreviated versions of programmes, they will hopefully provide further guidance to MHPSS programme designers and M&E planners seeking to incorporate at least one goal indicator and at least one outcome indicator from the common framework.

Selecting a means of verification (MoV)

Means of verification are the quantitative and qualitative tools used to measure the indicators. MoV of outcomes may be a straightforward collation of data (for example, number of members of at-risk groups who use safe spaces). However, most goal impact indicators will need more intensive assessment. The process of choosing an MoV, as shown in Figure 4, has multiple steps. This includes deciding whether to use recommended MoV (from Annexes 8–9), adapt a different MoV or create a new MoV. The following questions can assist in selecting the right MoV for your indicator(s) and programme:

- » **Is the MoV assessment approach relevant? Relevance** of assessment approach refers to the match between the assessment approach (for example, a quantitative survey or a qualitative observation) and what needs to be measured (for example, the indicator). For instance, a data collection tool that measures levels of distress in a target population quantitatively is relevant as a means of verification for the goal indicator of extent of prolonged disabling distress. Important elements that can influence the relevance of assessment approaches might also include context, disability, culture, language, gender, sexual orientation, age and developmental level, literacy, abilities and many others.
- » **Is the MoV accessible? Accessibility** refers to whether the tools to be used are freely available and in accessible formats (for example, no copyright restrictions or whether an MoV is available in the required language or accessible format (such as Braille, sign language or other accessible formats for people living with disabilities).
- » **Is the MoV feasible? Feasibility** refers to how easy or difficult it is to administer a measurement tool or qualitative approach. This may be in terms of time, human or financial resource needs, logistics and whether the people being assessed understand the questions they are being asked or the tasks they are being asked to do.

- » **Is the MoV acceptable? Acceptability** refers to attitudes of the users of the measurement tool; namely whether those administering the MoV and the people whose information will be collected consider it an acceptable way to seek out the needed information. Acceptability will include ensuring that the MoV does no harm (for example, it does not stress, embarrass, distress or stigmatise people), that it collects only essential information and avoids collecting data unnecessarily.
- » **Is the MoV reliable? Reliability** is the extent to which a tool produces stable and consistent results across time, raters and versions of the same tool.
- » **Is the MoV valid? Validity** is the extent to which a tool measures what it is intended to measure for a particular setting, population and purpose; and whether any differences in the results are a true reflection of the differences in the people being assessed. MoV validity depends on numerous factors, including the MoV's reliability, whether its content is relevant or whether the construct it measures is valid in the given context, cultural group or population.

The MoV recommended in this framework were all reviewed for their likely relevance, accessibility, acceptability, reliability and validity (see Annex 2, which describes selection criteria for the MoV). Likewise, authors of the selected quantitative MoV were consulted in developing the guidance included in Annex 8, while guidance materials for qualitative MoV listed in Annex 9 were selected according to their accessibility, relevance and feasibility. However, MoV may not always meet these criteria across settings. In MHPSS in emergencies, conditions are always different and changing. Even though the majority of the MoV (according to indicator(s) and ages) provided in this M&E framework are potentially useful in most situations, it is still important to consider these factors in every unique programme design and geographical location and to assess MoV against these criteria. This will also support a decision about whether to use or adapt an existing MoV or to create a new one.

When selecting the MoV for your indicator(s), an integration of both qualitative and quantitative methods is likely to deliver the most useful information.¹⁹ Quantitative information can provide statistical data to show the level of change (if any), while qualitative data can generate information to show the depth, type or process of change.



BOX 2

USE OF PROMISING, CULTURALLY SPECIFIC MEASURES OR MOV NOT INCLUDED IN THESE RECOMMENDATIONS

There are a range of potentially useful MoV that may not be included in this guide. These include locally developed MoV, organisation-specific MoV or other promising measures. It is likely that such MoV did not meet the criteria for inclusion in this document. For instance, they may not have been used in multiple settings or may not have been available in multiple languages, or key information about their measurement properties may have been unavailable (see Annex 2 for the MoV selection process).

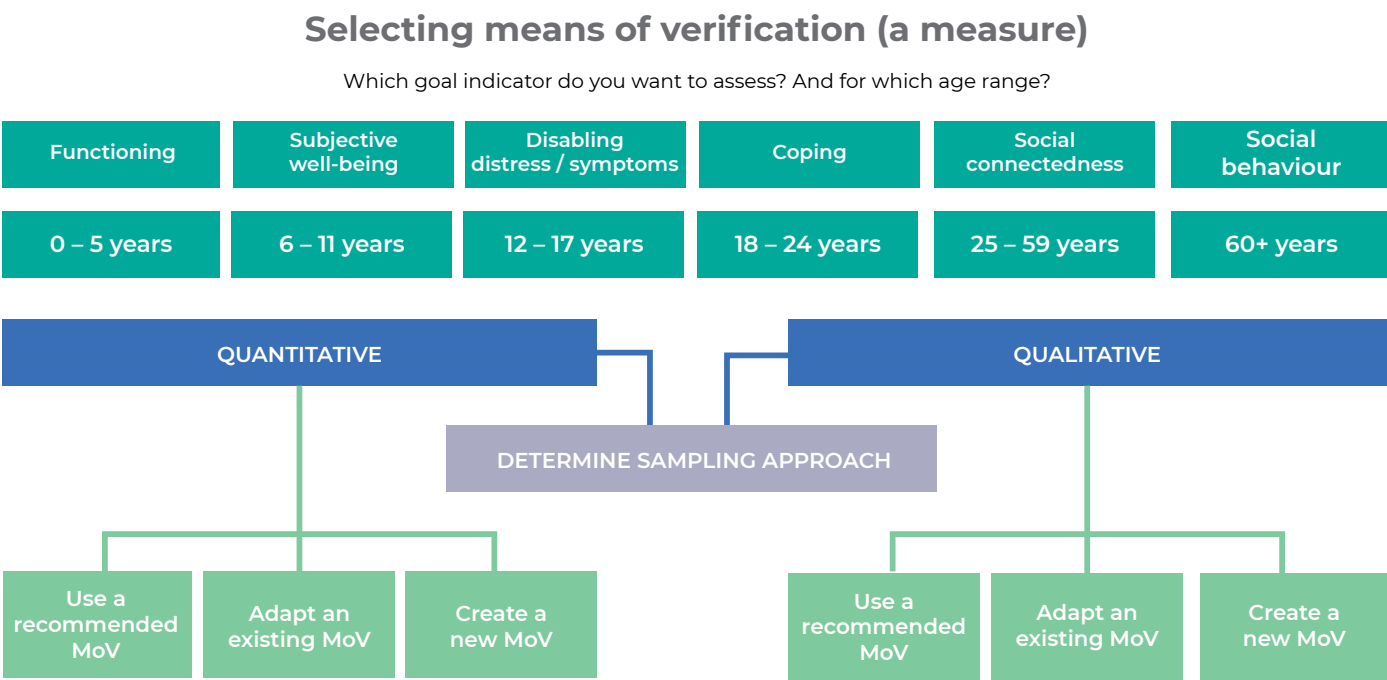
MHPSS programmes are not obligated to use only MoV included in this guide. In many contexts, local organisations or partners develop measurement tools specific to their own culture, language, situation or the interventions being applied. New measures may also be undergoing a pilot testing or research process. Assuming that these measures are relevant to what is being assessed and they meet (or are being assessed to meet) multiple feasibility, utility, reliability and validity criteria, their use is encouraged, particularly when they are logically or culturally specific.

DEVELOPING AND USING PARTICIPATORY INDICATORS AND MOV

Affected populations should always be consulted when indicators and their MoV are selected. This helps to ensure that what is being measured aligns with cultural ideas and norms, and that MoV are appropriate for their communities. It is also feasible for affected populations to identify and develop indicators unique to their own cultures, language and context – with such indicators measurable by locally determined MoV.

“SEE_PET” (adapted from an approach known as Stepwise Ethnographic Evaluation – Participatory Evaluation Process) is a rapid participatory method for developing indicators of psychosocial well-being in a specific cultural context. It also engages community members to operationalise their own definitions of psychosocial well-being and can lead towards establishing how aspects of a psychosocial programme might be measured to determine its success in meeting its outcomes. For further information on SEE_PET, refer to Chapter 16 in International Organization for Migration. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. Geneva: IOM; 2019.

FIGURE 4
Decisions to make when selecting an MoV



MoV = means of verification. A good monitoring and evaluation plan should include both quantitative and qualitative MoV. However, when selecting which quantitative and qualitative MoV and approaches to use you may need to consider these separately.

REVIEW COPYRIGHT INFORMATION

Copyright is the legal way that an author (or a corporation) can protect their work. It is a type of intellectual property* that provides exclusive publication, distribution and usage rights for the copyright owner. This means that whatever content is published cannot be used, republished or changed by anyone else without the consent of the author (or in this case, the creator or copyright owner of the MoV). It also means that if used or referenced in another publication (for example, in an M&E report), the official citation of that work must be included.

Although the MoV recommended in this framework can be used free of charge, there may be costs involved in adapting an existing tool or using a measure that has not been included in this guide. It is **essential** that copyright is considered when using any MoV, whether from this guide or elsewhere. If unsure about whether you can rightfully use (or adapt) a tool, please make sure to contact the author of the tool, informing them about plans to use (and/or adapt) it and to seek their permission.

* See: <https://techterms.com/definition/intellectualproperty>



© Italian Red Cross/Emiliano Albensi

USE A RECOMMENDED MOV

The quantitative and qualitative MoV provided in this framework have undergone a thorough selection process (see Annex 2). However, before using these MoV, remember to:

- » Check all items and instructions for the MoV, starting with information provided in Annexes 8–9.
- » Assess whether the MoV is likely to be valid in your context and for the people you will be assessing (for example, conduct a desk review to see if any local research suggests that a certain measure may not be valid with local groups or communities; contact MHPSS practitioners, or MHPSS Technical Working Group coordinators if applicable, to ask about MoV used commonly in the local context).
- » Use measures only as they are provided directly from the authors/sites. ANY changes (for example, to the wording of items and/or language translations) may breach copyright laws and influence the reliability, validity and relevance of the MoV. If you do want to make changes, request written permission from the copyright holder.
- » Carefully review instructions about how to administer the measure, and how to score it and interpret data.
- » Provide appropriate training to people who will be completing assessments with the selected MoV, such as training on conducting assessments with specific groups or in certain contexts.
- » Test the tool with a small group of people who represent the sample from whom you will be collecting data to ensure that the MoV is relevant, accessible, feasible and acceptable for use with the target population. If it is not, consider adapting the MoV (see Box 3).
- » Be sure to have the correct references when reporting results.

ADAPT AN EXISTING MOV

Culture and context heavily influence the ways that suffering, mental health and psychosocial well-being are experienced and expressed. **Adaptation is the process of developing a new version of an existing MoV to make it more suitable to the culture and/or context where the MoV is being used.** Adaptation of an MoV helps to avoid misleading or inaccurate data, and works towards meeting the principles of participation, do no harm and building on available resources and capacities.

Translation of an MoV into another language is one form of adaptation. Changes to words, the items (or questions) in a survey or administration procedures of an MoV are also considered adaptations. Such changes may be made with quantitative and qualitative MoV. Annex 3 outlines the necessary steps for adapting and contextualising an MoV and Annex 10 includes a sample form to support adaptation and translation.

CREATE A NEW MOV

In most cases, adapting or translating an MoV has many advantages over creating a new one. Adaptation generally reduces the costs and time spent on MoV development and allows for using an instrument that has been widely used before. It also allows for results that can be more easily compared with others. Nevertheless, creating a new and unique MoV may be necessary if local descriptions of distress, well-being or other MHPSS constructs are not sufficiently captured by existing MoV.²⁰ Creating new MoV might also be important if indicators have been locally developed, such as through participatory approaches, and these may help to reduce stigma.²¹ Detailed manuals have been developed to guide these processes.* When creating a new MoV, it is strongly advised to work with experts, such as researchers or facilitators of particular approaches and psychometrics, to lead new MoV development.

BOX 3

CONSIDERATIONS FOR ADAPTING AN MOV

When adapting an existing measurement tool or approach, it may be necessary to seek support from M&E, MHPSS or research experts. For adaptation, it is necessary to:

- » Check any copyright restrictions (and if necessary contact the authors for permission to adapt).
- » When possible, pilot the adapted MoV to assess its measurement properties (that is, relevance, accessibility, feasibility, acceptability, reliability, aspects of validity), because such factors usually change after adaptation.
- » Unless it is not permitted by the copyright holder, make your adapted MoV (and your adaptation process) publicly available so that others working in the same culture/context do not duplicate this work. One way to do this is through an MHPSS working group, if one exists in your country/humanitarian context.

If an MoV has been adapted and used successfully with a certain cultural group, this adaptation might also be useful with populations of the same or similar cultural background living in other contexts.

* For example, see: Applied Mental Health Research Group (AMHR). Design, implementation, monitoring and evaluation of cross-cultural trauma related mental health and psychosocial assistance programs: a user's manual for researchers and program implementers, module 2. 2013.

CHAPTER 9

Establishing plans and procedures for data collection

It is a duty to respect and protect the rights and dignity of all people who have shared information. Care is needed to avoid harm and to ensure appropriate management of data and their use in line with relevant data protection regulations. It is important that particularly vulnerable groups in a community are appropriately represented (including by disaggregation of data) and that the ways in which information will be collected are fair and representative (that is, sampling methods). Ethical considerations, including informed consent, are essential. Having a strong plan and procedures in place for data collection will help to protect individuals, communities and staff from harm.

All staff working with data – from trainers, data collectors and data entry or data analysis personnel to those who store or report on data – should be briefed on and should comply with a protocol for the protection, safe storage and use of data – for example, a standard operating procedure, a research protocol or a code of conduct. Such a protocol should be planned in advance and should clearly state:

- » What the purpose of data collection is (that is, what is being measured and why);
- » When data will be collected (for example, pre-, mid- and post-intervention);
- » What data will be collected (that is, what are the MoV);
- » How and from whom data will be collected (for example, by data collectors, project reports, patient records);
- » Where data will be collected (for example, households, community centres, remotely);
- » Who will be collecting the data, and the training they require;

- » Procedures for protecting and ensuring the confidentiality of respondents' information (for example, anonymising data);
- » A code of conduct for data collectors (that is, what behaviours are expected when they are working in communities and with adults/children);
- » Ways that data will be recorded (for example, paper-based or electronic) and how issues such as data cleaning, missing data and errors in the data will be managed;
- » What sampling approaches (including acknowledgement of no particular sampling method) will be used;
- » Procedures for supervision and support of data collectors;
- » The overall process for data collection, such as what might be described in a flowchart;
- » Standard procedures for responding in high-risk situations, such as when people show acute distress or suicidal behaviours, or disclose abuse or other risks;
- » Referral information, should cases arise that require immediate support (for example, disclosure of suicidal intent);
- » Procedures for when ethical breaches are observed and how these will be managed.

It is always important to test or pilot a process of data collection, management, data entry and analysis before large-scale data collection activities begin. This allows for any common errors or unexpected problems to be assessed and the procedures reviewed. The IASC MHPSS Reference Group's Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings can serve as a useful guide for establishing data collection, management and analysis protocols.²²



BOX 4

DISAGGREGATION OF DATA*

When collecting information to measure results against a goal and/or outcome, it is important that data are **inclusive** of particular groups who have special needs or who are likely to respond to interventions differently. Therefore, any indicators being measured must collect data that are disaggregated, including but not limited to gender and different age ranges, including age ranges for children and adults. Depending on the context or programme being implemented, it may also be necessary to disaggregate data by ethnicity, identity status (for example, refugee or host), disability, education, etc.

When data are disaggregated, this should also be reflected in the way that the data are analysed and reported, ensuring that information about these groups is uniquely described. Care should be taken not to endanger people or cause harm (for example, reporting small groups in a way that might make them identifiable or group trends that could be used against them).

* For additional guidance on special considerations to be made in data disaggregation and specific groups, please see: Sphere Association. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, fourth edition, Geneva, Switzerland; 2018. www.spherestandards.org/handbook

DETERMINING THE SAMPLING APPROACH

- » **Population** is the entire group or community that you are attempting to understand.
- » A **sample** refers to the individuals or groups from the targeted population you have included in your collection of data.
- » **Probability or representative sampling** indicates that a sample is randomly selected. This means that all people in the population you are assessing have a fair and equal chance of being selected to participate in the data collection process. It also means that the information you select from that sample is **representative** and thus is likely to be generalisable to the whole population being assessed.
- » **Non-probability sampling** indicates that the sample group is not randomly selected. For example, people may be selected because they are conveniently available at the time of data collection, live closer to the home of the data collector or they all attend the same community service. This also means that the information you receive from a non-probability sample cannot be considered representative of a wider population, but rather the information is representative only of those who participated.

Information about sampling approaches is available in relevant texts (see Box 5). However, deciding on the best sampling approach depends on a range of factors, including the method used, the available time and resources and the specific information that is being sought.

Both probability and non-probability sampling approaches are valuable for MoV data collection. There are four important reflections or actions that will be helpful when determining a sampling approach:

01

Be clear about the information that you hope to obtain through the data collection, and its purpose.

02

Discuss the methodological approach, including sampling methodology and related ethical considerations, with relevant experts. This will help to confirm that the sampling approach selected is appropriate to the information you wish to obtain and the extent of resources and time needed.

03

Determine if your sampling methods help to ensure that you are only collecting essential data. Too often, M&E evaluations involve collecting data that are neither analysed nor reported, thereby putting unnecessary strain on participants, staff and resources.

04

Use caution in interpreting and reporting data, because the sampling approach used will influence what conclusions you can draw from the data.

BOX 5

SELECTED RESOURCES FOR SAMPLING AND ASSESSMENT

- » Alexander J and Cosgrave J. Representative sampling in humanitarian evaluation. ALNAP; 2014.
- » Buchanan-Smith M, Cosgrave J and Warner A. Evaluation of Humanitarian Action Guide. ALNAP; 2016.
- » Applied Mental Health Research Group. Design, implementation, monitoring, and evaluation of mental health and psychosocial assistance programs for trauma survivors in low resource countries: a user's manual for researchers and program implementers (adult version). 2013.
- » IFRC. IFRC Monitoring and Evaluation Toolbox. Copenhagen, Denmark: IFRC; 2016.
- » SMART. Sampling Methods and Sample Size Calculation for the SMART Methodology. 2012.
- » World Health Organization and United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: WHO; 2012.
- » UNICEF. Rapid Assessment Sampling in Emergency Situations. Bangkok, Thailand: UNICEF; 2010.

ENSURE ETHICAL CONSIDERATIONS IN MONITORING AND EVALUATION

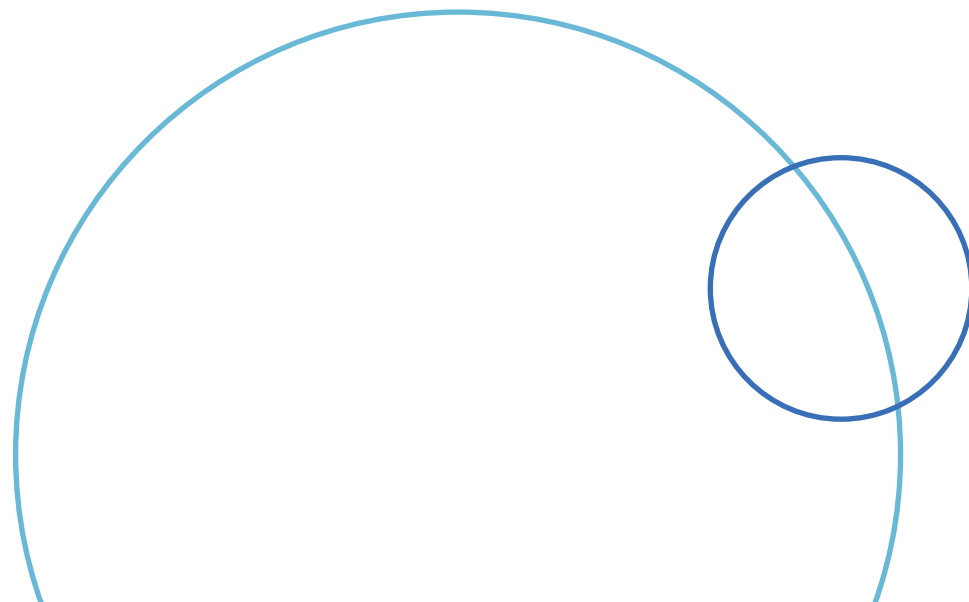
Ethical principles help to determine what is helpful or harmful. Applying ethical principles to all aspects of M&E is important in avoiding potentially risky or bad practices and keeping people involved safe. Research – often described as the systematic collection and analysis of data – encompasses many aspects of M&E work. Whether termed as research or M&E, both approaches involve the collection and analysis of data, and will likely include direct or indirect engagement with individuals throughout the process. Therefore, M&E must always involve the examination of specific ethical considerations to ensure that related activities do no harm to the people involved.

In this regard, the IASC Reference Group for Mental Health and Psychosocial Support has published Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergencies.²² These recommendations cover six important areas of research: (1) purpose and benefits, (2) analysis of ethical issues, (3) participation, (4) safety, (5) neutrality and (6) design. Within these six areas are sub-components that form a framework for undertaking data collection in emergency settings. All of these areas should be informed by ethical considerations, in accordance with IASC recommendations.



CONSIDERATIONS TO SUPPORT ETHICAL APPROACHES TO WORKING WITH MEANS OF VERIFICATION

- » Double-check that data collection tools or approaches have been carefully selected and assessed for appropriateness to the local language, culture and context.
- » Ensure the selection of appropriately qualified and skilled data collectors and consider if the characteristics of these data collectors (for example, their age, gender, community membership or standing) might influence how people respond to them. Factors such as power dynamics, depending on who is collecting the data, should be considered in selecting data collectors.
- » Adequately train data collectors according to established plans and procedures.
- » Be clear with data collectors about the importance of and procedures for obtaining informed consent (see pages 47-48), including for children and their caregivers.
- » Raise community awareness about the purpose of data collection and details about where respondents may go, or who they may contact, if they have questions or concerns. Descriptions of the purpose of the data collection should also aim to reduce the risk of biases in responding (for example, addressing situations where participants assume that responding in a certain way is required for aid or support to be received).
- » Complete a safety assessment to ensure that data collection is safe for both data collectors and respondents. Ensure that the system includes ways in which data collectors can be assisted if the situation becomes unsafe, along with daily tracking of data collectors' whereabouts. It is preferable for data collectors to work in pairs (preferably one male and one female, if possible). If data collectors are working alone, there must be a clear rationale and safety process in place both for them and for respondents.
- » Provide a system of support for data collectors if they are exposed to potentially distressing stories or situations.
- » Monitor data collection activities and approaches, and be flexible about changing procedures if there is a need to adapt or modify them, such as if the original plans are proving unsafe, creating difficulties for participants or increasing community tensions.
- » Always ensure that respondents know they can withdraw their participation at any time and for any reason.



INFORMED CONSENT

Informed consent is the permission that people give before agreeing to share information or have it documented in any way (including electronically or via photographs or recordings). Obtaining informed consent requires a person to understand the following:

- » The names, roles and organisation seeking their informed consent;
- » The purpose of the information being collected, how it will be used and for how long and where it will be stored;
- » The procedure(s) to be used when information is being collected;
- » How long their involvement will be required;
- » The potential risks, benefits or outcomes of being involved;
- » That they may withdraw their involvement in the activity at any time without any loss of benefits or adverse consequences;
- » That their identity and rights will be protected (including protection from potential adverse results of having shared information) and that they will not be asked to waive (give up) any of their personal human or legal rights (including not being asked to waive rights to legal action against the organisation/institution collecting the data);
- » That if they are in an especially vulnerable group, additional care will be taken to protect their information, anonymity and safety (for example, prisoners, children, survivors of torture or gender-based violence (GBV), unaccompanied minors);
- » Where and how they can submit a complaint or concern, or seek out further information;
- » Where and how information about the results of the research will be made available to them. Here it is critical to further emphasise that any information they share will be anonymised before it is reported.

The goal of an informed consent process is to provide sufficient information so that people understand what is being asked of them and that they can choose whether or not they will participate in a data collection activity. Providing complete and accurate information about the risks of participation is essential to obtaining informed consent and to promoting people's safety and well-being. This often necessitates analysis of all potential risks (including analysis of risks for different vulnerable groups) in advance of a data collection activity. This may also require consent to be obtained multiple times when multiple activities are under way (for example, if data are being collected through written responses as well as video recording). Additionally, this might involve providing people with a period of 24–48 hours to think about their participation. In all situations and whatever choice a person makes, they must be assured that they will always have access to their normal services, activities and resources.

Ideally, an explanation of informed consent should be provided in an information sheet that includes all the relevant details. A person's signed informed consent form should be separate from this information sheet so that it can be filed (but also kept separate from any other identifying data). There are situations where it is not safe or appropriate to request signed consent; in these cases verbal consent is sufficient, but the fact that verbal consent has been given should still be recorded by the data collector.

To be informed, people will need information in a format that they can understand and access. This may require information to be written in the local language or to be provided verbally (if participants are not literate) or in a simplified way (for example, explained using pictures), for instance for children or people with an intellectual disability. If a participant is of an age or ability that means they are unlikely to be able to provide informed consent, a relevant caregiver must also provide consent (see Box 6 on working with children).

BOX 6

WORKING WITH CHILDREN

When working with children, informed consent can be provided only if the child has the **legal capacity** to understand the information provided to them. This means that they are able to understand the information in the same way that an adult would. There might also be laws in different countries regarding the age at which a child may or may not provide informed consent. Always check local legal requirements for collecting information from children under the age of 18, as well as checking what is culturally acceptable. A good “standard” to follow is that if you are collecting data from children you should:

- 01** Seek full permission by providing and obtaining informed consent from their parent, legal guardian or caregiver; AND
- 02** Always provide children with an age-appropriate description of the process and seek their assent to participate, or informed consent if they are able to do so.

These are especially important considerations if seeking information from children who are particularly vulnerable, such as unaccompanied minors, youth, married children or children who are parents.

If a parent, legal guardian or caregiver does not give informed consent to information being collected about their child, OR a child does not assent to participate, data collection should not proceed.



CHAPTER 10

Reporting data

After data are entered and analysed, they must be reported in order to share results and critical information. Box 7 lists recommended elements of an M&E report.

Don't forget! When reporting data, remember also to report on any differences (including, if relevant, any statistical differences) identified from the disaggregated data. For example, are the results different, and in which ways, for girls and boys, or for women and men, or for people with disabilities? Has age influenced the results? Do other factors change the outcomes? Or has the local political, social or economic context influenced the results in any way? The reason to disaggregate data is to better understand the unique ways that certain groups (particularly groups with higher levels of vulnerability) respond to interventions. This is critical learning for humanitarian work to continuously ensure equal and equitable assistance for all.

BOX 7

M&E REPORT CHECKLIST

- » A title and date and the names of the author(s) and/or organisation presenting the report.
- » A suggested citation for the report in case others wish to reference it.
- » Acknowledgements of the people involved, such as project staff, data collection staff, data entry or analysis staff and report editors or reviewers; and especially, always thank, anonymously, the people who provided the information (for example, "We thank the women who participated in this programme and provided the information being reported") and any funding or government partners.
- » An executive summary giving an overview and brief interpretation of the important findings (that is, what the information is saying or what it means).
- » A table of contents.
- » A list of abbreviations/acronyms (for example, M&E = monitoring and evaluation).
- » An introduction to the purpose of the M&E work.
- » An overview of the project that is being evaluated, with a focus on its intended theory of change.
- » A methodology section defining indicators (for example, if indicators have multiple meanings), explaining the data collection process, the sample and how data were analysed.
- » The results, under sub-headings of key result areas, themes, evaluation questions or indicators (whichever makes most sense for your report).
- » A discussion or interpretation of what the results tell us. For example, if your data show fewer people with disabilities accessing services, the discussion or interpretation would highlight that people with disabilities are not accessing services and would explore possible barriers to access.
- » If appropriate, a list of recommendations (that is, things that could be improved by working differently). Some reports also suggest key actions necessary to achieve the recommendations.
- » Limitations of your results, which may relate to the MoV, sampling or other cautions that readers should consider if they wish to quote or use the data provided. All M&E processes (and research) have limitations. It is valuable to acknowledge these to help others avoid similar errors or to assist them in using your information appropriately.
- » A conclusion (1–2 paragraphs) about the report and its content.
- » A list of references cited in the report.
- » Any appendices. It can be very useful, if permitted, for measurement tools (such as MoV forms or interview schedules) to be added as appendices.

Sharing results and lessons learned

It has been recognised that the lack of a common M&E framework for MHPSS work in emergency settings has led to huge variations in the goals, outcomes and indicators that organisations use to measure the effectiveness of their work. This has also led to wide variations in the types of MoV used. Consequently, this has led to difficulties in demonstrating the value or impact of MHPSS programmes in emergency settings. However, even if organisations use this common M&E framework and similar MoV, it is critical that results are shared and widely disseminated so that others can benefit from lessons learned. Over time, the resulting data can be used to build a body of evidence to advocate for MHPSS resources. Therefore, when using this common framework, organisations are encouraged to share their findings, results, challenges and lessons, irrespective of whether the impact has been positive. It is just as critical to learn about what has not worked to avoid repeating the same mistakes.

Any MHPSS programme should include M&E reporting, in some format, as part of responsible and ethical programming practice and to promote accountability to affected communities. There are many formal and informal ways that results can be documented, including standard organisational or donor reporting templates, project notes, published reports, one-page fact sheets or (open access) peer-reviewed journal articles. Depending on how results are documented, there are also many formal and informal ways in which findings can be shared. For example, results can be posted on the www.MHPSS.net website, shared with others in the sector through MHPSS meetings, country-level coordination groups or conferences, or published as reports or articles.

The ultimate aim is to ensure that most, if not all, organisations implementing MHPSS activities in emergency settings are measuring some shared constructs, which can eventually form part of the literature reviews that move the collective state of knowledge for MHPSS forward.

BOX 8

SHARING RESULTS WITH RESPONDENTS AND COMMUNITIES

The participants and communities involved in M&E activities (including those who have contributed information) have a right to also review and learn from the findings. Unless there is a clear reason why such information should not be shared (for example, if it potentially poses harm), findings should be widely shared in a way that is suitable for respondents and their situation. This often requires additional effort and funding to present information in a way that can be easily understood, such as using plain language or graphics to explain the results and clear descriptions about how the information will be used (for example, how it will help to improve services or increase service user satisfaction). When adapting the findings, consider the target audience and what may be necessary according to age groups, gender, contexts or for people with disabilities. **Critically, any information shared from M&E activities must protect the anonymity and confidentiality of people who responded. Thus, data should be anonymised before being reported and shared publicly.** These actions are consistent with the principles of participation and do no harm, which are core principles of the IASC MHPSS Guidelines in Emergency Settings and of this framework. Additionally, findings may either confirm participants' beliefs or perceptions or, in some cases, they may be different from what is expected. Actors involved in sharing results should plan for both situations and identify the most useful approach to sharing results for their purposes in each scenario.

CHAPTER 12

Conclusion

Work in the area of MHPSS in emergency settings is expanding. The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings are widely used to direct that work. Efforts to ascertain the best possible impacts of MHPSS approaches have also grown, but global MHPSS actors have lacked a common M&E framework in which to report on their work in a unified way. Through academic, expert and global-, regional- and country-level consultations – underpinned by the six core principles of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings – the common M&E framework described in this publication offers a goal statement and five outcomes, plus a selection of indicators and MoV. The framework is intended to assist organisations in using at least one (or a few) of these measures, in an ethical way, as part of their efforts to reduce suffering and improve mental and psychosocial well-being.

WE WANT YOUR FEEDBACK

The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings is the first product of its kind, aiming to establish guidance for M&E approaches as they relate to the goals of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. After further regional and country-level use and testing, it is anticipated that valuable new lessons will emerge. Receiving feedback on how this publication has been helpful, or suggestions of ways that it could be improved, will greatly benefit any future revisions. Please forward your feedback to the IASC Reference Group for MHPSS at: mhpss.refgroup@gmail.com.



Academic reviews to support development of the common framework (goal, outcomes and indicators)

INTRODUCTION

Johns Hopkins University performed two reviews to help guide the development of the Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings. First, it reviewed logical frameworks (logframes) and “theory of change” documents. Second, it reviewed the academic literature to identify the most commonly applied strategies used to monitor and evaluate MHPSS interventions in humanitarian settings in low- and middle-income countries. Findings from the first phase of the review process revealed significant and confusing overlaps in project goals and outcomes, as well as confusion around the definitions of goals and purposes of MHPSS programmes and research. Furthermore, while most reports of MHPSS implementation projects focused on wider MHPSS constructs (such as descriptions of general psychosocial support, information provision and strengthening community and family supports), the review found that research continued to focus mainly on individual clinical interventions and training to achieve those goals. Findings from the first phase of the review confirmed that a common M&E framework for MHPSS, based on the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, would be very beneficial for improving the ability of MHPSS implementers to align their work plans to a common goal and range of outcomes. The second phase of the review focused on identifying potential indicators for the framework.

METHODS

Logframes and theory of change documents were collected from member organisations of the IASC Reference Group on Mental Health and Psychosocial Support (IASC MHPSS RG); these included multiple disciplines in which MHPSS work is implemented.

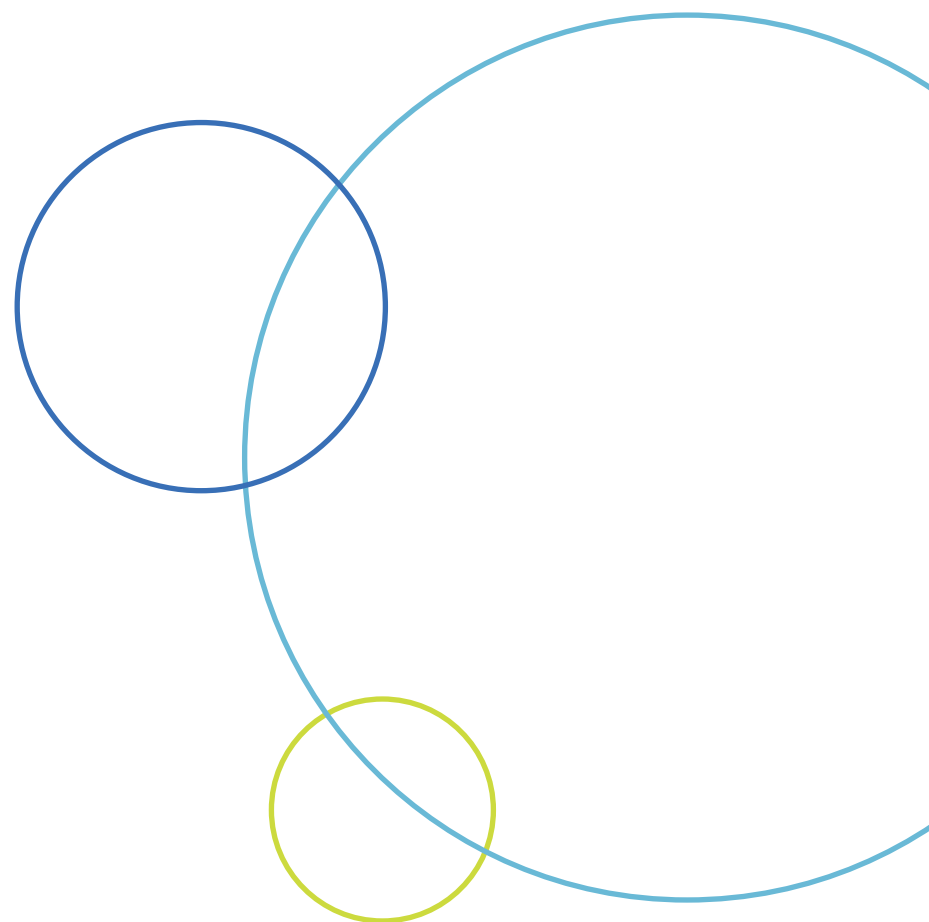
All logframes, theory of change documents, geographic locations, agencies, individuals, donors and budget details were anonymised prior to data being extracted from the documents. Embase, PILOTS, PsycInfo, PubMed/MEDLINE and WHO regional databases were searched for peer-reviewed studies. The academic literature search was restricted to peer-reviewed articles describing M&E for MHPSS in humanitarian settings in low- and middle-income countries. Inductive and deductive strategies were used for analysis. MHPSS constructs were grouped “from the ground up”, using the inductive strategy for thematic content analysis. The deductive strategy was used to first map data and then group themes according to the goal and outcomes drafted by the IASC MHPSS RG. Systematic differences in mapping and gaps in the current version of the framework were identified, based on the inductive development of themes.

RESULTS

Based on deductive analysis, the distribution of mapping the information extracted from the logframes and articles onto the draft common framework goal, outcomes and indicators is described in Figures 5 and 6. Across the logframes and peer-reviewed articles, **six distinct** themes were identified using the inductive analysis at the goal and outcome levels:

1. Increasing resilience, promoting social well-being and preventing mental health and psychosocial problems. The overarching idea behind this theme is that programmes strive to support or enhance individual resilience and well-being.
2. The goal of reducing mental illness and psychosocial symptoms and associated functional impairment through care.
3. Building capacity to identify, intervene in and monitor MHPSS problems. While this theme may be implicit within the overall goal drafted for the framework, it was not directly reflected in the outcomes, reflecting a potential gap in the draft (since many logframes and articles mentioned this explicitly as a goal).
4. The goal of promoting optimal human development within existing social systems. This theme differed from the second theme in that programmes specifically sought to support or enhance community-level structures and systems that would, in turn, promote individual healthy development and enhanced quality of life, including physical health and social and economic development.

5. Macro-level goals that sought to build peace among groups after conflict and to address structural problems within societies.
6. Goals pertaining to the protection of vulnerable groups, such as women, children, the elderly and people with disabilities.



CONCLUSIONS

Overall, the reviews indicated that the draft common framework could be generally applied to existing programmes and peer-reviewed literature, but clearly defining goals and outcomes would be essential to such an application. The reviews also found that even though psychometrically sound means of verification are published in peer-reviewed literature, these were not commonly applied to logframes or theories of change used in programming.

FIGURE 5
The common M&E framework outcome mapping frequencies for logframes

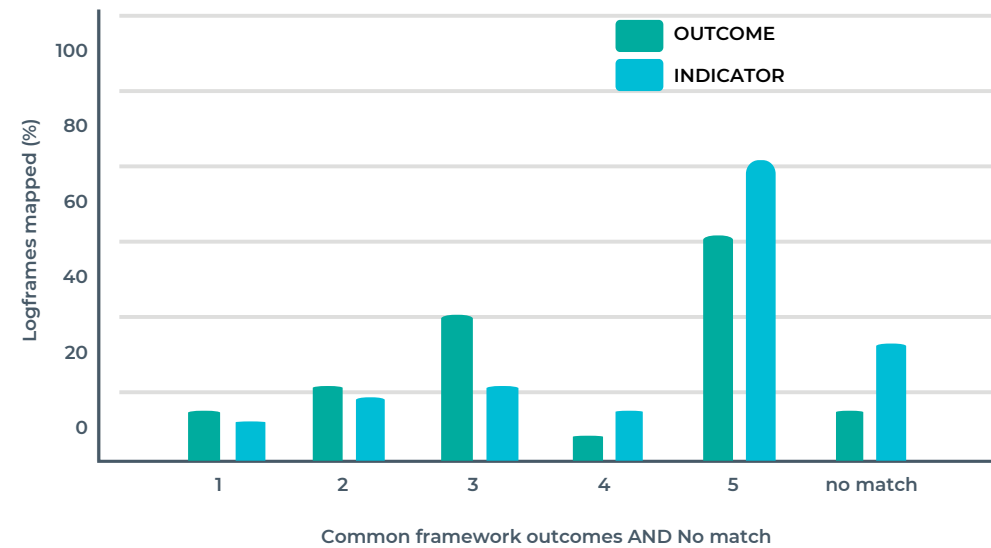
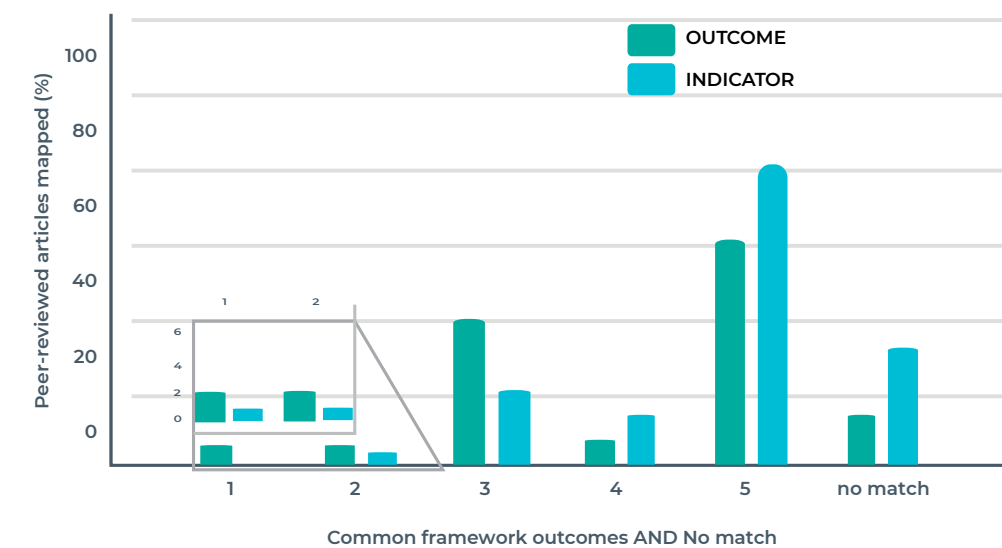


FIGURE 6
The common M&E framework outcome mapping frequencies for peer-reviewed articles and book chapters



ANNEX 2

Systematic process for the selection of means of verification

Means of verification corresponding to the six goal impact indicators were identified via literature reviews and through a call to member organisations of the IASC Reference Group on MHPSS in Emergency Settings (IASC MHPSS RG) to share commonly used MoVs and approaches, including quantitative and qualitative measurement approaches. Published studies were also identified from six literature reviews^{23,24,25,26,27} and were included in the review if they had used at least one measurement tool (MoV) to assess one of the six goal impact indicators.

To assess the MoV identified through the review process, a thematic working group within the IASC MHPSS RG determined “inclusion/exclusion” criteria against which every identified measure was assessed. For an MoV to be included it had to meet four criteria, which were assessed sequentially, meaning that if a given measure did not meet the first criterion, the remaining criteria were not assessed. The criteria were (in order):

1. Accessibility (that is, a global public good with free access);
2. Relevance (that is, relevant to at least one of the six indicators; used in at least one other language other than the language it was created in; used in a low-resource setting);
3. Feasibility (that is, brief administration time, available guidance for scoring and interpretation of data); and
4. Appropriate measurement properties (that is, demonstrated to be adequately reliable and valid in at least two settings).

Each of the measures identified from the review was assessed against the inclusion/exclusion criteria. Measures meeting the criteria were sorted according to age ranges and impact indicators. A multi-stakeholder meeting reviewed these measures and selected final measures for each impact indicator and age range.

- » Where there were more than five measures per age range (per indicator), the group provided a rationale for their selection (for example, well known, many organisations already use the measure, ease of administration).
- » During this process, gaps in measures within age groups and impact indicators were identified. To address this, the gap areas were specifically reviewed in-depth, and the same processes repeated. Specific gaps identified at this stage included measures of early child development (measures for children < 5 years), stigma, social connectedness and behaviour, and alcohol and substance use. Specific measures were also proposed by members of the IASC MHPSS RG part-way through the review and were assessed (based on the inclusion/exclusion criteria) when the proposals were received.
- » To identify MoV specifically pertaining to these particular gap areas, consultations with content experts were conducted and measures proposed by experts were evaluated against the inclusion/exclusion criteria.

The working group originally determined seven possible age ranges to consider for each goal impact indicator: ages 0–4, 5–9, 10–15, 16–19, 20–25, 26–59, and 60+. However, as measures were being assessed and selected, the children’s age ranges varied and showed a more common breakdown into ages 0–5, 6–11, and 12–17. Of the measures

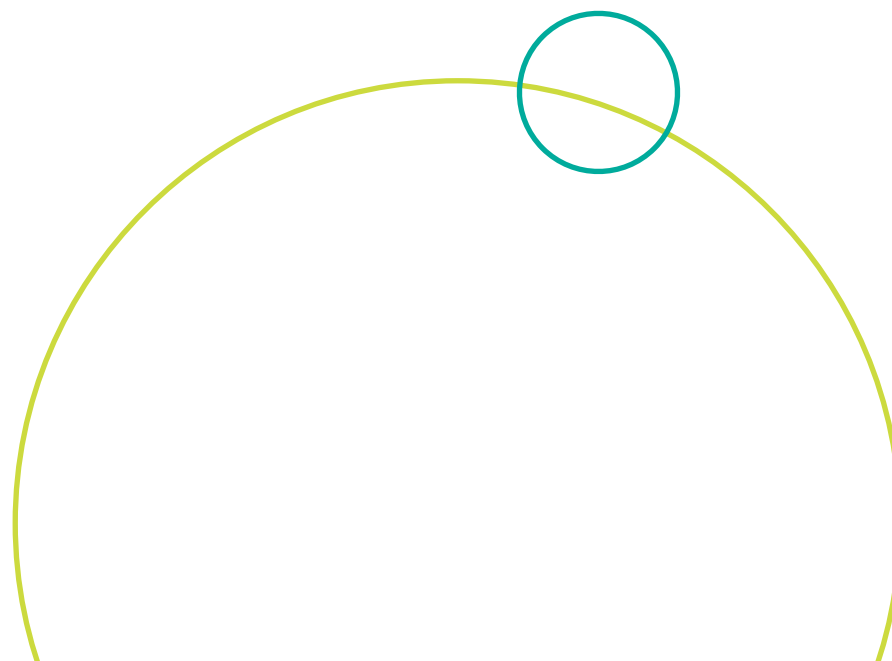
assessed, most did not make a clear distinction for the adult age groups, separating young adults (18–25), adults (26–59) and older persons (60+). These were therefore collapsed and provided as one age range. Nonetheless, the division of adult ages was documented in the framework to acknowledge the lack of differentiation of adult measures reflecting different phases of adult life. MoV for children are also indicated in Annexes 8 and 9 where they may be relevant for slightly older or younger children than represented in the specific age ranges.

Qualitative approaches were identified in the literature reviews and attempts were made to organise them according to a commonly used framework.²⁸ However, this resulted mainly in using only common qualitative approaches, such as focus group discussions (FGDs) or key informant interviews (KIIs), and the literature did not specify the range of strategies that could be used within such approaches (for example, body mapping, ranking). Therefore, a different strategy was employed. The working group defined the core concept of each goal impact indicator, with the intention that this could be used to inform the selection of qualitative methods.

It was understood that, in practice, the appropriateness and quality of qualitative approaches depend largely on the target population (for example, age appropriateness), how methods are implemented (such as how well an FGD is facilitated) and systems of analysis (for example, analysing themes or establishing theories according to theory of knowledge, theoretical perspective and methodology). Next, the working group requested commonly used qualitative approaches from members of the IASC MHPSS RG. These approaches were accordingly assessed for their appropriateness to the age-related impact indicators, with support from expert consultations.

For quantitative MoVs, the IASC MHPSS RG sought permission from the relevant developers for their materials to be included in this document. Developers additionally confirmed information provided in Annex 8. This final guidance document was prepared by agencies of the IASC MHPSS Reference Group and underwent multiple peer review processes before publication.

This process of assessing MoV identified important gap areas: notably, measures for young adults (as differentiated from adults), for people aged 60+ years and for people engaged in harmful alcohol and substance use. Although many tools in these areas are globally available, their utilisation and their appropriateness for humanitarian contexts require further research. Additionally, it must be noted that while the identified MoV may have demonstrated validity and reliability in multiple settings, these were not necessarily humanitarian settings, and no measures are universally applicable.



Adapting an existing MoV

Adapting an existing MoV to a local context or setting can be a very important process in initiating effective monitoring and evaluation. Adaptation processes vary, along with the length of time and number (or cost) of resources needed. It depends on how many adaptations are made. Figure 7 summarises the common steps involved in adapting an existing MoV. Any adaptation should ensure that each step is covered, although some steps may take less time or be less resource-intensive, depending on the adaptations being made. If you have a local MHPSS expert who speaks both the language of the original MoV and the language of the country or community where it is being implemented (for example, English and Zulu), the adaptation process may be more efficient.

FIGURE 7
Summary of adaptation process for existing MoV

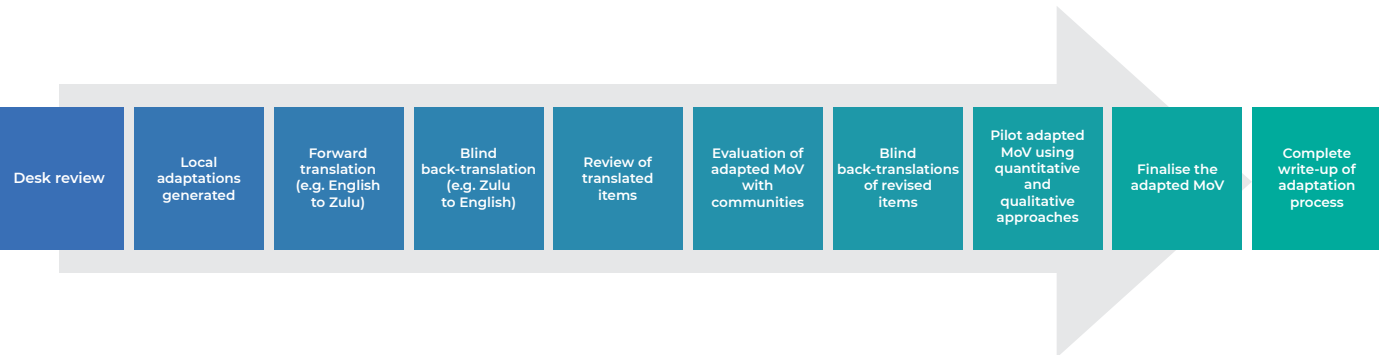


Table 6 details the steps highlighted in Figure 7. Written documentation of each stage is recommended. Appendix 10 provides a sample adaptation/translation monitoring form to support documentation, which should record decisions made about specific items, words or concepts and should track the process for future reference. This can be helpful when additional adaptations are made in the same language, since many MHPSS MoV refer to similar ideas or words (for example, stress, sadness, happiness, well-being), and can also serve as part of a living glossary of locally relevant terms to share with new MHPSS actors joining a response. At each step, an adaptation process should aim to achieve four important criteria:

1. **Comprehensibility:** Is the adapted/translated item known and clear to the local population?
2. **Acceptability:** Would certain individuals or communities be comfortable responding honestly to this item? For instance, is the item appropriate and might it cause any harm or impose a burden (for example, stigma, embarrassment, distress, length of time)?
3. **Relevance:** Is the item applicable (relevant) in the local culture?
4. **Completeness:** Does the adapted/translated item have the same meaning (assess the same concept) as the original MoV?

TABLE 6. DESCRIPTION OF STEPS FOR ADAPTING AN EXISTING MOV

Desk review (assessing for comprehensibility, acceptability, relevance)	<p>A review of existing documents about MHPSS and the local culture and context provides important knowledge for the adaptation process. It can inform what might be relevant or acceptable to local people and the terms they use (for example, describing depression or anxiety as “thinking too much”). Desk reviews may include information about:</p> <ul style="list-style-type: none"> • local expressions of distress; • how people understand or view mental health and psychosocial problems; • concepts of the self/person (for example, relations between body, mind, soul, spirit, community); • help-seeking patterns; • gender differences in all of the above factors. <p>Where existing documents are not available, it may be possible to undertake brief and informal discussions with local key informants (for example, health workers, community elders, children or parents) to seek out similar information. This is known as ethnographic information (but it may not be necessary or feasible to undertake a full ethnographic study).</p>
Local adaptations generated (assessing for comprehensibility, acceptability, completeness)	<p>Working with speakers of the local language, ideally with MHPSS and/or M&E experience, adaptations to the original MoV can be suggested. The changes needed will vary, but some common adaptations are:</p> <ul style="list-style-type: none"> • words or concepts that may be difficult to describe in a culture (for example, distinguishing stress from anxiety); • items that may be culturally insensitive or unacceptable to ask about (for example, sexual orientation or potentially offensive questions such as implying that a mother is a poor caregiver); • items that may be irrelevant (for example, ability to concentrate on television programmes); • the degrees of measurement (for example, local perceptions of “a little”, “somewhat” and “a lot”) and how these are presented (for example, are they best described in words or pictures?).
Forward translation	<p>A bilingual person (someone who reads and speaks both the language of the original MoV and the local language) translates the adapted MoV into the local language.</p>
Blind back-translation (assessing for comprehensibility, relevance, completeness)	<p>A different bilingual person translates the forward translation back into the original language of the MoV. This is called “blind” because the person doing this back-translation should not have access to, or have previously seen, the original MoV.</p>
Review of translated items (assessing for comprehensibility, acceptability, relevance, completeness)	<p>The original MoV is compared with the blind back-translation. Ideally, this should be completed in a meeting with the persons who completed the forward and blind back-translations, as well as an MHPSS expert who can confirm that the structure of the MoV and the meaning of the words and concepts are maintained. Where there are challenges with particular items or words, these can be discussed by the group (translators and MHPSS expert) and consensus reached on the best alternative.</p>
Evaluation of adapted MoV with communities (assessing for comprehensibility, acceptability, relevance)	<p>The fully translated and adapted MoV is reviewed by selected community members during focus group discussions (FGDs). People in the FGDs should represent any important disaggregated group that the MoV will be used with (for example, relevant gender, age ranges, people with disabilities, refugee/host groups). During the FGDs, participants can be asked, in age-appropriate ways, to:</p> <ul style="list-style-type: none"> • describe each item and to comment on its meaning (comprehensibility); • describe their likely response to being asked these questions (acceptability); • confirm if these items represent challenges for people in their communities (relevance); and • suggest alternatives or improvements to the items, such as different local words or ideas to communicate the topics being measured
Blind back-translation of revised items (assessing for comprehensibility, relevance, completeness)	<p>Following evaluation of the adapted MoV with communities, another blind back-translation of the revised items is undertaken and the review of translated items. Note: for more changes, you may need to work with a new bilingual translator to make additional blind back-translations.</p>

<p>Pilot adapted MoV using quantitative and qualitative approaches (assessing for comprehensibility, acceptability, relevance, completeness, as well as feasibility, accessibility, reliability and validity).</p> <p>Depending on how many adaptation changes are made, this may require support from MHPSS, M&E and/or research experts. There might also be a need for an ethics review and approval.</p>	<p>Pilot-testing an adapted MoV in the language it will be used in aims to see how it works in practice in the intended setting. It helps to determine if the adapted MoV meets the measurement criteria (of comprehensibility, acceptability, relevance, completeness) and, if using quantitative approaches, to assess reliability, validity and other psychometric properties. For qualitative approaches, it assesses criteria such as feasibility and accessibility.</p> <p>Where adaptation has resulted in few or minor changes from the original MoV, full quantitative assessment may not be necessary. However, it is recommended that if quantitative assessment is not being undertaken, greater emphasis is placed on the qualitative assessment. This would include cognitive interviewing. The purpose of cognitive interviewing is to ensure that respondents can understand the items/questions and that they do so in (a) a consistent way; and (b) in the way that is intended.</p> <p>Cognitive interviewing asks participants to verbalise their understanding of items to see if they interpret them as intended, or differently. Each pilot test participant is invited to respond to every item and then describe their decision-making process by asking:</p> <ul style="list-style-type: none"> • Why did you give that response? • How did you understand that question? <p>If an adapted (or new) MoV has undergone major changes (for example, to a number of items, to the response scale or response options, to the content of the items, or key word changes where meaning differs from the original), a quantitative assessment for reliability and validity may be necessary.</p> <p>Reliability is usually assessed in three ways:</p> <ul style="list-style-type: none"> • Internal reliability (internal consistency) to ensure that items across a measure consistently produce the same results; • Test/re-test reliability to ensure that responses are likely to be consistent/similar over time (that is, at different time points under similar conditions); • Inter-rater reliability to ensure that different people responding to the information give consistent/similar answers for the same behaviour or presentation of symptoms. <p>There are many types of measurement validity that can be assessed, but they fall under three main categories:</p> <ul style="list-style-type: none"> • Construct validity – the extent to which a measure assesses the theoretical construct it is intended to measure (for example, if a measure of hope correctly identifies a person with hope); • Content validity – the extent to which the MoV's content represents the concept(s) to be measured; • Criterion-related validity – strength of relationship between the MoV and a measurable external criterion. <p>The details and statistics necessary to determine quantitative reliability and validity are beyond the scope of this guide. Many M&E experts, MHPSS experts and academics engaged in health research are familiar with these approaches and can assist with plans to complete reliability and validity testing. However, it is crucial to be prepared. Establishing the reliability and validity of a measure is time-consuming (1–3 months) and can be resource-intensive. Multiple questionnaires may need to be administered multiple times with multiple individuals or groups. In a protracted crisis, there may be time and funds available for detailed work like this; however, it is unlikely to be a suitable approach in a rapid-onset emergency.</p>
<p>Finalise the adapted MoV</p>	<p>After pilot testing, additional minor adjustments are made to the MoV to finalise its adaptation. If the pilot suggests that major changes are needed for the MoV (for example, many items to be added, removed or reworded, or the administration procedure has changed significantly), then previous steps in the process will need to be repeated.</p>
<p>Complete write-up of adaptation process</p>	<p>Documenting the steps and adaptations as you go and including a final copy of the two language versions of the adapted MoV completes the write-up of the adaptation process. This information will assist greatly if new MoV are adapted to the same language. It will also provide supporting evidence of an MoV being appropriately adapted and viewed as a strong measurement tool. Sharing these resources (such as with Technical Working Groups or online) can also reduce duplication and save valuable time and resources for others working with these communities. Including challenges faced during the process and any limitations of the adapted MoV (which is true for every measure) will help others to use the information and the adapted measure appropriately.</p>

Notes on Annexes 4–7

The following annexes provide sample logframes for different types of MHPSS responses in emergencies. The logframes are not comprehensive or technical examples of MHPSS programmes. Nor are they intended to be instructive or illustrative of how MHPSS programmes should be designed. However, they are intended to provide an abbreviated example of how aspects of the common M&E framework and means of verification might be embedded into a wider, organisation-specific programme design.

The background and programme descriptions focus on common scenarios in emergency settings and the types of goals, outcomes and outputs that such programmes target. Based on the context, the assessed needs and the priorities of the organisation, a programme design is prepared, which should include the following:

- » For programme goals, at least one goal impact indicator (Gi) has been selected from the common framework and included as a measure.
- » For programme outcomes, at least one outcome plus one or more outcome indicators (I) have been selected from the common framework and included as a measure.
- » Sample outputs show the types of activities that may lead to the achievement of the outcomes and, ultimately, the goal.
- » Mov, which may include programmatic or other types of information and/or MoV included in this framework.

It is important to observe that goal and outcome statements, and even indicators, are not always worded exactly as they are in the common framework. Rather, key words from the common framework have been used to strengthen the relevance of the goal, outcome or indicator to the organisation-specific programme. However, the meaning of what is being targeted and measured remains the same. This

demonstrates the flexibility of the common framework for individual organisations and their unique programmes. Furthermore, it is important to note that the common framework does not cover all goals, outcomes or indicators.

To help understand where goals, outcomes and indicators in these abbreviated logframes link back to the common framework, specific reference numbers have been added to guide the reader.

ANNEX 4

Sample framework for providing emergency supplies in response to an earthquake

Background and programme description: An earthquake has struck the capital city, leaving hundreds of thousands of people without homes or access to basic services. Your organisation has mounted an emergency response to help families meet their immediate needs, including temporary shelter and the distribution of family kits for

non-food items. You are asked to integrate psychosocial aspects into the initial relief work, ensuring that the core principles of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings are followed and that people receive aid in a dignified and safe way.

Sample (abbreviated) logframe:

	Indicators	Means of verification
Programme goal: Earthquake-affected families feel safe, have access to emergency supplies and feel ready to cope with emergency recovery	<ul style="list-style-type: none"> Percentage of affected people who have necessary shelter and non-food items Percentage of women, men, girls and boys who report feeling safe, calm and able to cope with problems [G12] 	<ul style="list-style-type: none"> Project documentation Rapid post-distribution evaluation Key informant interviews Brief COPE Inventory
Outcome A: Equipment for basic needs is distributed to 5000 families	<ul style="list-style-type: none"> 5000 tents used by families in need 5000 family non-food item kits used by families in need 	<ul style="list-style-type: none"> Distribution records
Output A.1: Distribution of 5000 four-person tents		
Output A.2: Distribution of 5000 family non-food item kits		
Outcome B: Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable [O1]	<ul style="list-style-type: none"> Percentage of staff trained and following guidance from the IASC Guidelines on MHPSS in Emergency Settings [O1.4] Number of affected people who know codes of conduct for humanitarian workers and how to raise concerns about violations [O1.6] Percentage of affected people who report that emergency responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully [O1.1] 	<ul style="list-style-type: none"> Project training records Distribution records Rapid post-distribution evaluation Key informant interviews Focus group discussions
Output B.1: Emergency response staff are briefed on the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, using action sheets relevant to their sectors		
Output B.2: Women, men, girls and boys are consulted to identify critical items to be included in non-food item kits		
Output B.3: Flyers (including organisational information, list of beneficiary rights and a complaints mechanism description) are designed, printed and included in distribution kits		

Sample framework for a programme to protect and support women affected by or at risk of sexual violence

Background and programme description: A conflict has been raging for years in the Zal community and women widely report sexual violence, past and present. This has led women to feel unsafe and unable to move about the community. In addition, many women are experiencing depressive symptoms to the extent that they do not feel able

to engage in their daily activities. In collaboration with a local welfare services agency, your organisation establishes a programme to respond to the needs of women affected by or at risk of sexual violence.

Sample (abbreviated) logframe:

	Indicators	Means of verification
Programme goal: Reduced suffering and improved mental health and psychosocial well-being [G] among women in the Zal community	<ul style="list-style-type: none"> Percentage of Zal women who feel safe in their community [O2.6] Percentage of Zal women using mental health and psychosocial support services with improved daily functioning [Gi1] Number of reported incidences of sexual violence in Zal 	<ul style="list-style-type: none"> WHO Disability Assessment Schedule (WHODAS 2.0) Community survey of women with regard to subjective well-being and safety Risk and resource mapping Barriers to Accessing Care Evaluation (BACE) Documentation from local authorities
Outcome A: Women are safe, protected [O2] and able to move about their community	<ul style="list-style-type: none"> Percentage of Zal women who, after training, use new skills and knowledge for prevention of risks and referral [O2.4] Percentage of Zal women who feel safe in their community [O2.6] 	<ul style="list-style-type: none"> Project training records Community survey of women with regard to subjective well-being and safety FGDs
Output A.1: Risk mitigation interventions are implemented: better-located latrines with adequate lighting, fuel-efficient stoves and the formation of groups for safe movement		
Output A.2: Community groups learn and implement “smartphone safety” approaches to promote safe routes for women moving within their communities		
Output A.3: Posters are designed to promote services available for women who may be experiencing depression		
Outcome B: Community welfare officers provide interpersonal therapy for women with depression [O5]	<ul style="list-style-type: none"> Number of Zal women receiving interpersonal therapy [O5.4] Percentage of Zal women receiving interpersonal therapy who report increased functioning and reduced symptoms of depression [Gi1; Gi3] Lay helpers providing interpersonal therapy interventions report satisfaction with supervision support 	<ul style="list-style-type: none"> Client records WHO Disability Assessment Schedule (WHODAS 2.0) Patient Health Questionnaire (PHQ-9) Weekly data on depression collected at the beginning of interpersonal therapy sessions FGDs with lay helpers
Output B.1: Thirty interpersonal therapy lay helpers across 10 community welfare service offices are trained		
Output B.2: Lay helpers provide interpersonal therapy		
Output B.3: Interpersonal therapy lay helpers participate in weekly group supervision		

Sample framework for a children's informal education programme

Background and programme description: Families have been displaced by war for more than three years and are living in a refugee camp. Children are not permitted to attend school in their host community. Your organisation coordinates an

informal education programme with refugee children to promote ongoing learning, psychosocial support and life skills activities.

Sample (abbreviated) logframe:

	Indicators	Means of verification
Programme goal: Improved psychosocial well-being [G] of children living in the refugee camp	<ul style="list-style-type: none"> Improved feelings of social connectedness among children [Gi6] Improved subjective well-being among children [Gi2] Children's literacy and numeracy skills improve by at least two levels through the course of the programme 	<ul style="list-style-type: none"> Social Connectedness Scale – Revised (SCS-R) Social mapping Stirling Children's Wellbeing Scale (SCWBS) Storytelling Tracking of child-led indicators Education records
Outcome A: Children participating in the programme improve literacy, numeracy and problem-solving skills [O3]	<ul style="list-style-type: none"> Increased literacy skills Improved numeracy skills Ability of children to cope with psychosocial problems [Gi4] 	<ul style="list-style-type: none"> Education records Children's qualitative evaluation
Output A.1: Teachers deliver literacy and numeracy education modules		
Output A.2: Participatory life skills modules are implemented with children		
Output A.3: Teachers are trained to provide a teaching environment that promotes social interaction and psychosocial support for children		
Outcome B: Children with specific protection and mental health needs are referred for specialised care	<ul style="list-style-type: none"> Increased teacher knowledge of procedures for referral of children with specific protection and mental health needs Number of children referred to specialised services [O5.6] 	<ul style="list-style-type: none"> Referral records
Output B.1: Referral networks, pathways and processes are mapped and documented		
Output B.2: Teachers are trained in codes of conduct and to identify and manage referral of children where needed		

Sample framework for a health programme to treat people with mental health conditions in primary health-care clinics

Background and programme description: In an effort to reduce the mental health care gap, your organisation has partnered with the Ministry of Health to provide training and support to primary health care nurses to identify, manage and treat

women, men, girls and boys with mental health conditions. An important component of this work is community education about community-based care needs of people living with mental health conditions.

Sample (abbreviated) logframe:

	Indicators	Means of verification
Programme goal: People living with mental health conditions experience improved mental health and psychosocial well-being [G]	<ul style="list-style-type: none"> Number of individuals with mental health conditions reporting a reduction in symptoms [Gi3] Number of individuals with mental health conditions reporting an improvement in functioning [Gi1] 	<ul style="list-style-type: none"> Health-care facility records Patient records with relevant questionnaires Patient Health Questionnaire (PHQ-9) Generalized Anxiety Disorder (GAD-7) WHO Disability Assessment Schedule (WHODAS 2.0) Most significant change (MSC) FGDs
Outcome A: Nurses at primary health care facilities identify, manage and support individuals living with mental health conditions	<ul style="list-style-type: none"> Percentage of medical facilities which have staff trained to identify mental health conditions and to support people with mental health and psychosocial problems [O5.1] Number of women, men, girls and boys who receive clinical management of mental, neurological and substance use (MNS) disorders through primary health care services [O5.5] Increased availability and restocking of essential medicines for mental health conditions 	<ul style="list-style-type: none"> Ministry of Health records Health-care facility records Patient records
Output A.1: Nurses in primary health care facilities receive training and supervision in the WHO Mental Health GAP Action Programme Intervention Guide (mhGAP-IG)		
Output A.2: Provision of psychotropic medications is supported		
Outcome B: Communities and families support people with mental health and psychosocial problems [O4]	<ul style="list-style-type: none"> Perceptions, knowledge, attitudes and behaviours of community members towards people with mental health and psychosocial problems [O4.4] Level of social capital of individuals with mental health and psychosocial problems [O4.3] 	<ul style="list-style-type: none"> Community survey at baseline and follow-up Key informant interviews and social capital assessment of individuals receiving treatment for mental health conditions Discrimination and Stigma Scale (DISC-12) Short Adapted Social Capital Assessment Tool (SASCAT)
Output B.1: Implementation of community educational campaign about mental health		
Output B.2: Engagement with local organisations to encourage the inclusion of individuals living with mental health conditions to engage in community livelihoods opportunities		

Summary of recommended quantitative MoV

MoV full name	Adult Hope Scale
MoV short name	AHS
Relevant goal impact indicator(s)	Coping
Relevant for age ranges	17 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The Adult Hope Scale contains 12 items. Four items measure pathways thinking (that is, thinking that involves planning to meet goals), four items measure agency thinking (that is, motivation and confidence in one's ability to take action according to plans) and four are filler items. Participants respond to each item using an eight-point scale ranging from "definitely false" to "definitely true"; the scale takes only a few minutes to complete.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The AHS is a self-report instrument. Link to scoring: https://ppc.sas.upenn.edu/resources/questionnaires-researchers/adult-hope-scale
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Higher scores indicate more hope.
Versions/related measures	
Limitations	
Developer disclaimer	
Developer/author contact	Dr. Charles R. Snyder
Original access point (as at publication date)	https://ppc.sas.upenn.edu/resources/questionnaires-researchers/adult-hope-scale

MoV full name	Aggression Questionnaire
MoV short name	AQ
Relevant goal impact indicator(s)	Social behaviour
Relevant for age ranges	9–25 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The Aggression Questionnaire (AQ) is a 29-item, four-factor instrument that was designed as a measure of tendencies towards physical aggression, verbal aggression, anger and hostility.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The AQ is a self-report instrument.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/aggression-questionnaire-original-article-and-scoring</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	<p>The score for each scale is the sum of the ratings for its items. The total score for aggression is the sum of these scale scores.</p> <p>Remember to reverse the scoring of the two items worded in the direction opposite to aggression.</p>
Versions/related measures	
Limitations	The AQ was originally developed to measure stable tendencies towards aggression and not as a measure of change following an intervention. However, it has been used for these purposes in some settings.
Developer disclaimer	This measure is free to use for research purposes and in M&E.
Developer/author contact	<p>Arnold H. Buss buss@psy.utexas.edu</p> <p>Mark Perry mperry@uaptc.edu</p>
Original access point (as at publication date)	https://psycnet.apa.org/doiLanding?doi=10.1037%2F0022-3514.63.3.452

MoV full name	Alcohol, Smoking and Substance Involvement Screening Test*
MoV short name	ASSIST
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	18 years and older 12–17 with modified scoring cut-offs; see Table 3 in: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4301997/
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The ASSIST is an eight-item questionnaire developed to assess use of 10 different categories of substance. It can be used to provide an indication of the level of risk associated with a person's substance use, and whether use is hazardous and likely to be causing harm (now or in the future) if it continues.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The ASSIST was designed to be administered as an interview by a health or social service worker. It takes approximately 5–10 minutes to administer. Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/alcohol-smoking-and-substance-involvement-screening-test-assist-manual
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Scoring is done by adding the scores of questions 2 to 7. Responses to Q8 are not included in calculating specific substance involvement scores, but injecting is an indicator of risk.
Versions/related measures	There are some versions of the ASSIST available on the website linked above and in languages other than English. Please contact WHO for support and registration if you are planning to translate the ASSIST materials or resources into your language.
Limitations	It is extremely important for health workers to understand the scoring of the ASSIST responses to questions before first administering the questionnaire. If the client's responses are not coded appropriately then the final score may be erroneous, leading to inappropriate feedback and a potentially inappropriate intervention.
Developer disclaimer	
Developer/author contact	World Health Organization ASSIST Project MSD-ADA@who.int
Original access point (as at publication date)	https://www.who.int/publications/i/item/978924159938-2

* Some of the MoV recommended in this framework (for example, PHQ-9, GAD-7, PCL-5, RCADS-25, AUDIT, ASSIST) are self-report measures of clinical constructs. These measures are not recommended as a way to estimate exact prevalence of mental health conditions (that is, how many people have a condition in a population). Studies have shown that self-report measures commonly overestimate rates of mental health conditions.^{14,15,16} They are included here because they may be useful to give an approximate indication of an MHPSS programme's or project's impact on distress, such as depressive, anxiety and post-traumatic stress symptoms. As mentioned elsewhere in this guide, users of these MoV should give due attention to evidence for validity in the local or in similar contexts before using them.

MoV full name	Alcohol Use Disorders Identification Test*
MoV short name	AUDIT
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	12 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The AUDIT is a 10-item questionnaire that assesses an individual's alcohol use. It includes questions as to quantity and frequency of alcohol use, binge drinking, symptoms of dependence and alcohol-related problems. It is well known for identifying people who have alcohol-related problems but for whom alcohol dependence does not apply. It has also been found to be useful across multiple cultural groups and in identifying alcohol use problems among men and women.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The measure can be administered as either a self-report instrument or an interview. Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/alcohol-use-disorders-identification-test-audit-manual
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	A score of 8+ on the AUDIT generally indicates harmful or hazardous drinking. Questions 1–8 = 0, 1, 2, 3 or 4 points. Questions 9 and 10 are scored 0, 2 or 4 only.
Versions/related measures	
Limitations	
Developer disclaimer	
Developer/author contact	WHO Department of Mental Health and Substance Use MSD-ADA@who.int
Original access point (as at publication date)	https://www.who.int/substance_abuse/publications/audit/en/

*Some of the MoV recommended in this framework (for example, PHQ-9, GAD-7, PCL-5, RCADS-25, AUDIT, ASSIST) are self-report measures of clinical constructs. These measures are not recommended as a way to estimate exact prevalence of mental health conditions (that is, how many people have a condition in a population). Studies have shown that self-report measures commonly overestimate rates of mental health conditions.^{14,15,16} They are included here because they may be useful to give an approximate indication of an MHPSS programme's or project's impact on distress, such as depressive, anxiety and post-traumatic stress symptoms. As mentioned elsewhere in this guide, users of these MoV should give due attention to evidence for validity in the local or in similar contexts before using them.

MoV full name	Barriers to Accessing Care Evaluation
MoV short name	BPNSFS
Relevant goal impact indicator(s)	Subjective well-being
Relevant for age ranges	12 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The BPNSFS assesses both satisfaction with one's needs in general in life and frustration about meeting one's needs. It has 21 items assessing the needs of competence, autonomy and relatedness.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The measure is a self-report instrument.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/barriers-to-accessing-carebase-manual</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Composite scores can be compiled for need satisfaction and for frustration. Higher scores indicate greater satisfaction with basic needs being met or greater frustration.
Versions/related measures	The measure has both an adult and a child version. There are also many translations available here: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/barriers-to-accessing-care-base-manual
Limitations	
Developer disclaimer	<p>This scale is free for use in research and M&E. If you wish to adapt the scale to a specific situation or translate it into your own language, please email Jolene.Deeder@ugent.be and Maarten.Vansteenkiste@ugent.be for tracking purposes.</p> <p>The scale cannot be used for commercial purposes without formal, written permission from the authors. If you are considering using the scale for commercial purposes, you need to contact the authors above.</p>
Developer/author contact	<p>Maarten Vansteenkiste Maarten.Vansteenkiste@ugent.be</p>
Original access point (as at publication date)	https://selfdeterminationtheory.org/basic-psychological-needs-scale/

MoV full name	Basic Psychological Need Satisfaction and Frustration Scales
MoV short name	BACE
Relevant goal impact indicator(s)	Subjective well-being; Disabling distress/symptoms
Relevant for age ranges	18 and over
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The BACE measures 30 barriers to mental health care, with an emphasis on stigma-specific barriers. In addition, it includes a treatment stigma subscale in order to understand the extent to which stigma associated with mental health services precludes an individual from seeking care.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The measure is a self-report instrument.</p> <p>Link to manual and scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/the-basic-psychological-need-satisfaction-and-frustration-scale-bpnsfs-manual-mov</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The BACE has response categories from 0 (not at all) to 3 (a lot) with higher scores indicating a greater barrier. For each barrier three different scores may be given: 1) the mean of the response scores; 2) the percentage of respondents reporting that they have experienced the barrier to any degree (that is, the percentage circling 1, 2 or 3); or 3) the percentage experiencing the barrier as a major barrier (that is, the percentage circling 3).
Versions/related measures	The measure is available in multiple languages. For more information, see: http://www.indigo-group.org/stigma-scales/
Limitations	
Developer disclaimer	
Developer/author contact	<p>Dr. Graham Thornicroft graham.thornicroft@kcl.ac.uk</p> <p>Ms. Maria Milenova maria.milenova@kcl.ac.uk</p>
Original access point (as at publication date)	http://www.indigo-group.org/stigma-scales/

MoV full name	Brief COPE Inventory
MoV short name	Brief COPE
Relevant goal impact indicator(s)	Coping
Relevant for age ranges	18 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The Brief COPE is an abbreviated version of the COPE Inventory and was created for use in time-limited settings. It contains 28 items measuring 14 subscales.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The Brief COPE is a self-report instrument.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/brief-cope-mov-and-scoring</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Scales are computed by summing items as follows (with no reversals of coding): Self-distraction, items 1 and 19; Active coping, items 2 and 7; Denial, items 3 and 8; Substance use, items 4 and 11; Use of emotional support, items 5 and 15; Use of instrumental support, items 10 and 23; Behavioural disengagement, items 6 and 16; Venting, items 9 and 21; Positive reframing, items 12 and 17; Planning, items 14 and 25; Humour, items 18 and 28; Acceptance, items 20 and 24; Religion, items 22 and 27; Self-blame, items 13 and 26
Versions/related measures	The Brief COPE is a short version of the longer COPE measure.
Limitations	The Brief COPE is free to use and adapt as needed.
Developer disclaimer	
Developer/author contact	Dr. Charles S. Carver
Original access point (as at publication date)	https://local.psy.miami.edu/faculty/ccarver/scIBrCOPE.phtml

MoV full name	Brief Resilience Scale*
MoV short name	BRS
Relevant goal impact indicator(s)	Coping
Relevant for age ranges	18 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The six-item Brief Resilience Scale (BRS) was created to assess a person's ability to bounce back or recover from stress.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The measure is a self-report instrument. Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/brs-scoring
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The measure is scored by summing the items to create a total score. Higher scores indicate greater resilience.
Versions/related measures	
Limitations	
Developer disclaimer	
Developer/author contact	Bruce Smith BW-smith@unm.edu
Original access point (as at publication date)	https://ogg.osu.edu/media/documents/MB%20Stream/Brief%20Resilience%20Scale.pdf

* Despite genuine and repeated attempts, the original developer(s) could not be reached and permission and guidance were not obtained for this measure. It is included here and described in line with published guidance.

MoV full name	Children's Hope Scale*
MoV short name	CHS
Relevant goal impact indicator(s)	Coping
Relevant for age ranges	8–16 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	This six-item measure is “based on the premise that children are goal directed and that their goal-related thoughts can be understood according to two components: agency and pathways” (Snyder et al., 1997, p.400). These two components, agency (ability to initiate and sustain action towards goals) and pathways (capacity to find a means to carry out goals), are assessed by the measure.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The CHS is a self-report instrument. Link to scoring: https://academic.oup.com/jpepsy/article-abstract/22/3/399/917485
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Each item of the scale is summed to create a total score.
Versions/related measures	
Limitations	
Developer disclaimer	
Developer/author contact	Dr. Charles R. Snyder
Original access point (as at publication date)	https://academic.oup.com/jpepsy/article-abstract/22/3/399/917485

* Despite genuine and repeated attempts, the original developer(s) could not be reached and permission and guidance were not obtained for this measure. It is included here and described in line with published guidance.

MoV full name	Concern for Others Scale
MoV short name	None
Relevant goal impact indicator(s)	Social behaviour
Relevant for age ranges	9–12 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 10-item Concern for Others scale was developed for use as a student questionnaire in the Child Development Project for elementary school students, to assess caring for others.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>This is a self-report instrument.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/concern-for-others-mov-scoring</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The scale is scored by summing the items. A higher score indicates higher concern for others.
Versions/related measures	
Limitations	
Developer disclaimer	
Developer/author contact	Collaborative Classroom (formerly Developmental Studies Center): kstuart@collaborativeclassroom.org or pbrunn@collaborativeclassroom.org
Original access point (as at publication date)	https://www.collaborativeclassroom.org/wp-content/uploads/2017/11/Scales%20from%20Student%20Questionnaire.%20Child%20Development%20Project%20for%20Elementary%20School%20Students%20(Grades%203%E2%80%93936).pdf

MoV full name	Child Psychosocial Distress Screener
MoV short name	CPDS
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	8–14 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The seven-item CPDS is a multi-source instrument that assesses non-specific child psychosocial distress and the likelihood of need for psychosocial treatment. The instrument has been developed as a primary screener in conflict-affected community settings (especially low- and middle-income settings), for children aged 8–14 years. Development of the CPDS followed a culturally grounded approach. The CPDS uses broad questions, and focuses on domains of distress, resilience and school functioning.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The CPDS needs to be contextualised to setting and context, particularly the probes used for scoring the measure. These are described in the link below. Link to CPDS administration and scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/the-child-psychosocial-distress-screener-cpds-m-and-e
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The higher the total score, the higher the level of psychosocial distress.
Versions/related measures	
Limitations	
Developer disclaimer	The authors recommend the instrument for assessing indications for secondary preventive group-based psychosocial interventions.
Developer/author contact	Mark Jordans mark.jordans@kcl.ac.uk
Original access point (as at publication date)	Jordans MJD, Komproe IH, Ventevogel P, Tol WA and de Jong JTVM. Development and validation of the Child Psychosocial Distress Screener in Burundi. American Journal of Orthopsychiatry, 2008; 78, 290-299. doi:10.1037/a001421

MoV full name	Child and Youth Resilience Measure
MoV short name	CYRM/CYRM-R
Relevant goal impact indicator(s)	Coping
Relevant for age ranges	5–23 years (CYRM/CYRM-R)
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 28-item CYRM was established through a process of interviews with youth and their caregivers in 11 countries about the obstacles that youth face, as well as possible resources called upon to navigate through and/or around these obstacles. The measure provides an overview of an individual's resilience at a moment in time using a social-ecological perspective.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The measure is a self-report instrument. It can be given to individuals to complete or read aloud by administrators.</p> <p>Link to scoring: http://cyrm.resilienceresearch.org/how-to-use/</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Overall resilience scores can be computed by summing all responses. Subscale scores can also be computed to determine individual, relational and contextual resources. You can use this information to help inform decisions on what supports could be added to bolster resilience in each participant's life. For example, if the participant scores 4.3 on physical caregiving but only 2.1 on psychological caregiving, that may indicate that he or she is getting food and supervision but does not feel connected or safe when with family members.
Versions/related measures	Person Most Knowledgeable (PMK) versions are available that can be completed by someone who knows the target individual well.
Limitations	
Developer disclaimer	
Developer/author contact	<p>Resilience Research Centre +1 (902) 494-3050 Philip.Jefferies@dal.ca</p>
Original access point (as at publication date)	http://cyrm.resilienceresearch.org/

MoV full name	Discrimination and Stigma Scale
MoV short name	DISC
Relevant goal impact indicator(s)	Subjective well-being; Social connectedness
Relevant for age ranges	18 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 32-item DISC is an interview-based scale which measures experiences of mental health-related discrimination within key areas of daily and social life, such as work, marriage, parenting, housing, leisure and religious activities. It was designed to be completed by people who have experienced challenges related to mental health. The scale has been demonstrated to be a reliable and valid measure and has been utilised in over 60 countries.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	This measure is administered as an interview. Link to administration manual and scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/manual-version3-discrimination-and-stigma-scaledisc-version-12
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	A total score is calculated for each subscale by counting the number of items for which the participant scores 1 (a little), 2 (moderately) or 3 (a lot) in each. Items which are scored as 0 (no difference), -8 (not applicable) or -9 (missing) are not included in this count. The possible range for each subscale is: Subscale 1 – Unfair treatment (0–21), Subscale 2 – Stopping self (0–4), Subscale 3 – Overcoming stigma (0–2), Subscale 4 – Positive treatment (0–5).
Versions/related measures	A shorter 11-item version of the DISC, called the DISCUS, was developed in 2019. Many translations have been completed. For more information, see: http://www.indigo-group.org/stigma-scales/
Limitations	
Developer disclaimer	
Developer/author contact	Dr. Graham Thornicroft graham.thornicroft@kcl.ac.uk Ms. Maria Milenova maria.milenova@kcl.ac.uk
Original access point (as at publication date)	http://www.indigo-group.org/stigma-scales/

MoV full name	Drug Abuse Screening Test
MoV short name	DAST-10 and DAST-20
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	12–17, 18–25, 26–59, 60+
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The Drug Abuse Screening Test (DAST) was designed to be used in a variety of settings to provide a quick index of drug use problems. The 10-item DAST-10 is intended as a short tool for screening and case finding in a range of settings, such as health care, workplace, social services, education and the criminal justice system. The 20-item DAST-20 with its additional items provides a broader assessment of content areas intended more for clinical assessment and research purposes.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The DAST score is computed by summing all items that are endorsed in the direction of increased drug problems. Scores on the DAST-10 can range from 0 to 10, and scores on the DAST-20 can range from 0 to 20.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/guide-for-using-the-drug-abuse-screening-test-dast</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The DAST-10 and DAST-20 total scores order an individual along a continuum with respect to their degree of problems or consequences related to drug abuse. A score of zero indicates that no evidence of drug-related problems was reported. As the DAST score increases, one may infer that the person is reporting more drug use problems. Examiners may also look at specific item responses to identify specific problem areas.
Versions/related measures	
Limitations	Limitations of the DAST are described in the DAST Manual.
Developer disclaimer	<p>Please include acknowledgement of authorship and copyright: © Copyright 1982 by the test author Dr. Harvey Skinner, York University, Toronto, Canada and by the Centre for Addiction and Mental Health, Toronto, Canada.</p>
Developer/author contact	<p>The DAST-10 and DAST-20 are published by the Centre for Addiction and Mental Health (CAMH), Toronto. Dr. Harvey Skinner (York University, Toronto) is the test author and copyright holder along with CAMH.</p> <p>For permission or licence to use the DAST, contact: Dr. Harvey Skinner, York University, Toronto (hskinner@yorku.ca)</p> <p>Andrew Johnson, Centre for Addiction and Mental Health (CAMH), Toronto (Andrew.Johnson@camh.ca)</p>
Original access point (as at publication date)	http://bit.ly/DAST_inst

MoV full name	Early Child Development Index
MoV short name	ECDI; ECDI2030
Relevant goal impact indicator(s)	Functioning; Social behaviour
Relevant for age ranges	ECDI (ages 36–59 months); ECDI2030 (ages 24–59 months)
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	<p>The 10-item Early Childhood Development Index (ECDI) was developed by UNICEF, with inputs from a broad group of experts, within the context of the Multiple Indicator Cluster Survey (MICS) programme. The ECDI is used to measure child development outcomes. The questionnaire used to calculate the ECDI covers four early development domains: literacy/numeracy; physical; social and emotional; and approaches to learning.</p> <p>In 2020, UNICEF released a new measure, the ECDI2030, which captures the achievement of key developmental milestones by children between the ages of 24 and 59 months. The questionnaire used to calculate the ECDI2030 includes 20 items and three domains: health; learning; and psychosocial well-being.</p>
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>Interview with mother or primary caregiver.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/eci-quick-implementation-guide</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	<p>For the ECDI, the standard indicator for reporting is the percentage of children aged 36–59 months who are developmentally on track in at least three of the four domains.</p> <p>For the ECDI2030, the standard indicator for reporting is the percentage of children aged 24–59 months who are developmentally on track in health, learning and psychosocial well-being (defined by achievement of the minimum number of milestones expected for their age group).</p>
Versions/related measures	
Limitations	The ECDI2030 is not intended to generate data for reporting on individual domains but rather to produce one single summary estimate that recognises the underlying conceptual view of ECD as holistic and the fact that capabilities within domains of development are interlinked.
Developer disclaimer	
Developer/author contact	Claudia Cappa ccappa@unicef.org
Original access point (as at publication date)	http://mics.unicef.org/tools?round=mics6

MoV full name	Generalized Anxiety Disorder Seven*
MoV short name	GAD-7
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	12 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The GAD-7 is useful in primary care and mental health settings as a screening tool and measure of symptom severity for the four most common anxiety disorders (generalized anxiety disorder, panic disorder, social phobia and post-traumatic stress disorder (PTSD)).
Administration notes and scoring instructions (who best to administer; link to scoring templates)	Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/instruction-manual-instructions-for-patient-health-questionnaire-phq-and-gad-7-measures
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Higher scores indicate higher levels of anxiety.
Versions/related measures	
Limitations	
Developer disclaimer	The copyright for the GAD-7 was formerly held by Pfizer, which provided the educational grant for Drs Spitzer, Williams and Kroenke, who originally designed the measure. This is no longer the case and no permission is required to reproduce, translate, display or distribute the GAD-7.
Developer/author contact	Dr. Robert Spitzer Dr. Janet B.W. Williams jwilliams@medavante.net Dr. Kurt Kroenke kkroenke@regenstrief.org
Original access point (as at publication date)	https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410326

* Some of the MoV recommended in this framework (for example, PHQ-9, GAD-7, PCL-5, RCADS-25, AUDIT, ASSIST) are self-report measures of clinical constructs. These measures are not recommended as a way to estimate the exact prevalence of mental health conditions (that is, how many people have a condition in a population). Studies have shown that self-report measures commonly overestimate rates of mental health conditions.^{14,15,16} They are included here because they may be useful to give an approximate indication of an MHPSS programme's or project's impact on distress, such as depressive, anxiety and post-traumatic stress symptoms. As mentioned elsewhere in this guide, users of these MoV should give due attention to evidence for validity in the local or in similar contexts before using them.

MoV full name	Impairment Rating Scale
MoV short name	IRS
Relevant goal impact indicator(s)	Functioning
Relevant for age ranges	4–18 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 14-item Impairment Rating Scale assesses functional impairment across domains of a child's life, in both school and non-school settings, with teacher and parent ratings.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The scale is a self-report instrument.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/irs-mov-narrative-description-of-child-parent</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	If any of the domains assessed is scored at 3 or higher, then that domain is considered to be impaired.
Versions/related measures	Empirical evaluations of the IRS have demonstrated its utility for child, adolescent and adult samples (references available from the authors).
Limitations	The IRS has typically been validated with ADHD samples. Additional study is needed with other diagnoses.
Developer disclaimer	The IRS is publicly available. Please cite the published paper where appropriate: Fabiano GA, Pelham W, Waschbusch D, Gnagy EM, Lahey BB, Chronis AM et al. A practical impairment measure: Psychometric properties of the Impairment Rating Scale in samples of children with attention-deficit/hyperactivity disorder and two school-based samples. Journal of Clinical Child and Adolescent Psychology, 2006; 35, 369.
Developer/author contact	<p>Gregory Fabiano gfabiano@fiu.edu</p> <p>William E. Pelham, Jr. wpelham@fiu.edu</p>
Original access point (as at publication date)	Fabiano GA, Pelham WE, Waschbusch D, Gnagy EM, Lahey BB, Chronis AM et al. A practical impairment measure: Psychometric properties of the Impairment Rating Scale in samples of children with attention-deficit/hyperactivity disorder and two school-based samples. Journal of Clinical Child and Adolescent Psychology, 2006; 35, 369. doi:10.1207/s15374424jccp3503_3

MoV full name	Malawi Development Assessment Tool
MoV short name	MDAT
Relevant goal impact indicator(s)	Functioning; social behaviour; social connectedness
Relevant for age ranges	0–5 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	<p>The MDAT is a general child development assessment tool for ages 0–5 years. It measures motor milestones (gross motor and fine motor), language and social development, as well as cognitive development across the domains.</p> <p>The MDAT was first developed through comprehensive qualitative approaches aiming to understand child development in African settings. It was then validated with 1446 children, and population-based age bands for developmental milestones for 0–6 years were established. It has since been used in over 200 studies. The MDAT is predictive of later school achievement, sensitive to differences between children with different medical conditions (children affected by prematurity, difficult births, cerebral malaria, encephalitis, HIV, malnutrition, poor sanitation, refugee situations and specific neurodevelopmental disorders) in Africa, South-East Asia, the Middle East and South America. It has a simple scoring system for use.</p>
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The MDAT is administered through observer ratings and questions put to parents or caregivers.</p> <p>Link to scoring: The measure comes with a scoring app (using Malawian normative data) which can be used online once data are collected: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/mental-illness-clinicians-attitudes-scale-mica-manual-for-researchers</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	<p>The measure can provide information on change and progress in children's development in relation to interventions, and can provide information about children's development within a sample or population.</p> <p>Scoring is related to original data but z-scores can be compared within a population or country.</p>
Versions/related measures	
Limitations	
Developer disclaimer	
Developer/author contact	Dr. Melissa Gladstone melglad@liverpool.ac.uk
Original access point (as at publication date)	www.mdat.org.uk

MoV full name	Mental Illness: Clinician's Attitudes Scale
MoV short name	MICA-4
Relevant goal impact indicator(s)	Social behaviour
Relevant for age ranges	18 and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 16-item MICA-4 scale assesses attitudes of medical students. It is also suitable for staff and students in a wide range of health professions, and has been validated among nursing students. The scale has been demonstrated to be reliable, valid and responsive to change.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>This measure is a self-report instrument.</p> <p>Link to administration and scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/mental-illness-clinicians-attitudes-scale-mica-manual-for-researchers</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Each item is rated on a six-point scale anchored at 1=totally agree and 6=totally disagree. The items on the scale are summed to create a total score. Scores can range from 16 to 96, with a lower score indicating less stigma.
Versions/related measures	Many translations have been made. For more information, see: http://www.indigo-group.org/stigma-scales/
Limitations	
Developer disclaimer	
Developer/author contact	<p>Dr. Graham Thornicroft graham.thornicroft@kcl.ac.uk</p> <p>Ms. Maria Milenova maria.milenova@kcl.ac.uk</p>
Original access point (as at publication date)	http://www.indigo-group.org/stigma-scales/

MoV full name	Multidimensional Scale of Perceived Social Support
MoV short name	MSPSS
Relevant goal impact indicator(s)	Social connectedness
Relevant for age ranges	12 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 12-item MSPSS measures perceptions of support from three sources: family, friends and a significant other. The scale comprises a total of 12 items, with four items for each subscale.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>This measure is a self-report instrument.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/msspss-scoring-options</p> <p>Note on instructions: When evaluating this measure in some countries, two factors have been identified rather than three. The addition of “Note: special person excludes friends and family” to the instructions has resulted in identifying the three factors in a Thai version of the measure.</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The items in the measure can be summed to create a total score and three subscale scores. A higher score indicates greater social support.
Versions/related measures	Approximately 35 translations of the measure have been completed to date. Many are available here: https://mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Limitations	
Developer disclaimer	
Developer/author contact	<p>Gregory D. Zimet, PhD Indiana University School of Medicine gzimet@iu.edu</p>
Original access point (as at publication date)	http://docs.wixstatic.com/ugd/5119f9_2f88fadcd382463daf5821e8af94a865.pdf

MoV full name	Neighborhood Cohesion Instrument*
MoV short name	NCI
Relevant for age ranges	18 and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The NCI is an 18-item measure that assesses community, neighbourhood attractiveness and social connectedness within a neighbourhood, all in conjunction with the psychological outcomes that stem from these factors. The scale is administered at the individual level and the score provides a measure of neighbourhood cohesiveness.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>This measure is a self-report instrument.</p> <p>Link to scoring: Table 2 in Buckner JC. The development of an instrument to measure neighborhood cohesion. American Journal of Community Psychology, 1988; 16(6), 771-791. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/the-development-of-an-instrument-to-measure-neighborhood-cohesion</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Higher scores indicate higher levels of neighbourhood cohesion.
Versions/related measures	
Limitations	
Developer disclaimer	
Developer/author contact	John C. Buckner john.buckner@childrens.harvard.edu
Original access point (as at publication date)	Buckner JC. The development of an instrument to measure neighborhood cohesion. American Journal of Community Psychology, 1988; 16(6), 771-791. doi:10.1007/BF00930892

* Despite genuine and repeated attempts, the original developer(s) could not be reached and permission and guidance were not obtained for this measure. It is included here and described in line with published guidance.

MoV full name	Oslo 3 Social Support Scale*
MoV short name	OSSS-3
Relevant goal impact indicator(s)	Social connectedness
Relevant for age ranges	17 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The OSSS-3 includes three items that are considered to be predictive of mental health and related to social support. It has been used in numerous studies and these have confirmed the feasibility and predictive validity of the measure. It was developed as the outcome of an analysis of 1717 people in a neighbourhood in Norway.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	This measure is a self-report instrument. Link to scoring: https://mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Based on the raw scores, the scale allows a summary score (range 3–14) or categories of social support (strong, average and poor) to be generated. Scores and associated ranges indicate poor support (3–8), moderate support (9–11) and strong support (12–14).
Versions/related measures	
Limitations	
Developer disclaimer	
Developer/author contact	Hege Bøen hege.boen@fhi.no Odd Steffen Dalgard odd.steffen.dalgard@fhi.no Espen Bjertness espen.bjertness@medisin.uio.no
Original access point (as at publication date)	https://pubmed.ncbi.nlm.nih.gov/22682023/

* Despite genuine and repeated attempts, the original developer(s) could not be reached and permission and guidance were not obtained for this measure. It is included here and described in line with published guidance.

MoV full name	Patient Health Questionnaire-9*
MoV short name	PHQ-9
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	18 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The PHQ-9 is a nine-item self-report measure of depressive symptoms. The brief measure has been used in multiple settings and validated among multiple cultural groups.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The PHQ-9 is a self-report measure.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/instruction-manual-instructions-for-patient-health-questionnaire-phq-and-gad-7-measures-m-and-e </p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The total score can range from 0 to 27, with higher scores indicating a greater severity of depression.
Versions/related measures	PHQ-9-modified adolescent version.
Limitations	
Developer disclaimer	The copyright for the PHQ-9 was formerly held by Pfizer, which provided the educational grant for Drs Spitzer, Williams and Kroenke, who originally designed it. This is no longer the case and no permission is required to reproduce, translate, display or distribute the PHQ-9.
Developer/author contact	<p>Dr. Robert Spitzer</p> <p>Dr. Janet B.W. Williams jwilliams@medavante.net </p> <p>Dr. Kurt Kroenke kkroenke@regenstrief.org </p>
Original access point (as at publication date)	Kroenke K, Spitzer RL and Williams JB. The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine, 2001; 16(9), 606-613. doi:10.1046/j.1525-1497.2001.016009606.x

* Some of the MoV recommended in this framework (for example, PHQ-9, GAD-7, PCL-5, RCADS-25, AUDIT, ASSIST) are self-report measures of clinical constructs. These measures are not recommended as a way to estimate the exact prevalence of mental health conditions (that is, how many people have a condition in a population). Studies have shown that self-report measures commonly overestimate rates of mental health conditions.^{14,15,16} They are included here because they may be useful to give an approximate indication of an MHPSS programme's or project's impact on distress, such as depressive, anxiety and post-traumatic stress symptoms. As mentioned elsewhere in this guide, users of these MoV should give due attention to evidence for validity in the local or in similar contexts before using them.

MoV full name	IFRC Reference Centre for Psychosocial Support and Save the Children Denmark – PIA Resilience Questionnaire
MoV short name	PIA
Relevant goal impact indicator(s)	Coping
Relevant for age ranges	10–14 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 20-item PIA offers a questionnaire allowing for comparison of changes in pre-defined indicators of child psychosocial well-being before and after an intervention.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The questionnaire is designed to be administered by any staff working with children. Minimal instructions are required to use the tools. The data evaluation requires basic skill in Microsoft Excel.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/monitoring-and-evaluation-guidelines-for-the-childrens-resilience-programme</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The PIA questionnaire is a tool to assist with the M&E of psychosocial support interventions, comparing “before” and “after” states. When data from the questionnaire are entered into the Excel sheet, different diagrams are automatically generated.
Versions/related measures	
Limitations	The PIA questionnaire is designed to indicate relative changes and to inform projects and interventions accordingly. It is not suited to creating absolute values that can be compared across groups or even projects. It is important to note also that it does not represent medical research and that there are many possible factors in a child's well-being. Impactful events, for example, cannot be well captured in the standard questions and would need to be identified through other methods, such as free interviews or FGDs.
Developer disclaimer	It is mandatory to apply the PIA tool ethically by avoiding the risk of harm at all times. For example, if a child prefers not to participate in the questionnaire or to stop halfway for any reason, they are absolutely at liberty to do so.
Developer/author contact	<p>IFRC Reference Centre for Psychosocial Support psychosocial@ifrc.org</p> <p>Save the Children Denmark</p>
Original access point (as at publication date)	Monitoring and Evaluation Guidelines for the Children's Resilience Programme. Copenhagen: IFRC Reference Centre for Psychosocial Support and Save the Children; 2012.

MoV full name	Postpartum Bonding Questionnaire
MoV short name	PBQ
Relevant goal impact indicator(s)	Social behaviour
Relevant for age ranges	0–5 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 25-item PBQ assesses the mother–infant relationship to detect post-partum mental health issues.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>This is a self-report instrument.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/postpartum-bonding-questionnaire-pbq-mov-scoring</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The items for each factor are summed to create total scores for each factor. A high score indicates greater problems in bonding.
Versions/related measures	
Limitations	It is important to remember that the PBQ is merely a screening questionnaire. If the scores are high (especially the score on factor 2), it is essential to interview the mother about her responses to the questionnaire and her feelings about the infant, including anger.
Developer disclaimer	
Developer/author contact	<p>Ian Brockington i.f.brockington@bham.ac.uk</p>
Original access point (as at publication date)	https://link.springer.com/article/10.1007%2Fs00737-006-0132-1

MoV full name	PTSD Checklist for DSM-5 ^{*,**}
MoV short name	PCL-5
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	18 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 20-item PCL-5 is a self-report measure that assesses the 20 DSM-5 symptoms of PTSD. The PCL-5 has a variety of purposes, including monitoring changes in symptoms during and after treatment, screening individuals for PTSD and making a provisional PTSD diagnosis.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The measure is a self-report instrument. It takes approximately 5–10 minutes to complete. A total symptom severity score (range 0–80) can be obtained by summing the scores for each of the 20 items. DSM-5 scores for symptom cluster severity can be obtained by summing the scores for the items within a given cluster as follows: criterion B (items 1–5), criterion C (items 6–7), criterion D (items 8–14) and criterion E (items 15–20).</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/ptsd-checklist-for-dsm-5</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Higher scores indicate greater symptoms of PTSD.
Versions/related measures	
Limitations	
Developer disclaimer	This measure is intended for use by qualified mental health professionals and researchers. Interpretation of the PCL-5 should be made by a clinician.
Developer/author contact	National Center for PTSD PTSDconsult@va.gov
Original access point (as at publication date)	Blevins CA, Weathers FW, Davis MT, Witte TK and Domino JL. The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. Journal of Traumatic Stress, 2015; 28, 489–498. doi:10.1002/jts.22059

* Some of the MoV recommended in this framework (for example, PHQ-9, GAD-7, PCL-5, RCADS-25, AUDIT, ASSIST) are self-report measures of clinical constructs. These measures are not recommended as a way to estimate the exact prevalence of mental health conditions (that is, how many people have a condition in a population). Studies have shown that self-report measures commonly overestimate rates of mental health conditions.^{14,15,16} They are included here because they may be useful to give an approximate indication of an MHPSS programme's or project's impact on distress, such as depressive, anxiety and post-traumatic stress symptoms. As mentioned elsewhere in this guide, users of these MoV should give due attention to evidence for validity in the local or in similar contexts before using them.

** The PCL-5 is used to assess for PTSD symptoms. While PTSD is included in the World Health Assembly-approved ICD-11 and is thus supported globally by governments, PTSD is a clinical construct that captures only some aspects of the distress that emergency-affected populations experience. There tends to be an inappropriately narrow focus on PTSD in many humanitarian crises, and the concept of PTSD is often a topic of debate among humanitarian agencies, academic communities and clinicians.

MoV full name	Psychological Screening Tool for Young Children aged 6 to 36 months
MoV short name	PSYCa 6–36
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	6–36 months
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 20-item PSYCa 6–36 is meant for rapid screening of general psychological difficulties in children aged 6 to 36 months. It consists of a questionnaire and is meant to be answered by a caregiver or parent, through the intermediary of a non-specialist trained interviewer.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The measure is an interview facilitated by a caregiver/parent. A trained interviewer reads each item one by one. For each item, the caregiver/parent is asked to respond either “no or not at all”, “sometimes or occasionally” or “often or frequently”. The interviewer rates each item (0, 1 or 2) accordingly, and at the end of administration computes a total score ranging from zero to 40.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/a-screening-tool-for-psychological-difficulties-in-children-aged-6-to-36-months-cross-cultural-validation-in-kenya-cambodia-and-uganda</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Scoring on the PSYCa 6–36 can range from zero to 40, with higher scores indicating greater psychological distress and a need for further mental health assessment. It is a tool for screening and orientation, and not a diagnostic tool. If the total score is above or equal to a cut-off of 8, the child should be referred to a specialist for further assessment.
Versions/related measures	
Limitations	<p>It is important to recognise that a screening tool should be used only in contexts where referral to appropriate care is possible.</p> <p>The PSYCa 6–36 would benefit from further use and validation in populations with a higher prevalence of psychological difficulties, such as migrants, refugees or internally displaced children, or children living in conflict situations or in the aftermath of a natural disaster. Further investigation is also needed among specific age groups, such as children below one year of age.</p>
Developer disclaimer	
Developer/author contact	<p>Fabienne Nackers Fabienne.Nackers@brussels.msf.org Caroline Marquer Caroline.Marquer@epicentre.msf.org</p>
Original access point (as at publication date)	Nackers F et al. A screening tool for psychological difficulties in children aged 6 to 36 months: cross-cultural validation in Kenya, Cambodia and Uganda. BMC Pediatrics, 2019; 19(1). oi:10.1186/s12887-019-1461-3

MoV full name	Psychological Screening Tool for Young Children aged 3 to 6 years
MoV short name	PSYCa 3–6
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	3–6 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 20-item PSYCa 3–6 assesses psychological difficulties in children aged 3–6 years. It is a tool for screening and orientation, and not a diagnostic tool. It comprises a scaled assessment to be filled in by the parent or caregiver with support from a person formally trained to conduct interviews.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The measure is an interview facilitated by a caregiver/parent. A trained interviewer reads each item one by one. For each item, the caregiver/parent is asked to respond either “no or not at all”, “sometimes or occasionally” or “often or frequently”. The interviewer rates each item (0, 1 or 2) accordingly, and at the end of administration computes a total score ranging from zero to 44.</p> <p>Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/a-rapid-screening-tool-for-psychological-distress-in-children-36years-old-results-of-a-validation-study</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The PSYCa 3–6 scoring can range from zero to 44 (calculating a number of 0, 1 or 2 per column). The cut-off is 9. For any score of 9 or above, the child should be referred for additional evaluation.
Versions/related measures	
Limitations	It is important to recognise that a screening tool should be used only in contexts where referral to appropriate care is possible. The authors aimed to ensure that the scale was sufficiently flexible, evidence-based and culturally, socially and age-appropriate, and also standardised to enable cross-cultural comparisons. However, only two confirmatory validations have been performed to date.
Developer disclaimer	
Developer/author contact	Caroline Marquer caroline.marquer@epicentre.msf.org
Original access point (as at publication date)	Marquer C, Barry C, Mouchenik Y, Hustache S, Djibo D, Manzo M. et al. A rapid screening tool for psychological distress in children 3–6 years old: results of a validation study. BMC Psychiatry, 2012; 12(1), 170. doi:10.1186/1471-244x-12-170

MoV full name	Psychological Outcome Profiles
MoV short name	PSYCHLOPS
Relevant goal impact indicator(s)	Functioning; Subjective well-being; Disabling distress/symptoms
Relevant for age ranges	18–25, 26–59, 60+
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The five-item PSYCHLOPS is a measure designed to assess client-generated outcomes. It consists of four questions measuring three domains: problems, function and well-being.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The PSYCHLOPS is a self-report instrument.</p> <p>Link to scoring: Available at PSYCHLOPS.org: http://psychlops.org.uk/versions</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The PSYCHLOPS includes both qualitative and quantitative components. Free text responses are elicited for the problem and function domains. Quantitative responses are scored on an ordinal six-point scale, producing a maximum score of 18 (six points per domain).
Versions/related measures	The PSYCHLOPS has been translated into multiple languages, available at: http://psychlops.org.uk/versions
Limitations	
Developer disclaimer	Since 2015, access to all versions of PSYCHLOPS has been available free of charge (“copyleft”).
Developer/author contact	<p>Mark Ashworth mark.ashworth@kcl.ac.uk</p> <p>Maria Kordowicz maria.kordowicz@kcl.ac.uk</p>
Original access point (as at publication date)	Ashworth M, Shepherd M, Christey J, Matthews V, Wright K, Parmentier H et al. A client-generated psychometric instrument: the development of ‘PSYCHLOPS’. Counselling and Psychotherapy Research, 2004; 4(2), 27-31.

MoV full name	Reported and Intended Behaviour Scale
MoV short name	RIBS
Relevant goal impact indicator(s)	Social behaviour
Relevant for age ranges	18 and over
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The eight-item RIBS can be used to assess and track mental health discrimination from the public. Various studies have proven the significance and high prevalence of discrimination that mental health service users experience. The focus of RIBS is to measure and track discrimination.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	This measure is a self-report instrument. Link to administration and scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/instructions-for-using-the-reported-and-intended-behaviour-scale-ribs
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	RIBS items 5–8 are scored on an ordinal scale (1–5). Items where the respondent strongly agrees that they might engage in the stated behaviour have a value of 5, while items where the individual strongly disagrees that they might engage in the stated behaviour score 1 point. The total score for each participant is calculated by adding together the response values for items 5–8. “Don’t know” is coded as neutral (i.e. 3) for the purposes of determining a total score. As items 1–4 only calculate the prevalence of behaviours and respondents may or may not have engaged in those behaviours, they are not given a score value.
Versions/related measures	Many translations have been made. For more information, see: http://www.indigo-group.org/stigma-scales/
Limitations	
Developer disclaimer	
Developer/author contact	Dr. Graham Thornicroft graham.thornicroft@kcl.ac.uk Ms. Maria Milenova maria.milenova@kcl.ac.uk
Original access point (as at publication date)	http://www.indigo-group.org/stigma-scales/

MoV full name	Revised Child Anxiety and Depression Scale-25*
MoV short name	RCADS-25
Relevant goal impact indicator(s)	Disabling distress/symptoms
Relevant for age ranges	8–18 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 25-item RCADS-25 can be scored using spreadsheets or syntax available from the developer (https://www.childfirst.ucla.edu/resources/); or manually, where each item is assigned a numerical value of 0–3, where 0 = never, 1 = sometimes, 2 = often and 3 = always. For each subscale, the numerical values for each item are added together.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The measure is a self-report instrument. Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/revised-childrens-anxiety-and-depression-scale-users-guide
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	A t-score of 65 means that the score is roughly in the top 7% of scores of unreferred young people of the same age (described as borderline clinical by the developer), and a score of 70 means that the score is roughly in the top 2% of scores of unreferred young people of the same age.
Versions/related measures	Please see: https://www.childfirst.ucla.edu/resources/
Limitations	
Developer disclaimer	The RCADS and its derivative works (including translations) are copyrighted by Chorpita and Spence. At the time of publication, the RCADS was available for use through Dr. Chorpita's UCLA resource page at no cost (https://www.childfirst.ucla.edu/resources/). However, this may change. It is recommended that the terms of use are reviewed prior to implementation; noting that any use of these instruments implies that the user has read and agreed to the terms of use at that point in time.
Developer/author contact	Chad Ebesutani ebesutani@duksung.ac.kr Bruce Chorpita chorpita@ucla.edu
Original access point (as at publication date)	Ebesutani C, Korathu-Larson P, Nakamura BJ, Higa-McMillan C and Chorpita B. The Revised Child Anxiety and Depression Scale 25–Parent Version: Scale Development and Validation in a School-Based and Clinical Sample. <i>Assessment</i> , 2017; 24(6), 712–728. doi:10.1177/1073191115627012

* Some of the MoV recommended in this framework (for example, PHQ-9, GAD-7, PCL-5, RCADS-25, AUDIT, ASSIST) are self-report measures of clinical constructs. These measures are not recommended as a way to estimate the exact prevalence of mental health conditions (that is, how many people have a condition in a population). Studies have shown that self-report measures commonly overestimate rates of mental health conditions.^{14,15,16} They are included here because they may be useful to give an approximate indication of an MHPSS programme's or project's impact on distress, such as depressive, anxiety and post-traumatic stress symptoms. As mentioned elsewhere in this guide, users of these MoV should give due attention to evidence for validity in the local or in similar contexts before using them.

MoV full name	Short Adapted Social Capital Assessment Tool
MoV short name	SASCAT
Relevant goal impact indicator(s)	Social connectedness
Relevant for age ranges	18 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The nine-item SASCAT, a modified version of the Adapted Social Capital Assessment Tool (A-SCAT), is used to measure the individual social capital of caregivers of children aged 1–8 years old. The measure was first used in the Young Lives study in order to explore the association between caregivers' social capital and different aspects of child well-being, for example educational outcomes and physical and mental health. The tool can also be used to measure ecological social capital by administering it to a representative sample of a community and aggregating their responses.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>This instrument is administered by an interviewer.</p> <p>Link to scoring: De Silva MJ, Harpham T, Tuan T, Bartolini R, Penny ME and Huttly SR. Psychometric and cognitive validation of a social capital measurement tool in Peru and Vietnam. <i>Social Science & Medicine</i>, 2006; 62(4), 941-953. doi:10.1016/j.socscimed.2005.06.050</p> <p>De Silva MJ, Huttly SR, Harpham T and Kenward MG. Social capital and mental health: A comparative analysis of four low income countries. <i>Social Science & Medicine</i>, 2007; 64(1), 5-20. doi:10.1016/j.socscimed.2005.06.050</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	High scores indicate more social capital.
Versions/related measures	The SASCAT has been translated into multiple languages.
Limitations	
Developer disclaimer	
Developer/author contact	Mary J. De Silva
Original access point (as at publication date)	De Silva MJ, Harpham T, Tuan T, Bartolini R, Penny ME and Huttly SR. Psychometric and cognitive validation of a social capital measurement tool in Peru and Vietnam. <i>Social Science & Medicine</i> , 2006; 62(4), 941-953. doi:10.1016/j.socscimed.2005.06.050

MoV full name	Social Connectedness Scale – Revised
MoV short name	SCS-R
Relevant goal impact indicator(s)	Social connectedness
Relevant for age ranges	12 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	This 20-item scale is used to assess the extent to which persons feel connected to others in their surrounding social area. It is assessed on a Likert scale, from 1 being “strongly disagree” to 6 being “strongly agree”.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The scale is a self-report instrument.</p> <p>Link to scoring: Lee RM, Draper M and Lee S. Social connectedness, dysfunctional interpersonal behaviors, and psychological distress: Testing a mediator model. Journal of Counseling Psychology, 2001; 48, 310-318.</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	On the basis of the factor analysis, the SCS-R consists of all 20 original items (10 positive and 10 negative). The negatively worded items are reverse scored and summed together with the positively worded items to create a scale score with a possible range from 20 to 120. An item mean score with a possible range from 1 to 6 can also be calculated by dividing the total scale score by 20 (or the number of scale items). Higher scores on the SCS-R reflect a stronger sense of social connectedness.
Versions/related measures	<p>The measure has been translated into 15+ languages. There are also other versions, as described below:</p> <p>15-item version of the scale: Lee RM, Dean BL and Jung KR. Social connectedness, extraversion, and subjective well-being: Testing a mediation model. Personality and Individual Differences, 2008; 45(5), 414-419. doi:10.1016/j.paid.2008.05.017</p> <p>Modified Connectedness to Parents version: http://jea.sagepub.com/content/early/2010/09/02/0272431610376249</p>
Limitations	
Developer disclaimer	There is no separate scoring or interpretation manual. There is also no recommended cut-off score as the scale should be used as a continuous variable. Use of this measure requires permission from the authors.
Developer/author contact	Dr Richard M. Lee richlee@umn.edu
Original access point (as at publication date)	Lee RM, Draper M and Lee S. Social connectedness, dysfunctional interpersonal behaviors, and psychological distress: Testing a mediator model. Journal of Counseling Psychology, 2001; 48(3), 310.

MoV full name	Strengths and Difficulties Questionnaire
MoV short name	SDQ
Relevant goal impact indicator(s)	Disabling distress/symptoms; Social behaviour
Relevant for age ranges	2–17 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 25-item SDQ is a brief behavioural screening questionnaire for use with persons 2–17 years old. It exists in several versions to meet varying needs. All versions of the SDQ ask about 25 attributes, some positive and others negative. These 25 items are divided between five scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The SDQ is a self-report instrument and can be scored manually or online. To register for an online system for administering and scoring the SDQ, email: sdq.scoring@gmail.com . Printable versions can be downloaded at http://sdqinfo.org/py/sdqinfo/b0.py , after registering. All computer-processed use or conversion of the SDQ is subject to a licence or fee.
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Although the SDQ is free to download and can be manually scored, due to the level of scoring errors the authors recommend use of the online scoring version, available for a small fee, from US\$ 0.25. For more information, see https://admin.sdqscore.org .
Versions/related measures	The SDQ exists in several versions. See http://sdqinfo.org/
Limitations	Copyright notice: Please note that Strengths and Difficulties Questionnaires , whether in English or in translation, are copyright documents that are not in the public domain . As such, they may not be modified in any way (for example, changing the wording of questions, adding questions or administering only subsets of questions). This is to ensure that the SDQ is fully comparable across studies and settings. Similarly, to ensure high quality and consistency, unauthorised translations are not permitted. Paper versions may be downloaded and subsequently photocopied without charge by individuals or non-profit organisations provided they are not making any charge to families. Users are not permitted to create or distribute electronic versions for any purpose without prior authorisation from youthinmind. If you are interested in making translations or creating electronic versions you MUST first contact youthinmind@gmail.com .
Developer disclaimer	The SDQ comes as it is and has been widely and successfully used on this basis without any complaints.
Developer/author contact	Professor Robert Goodman youthinmind@gmail.com
Original access point (as at publication date)	http://sdqinfo.org/

MoV full name	Social Support Inventory Scheme
MoV short name	SSIS
Relevant goal impact indicator(s)	Social connectedness
Relevant for age ranges	8–13
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The SSIS is a four-item measure that asks children what type of social support they receive, including material, emotional, guidance and play and social support. Responses range on a scale of 0–5. Children can name up to five people from whom they receive support across the four domains. The number of possible network members who provide support is obtained by summing across the four domains to create an index of support ranging from 0 to 20.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	This is a self-report instrument. Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/social-support-inventory-scheme-scoring
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Two types of summary measure may be calculated from the SSIS: (a) from whom social support was received (from parents, siblings, extended family, peers and adults outside the household; range 0–5) and (b) what type of social support was received (material, emotional, guidance, play and social support). The number of possible network members who provided support is obtained by summing across the four domains to create an index of support ranging from 0 to 20.
Versions/related measures	The measure has been adapted for use in a number of other studies, including in Indonesia: https://jamanetwork.com/journals/jama/fullarticle/182378 and in Burundi: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3994237/
Limitations	
Developer disclaimer	The measure is free to use and adapt.
Developer/author contact	Brechtje Paardekooper brechtje@brechtje.nl
Original access point (as at publication date)	

MoV full name	Short Warwick–Edinburgh Mental Well-Being Scale
MoV short name	SWEMWBS (also referred to as WEMWBS-7)
Relevant goal impact indicator(s)	Subjective well-being
Relevant for age ranges	11–17, 18–25, 26–59, 60+
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The SWEMWBS is a seven-item short form of the WEMWBS, developed to enable monitoring of mental well-being in the general population and the evaluation of interventions and policies that aim to improve mental well-being.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The SWEMWBS is a self-report measure; responses are captured on paper or digitally. SWEMWBS captures experiences over the past two weeks and should not be re-administered before two weeks.</p> <p>More information about the scale is available here: https://warwick.ac.uk/wemwbs</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	Each of the seven-item responses in SWEMWBS is scored from 1 (none of the time) to 5 (all of the time), and a total scale score is calculated by summing the individual item scores and transforming them with a simple table. Scores can be compared with other populations using a t-test. A user guide is provided under licence. This includes a workbook for scoring, information on banding and cut-points and an Excel spreadsheet for calculating a t-test. See: https://warwick.ac.uk/wemwbs/using
Versions/related measures	Some translations and adaptations are available via the link above, along with instructions on how to request permission to translate.
Limitations	SWEMWBS is a non-diagnostic measure and was not developed to screen for mental illness. It has not been validated for this and should not be used for this purpose.
Developer disclaimer	SWEMWBS is subject to copyright (© The University of Warwick) and a licence is required to use the scale. This is available free of charge to non-commercial organisations, which includes public sector organisations (for example, universities, schools, public health, social services and NGOs), registered charities, registered community interest companies and registered social enterprises only. For further information on the type of licence required and to apply online, please go to: https://warwick.ac.uk/wemwbs/using
Developer/author contact	<p>Professor Sarah Stewart-Brown</p> <p>For enquiries, please use wemwbs@warwick.ac.uk</p>
Original access point (as at publication date)	Stewart-Brown S, Tennant A, Tennant R, Platt S, Parkinson J, Weich S. Internal construct validity of the Warwick-Edinburgh mental well-being scale (WEMWBS): a Rasch analysis using data from the Scottish health education population survey. <i>Health and Quality of Life Outcomes</i> , 2009;7(1):15.

MoV full name	<u>Stirling Children's Wellbeing Scale*</u>
MoV short name	SCWBS
Relevant goal impact indicator(s)	Subjective well-being
Relevant for age ranges	8–15 years
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 12-item SCWBS was developed by the Stirling Council Educational Psychology Service (UK) as a holistic, positively worded measure of emotional and psychological well-being in children. Drawing on current theories of well-being and positive psychology, the aim was to provide a means of measuring the effectiveness of interventions and projects designed to promote children's well-being and emotional development.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	This is a self-report instrument. Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/emotional-and-psychological-wellbeing-in-children-the-standardisation-of-the-stirling-childrens-wellbeing-scale
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	For children scoring low on the scale, the option of further mental health assessment should be considered.
Versions/related measures	
Limitations	
Developer disclaimer	
Developer/author contact	Ian Liddle, Stirling Council Educational Psychology Service, Stirling Council, UK Liddle.ian@gmail.com
Original access point (as at publication date)	https://pdfs.semanticscholar.org/8def/e9c4648f44088d0e508e8248747523c7f885.pdf

* Despite genuine and repeated attempts, the original developer(s) could not be reached and permission and guidance were not obtained for this measure. It is included here and described in line with published guidance.

MoV full name	WHO Five Well-being Index
MoV short name	WHO-5
Relevant goal impact indicator(s)	Subjective well-being
Relevant for age ranges	9 years and above
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The five-item WHO-5 was first presented by the WHO Regional Office in Europe at a 1998 WHO meeting in Stockholm as an element of the DepCare project on the measures of well-being in primary health care. Since this time, the WHO-5 has been validated in a number of studies with regard to both clinical and psychometric validity. It measures subjective quality of life based on positive mood (good spirits, relaxation), vitality (being active and waking up feeling fresh and rested) and general interest (being interested in things).
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The measure is a self-report instrument. Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The total raw score, ranging from 0 to 25, is multiplied by 4 to give the final score, with 0 representing the worst imaginable well-being and 100 representing the best imaginable well-being. Cut-off scores for need for treatment have been recommended and are available in Table 4 of the article linked here: https://doi.org/10.1080/08039488.2018.1451918
Versions/related measures	
Limitations	
Developer disclaimer	This questionnaire is in the public domain and may be used freely without any charge, but with referencing to: Bech P. Clinical Psychometrics. Oxford, Wiley-Blackwell; 2012. Topp CW, Østergaard SD, Søndergaard S, Bech P. The WHO-5 Well-being Index: A systematic review of the Literature. Psychotherapy & Psychosomatics. 2015;84(3):167-76
Developer/author contact	Psychiatric Center North Zealand, Psychiatric Research Unit pcnordsjaelland@regionh.dk ; kate.aamund@regionh.dk
Original access point (as at publication date)	https://www.psykiatri-regionh.dk/who-5/Documents/WHO5_English.pdf

MoV full name	WHO Disability Assessment Schedule 2.0
MoV short name	WHODAS 2.0
Relevant goal impact indicator(s)	Functioning
Relevant for age ranges	18 and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The WHODAS 2.0 (12-item version) is a short, simple and generic assessment instrument for health and disability in adult populations. It measures cognition, mobility, self-care, getting along, life activities and participation. This measure was developed on the basis of an extensive cross-cultural study, spanning 19 countries around the world.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	The WHODAS 2.0 is available as both an interview and a self-report instrument. Link to scoring: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/measuring-health-and-disability-manual-for-who-disability-assessment-schedule
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	In the WHODAS 2.0, the scores assigned to each of the 12 items are summed. The simple sum of these scores across all domains constitutes a statistic that is sufficient to describe the degree of functional limitations.
Versions/related measures	As well as a 12-item version, the WHODAS 2.0 has a 36-item version and an interview version.
Limitations	
Developer disclaimer	
Developer/author contact	The WHODAS 2.0 is a WHO instrument. For permission to use any WHO instrument, please contact permissions@who.int
Original access point (as at publication date)	http://www.who.int/classifications/icf/whodasii/en/

MoV full name	WHOQOL Social Subscale
MoV short name	WHO Quality of Life (QOL) Social Subscale - WHOQOL Social
Relevant goal impact indicator(s)	Social connectedness
Relevant for age ranges	18–25, 26–59, 60+
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	The 12-item Social Subscale of the WHO Quality of Life (WHOQOL) scale explores the extent to which people feel they have companionship and support. It also measures commitment to and experience of caring for others. It includes an examination of personal relationships, social support and sexual activity.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The WHOQOL is self-administered if respondents have sufficient ability; otherwise, interviewer-assisted or interview-administered forms can be used.</p> <p>Further information on administration, scoring and scale background is available at: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/australian-version-manual-and-and-questionnaires-whoqol-100</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	<p>The social score of the WHOQOL is a “domain score” that results from the averaging of three “facet” scores – personal relationships, social support and sexual activity. Facets are scored through summative scaling, and each item contributes equally to the facet score. Domain and facet scores can be transformed to a 0–100 scale.</p> <p>Further information is available at: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/australian-version-manual-and-and-questionnaires-whoqol-100</p>
Versions/related measures	The WHOQOL has been translated into over 20 languages. See section 9 of the WHOQOL website for more information: https://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/index2.html
Limitations	
Developer disclaimer	Copyright for the WHOQOL is held by WHO on behalf of the WHO field centres. For permission to use any WHO instrument, please contact: permissions@who.int
Developer/author contact	Contact: permissions@who.int
Original access point (as at publication date)	<p>WHOQUAL User Manual, 1998.</p> <p>https://apps.who.int/iris/bitstream/handle/10665/77932/WHO_HIS_HSI_Rev.2012.03_eng.pdf?sequence=1&isAllowed=y&ua=1</p>

MoV full name	WHO Quality of Life-BREF
MoV short name	WHO Quality of Life (WHOQOL)-BREF
Relevant goal impact indicator(s)	Subjective well-being
Relevant for age ranges	18 years and older
Summary of MoV (including information about screening, monitoring, pre-/post-test, etc.)	WHO developed the 26-item WHOQOL-BREF as a shorter version of the WHOQOL-100. Both scales measure quality of life on the basis of statements made by patients with a range of diseases, by well people and by health professionals in a variety of cultures.
Administration notes and scoring instructions (who best to administer; link to scoring templates)	<p>The WHOQOL-BREF should be self-administered if respondents have sufficient ability; otherwise, interviewer-assisted or interview-administered forms should be used.</p> <p>Scoring information for the WHOQOL-BREF is available in the WHOQOL manual (p.54 in the English version): https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit/resource/world-health-organization-quality-of-life-whoqol-user-manual</p>
Summary scoring and interpretations (for example, expected output from scores and what they tell you)	The WHOQOL-BREF items are scored using a five-point scale (1–5). Note that some items are reverse scored. Mean scores of items in each domain are used to produce four domain scores. These mean scores can be transformed to make them comparable to the full-scale WHOQOL-100 measure. Higher scores indicate greater quality of life.
Versions/related measures	The WHOQOL has been translated into over 20 languages. See section 9 of the WHOQOL website for more information: https://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/index2.html
Limitations	
Developer disclaimer	Copyright for the WHOQOL is held by WHO on behalf of the WHO field centres. For permission to use any WHO instrument, please contact: permissions@who.int
Developer/author contact	Contact: permissions@who.int
Original access point (as at publication date)	The World Health Organization Quality of Life (WHOQOL) - BREF. WHO; 2004. http://www.who.int/substance_abuse/research_tools/en/english_whoqol.pdf

Summary of recommended qualitative MoV approaches

MoV full name	Body mapping
Qualitative MoV categories	Mapping
Relevant for age ranges	6–17 years**
Summary of MoV	Body mapping involves a process of creating visual representations that holistically explore people's minds and bodies. Body mapping has been used in participatory projects exploring many topics and with many populations, including persons living with HIV/AIDS, refugee youth, undocumented workers, persons living with fibromyalgia, survivors of torture and survivors of gender-based violence (GBV). Resources required include sheets of paper or pieces of large fabric and markers or other tools to write with.
Administration guidance (plus any link to manuals or methodology)	<p>For administration guidance, see: Solomon J. "Living with X": A body mapping journey in time of HIV and AIDS. Facilitator's Guide. Psychosocial Wellbeing Series. Johannesburg: REPSSI; 2002.</p> <p>Link to guidance: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>
Limitations	<p>Please be aware that there are several approaches to conducting body mapping. It is also important to be aware of the cultural context when considering this approach. In some settings it may be appropriate for males to lead discussions on body mapping with other males, and females with other females.</p> <p>Also, be aware that body mapping can be distressing for certain groups, such as survivors of sexual and gender-based violence, and should only be undertaken with the supervision of providers who have expertise in MHPSS and GBV. Ensure that teams are trained to support people in distress and on properly implementing the approach with various groups.</p> <p>Body mapping is not recommended for use with people with conflict-related injuries or where people have lost a limb (for example, victims of explosive remnants of war).</p>
Resources for further guidance	<p>Cornwall A. Body mapping in RRA/PRA, RRA notes. 1992. In Welbourn A, ed. RRANotes 16, Special issue on applications for health, pp.69-76. London: International Institute for Environment and Development.</p> <p>Gastaldo D, Magalhães L, Carrasco C and Davy C. Body-map storytelling as research: Methodological considerations for telling the stories of undocumented workers through body mapping. 2012.</p>

** Body mapping may also be applicable with participants aged 18+ depending on culture and context.

MoV full name	<u>Brief ethnographic interview</u>
Qualitative MoV categories	Interviews
Relevant for age ranges	12 years and older
Summary of MoV	Brief ethnographic interviews can be conducted to collect and assess indicators of well-being.
Administration guidance (plus any link to manuals or methodology)	For administration guidance, see: Tacchi JA, Fildes J, Martin K, Mulenahalli K, Baulch E and Skuse A. Ethnographic Action Research Handbook. UNESCO; 2007. Link to guidance: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Limitations	
Resources for further guidance	International Medical Corps. Summary Report: Ethnographic Assessment of Psychosocial Needs of Children at Vasilika Camp. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit

MoV full name	<u>Cards/visual prompts</u>
Qualitative MoV categories	Focus group discussions; interviews
Relevant for age ranges	6 years and older
Summary of MoV	Cards/visual prompting can be used to prompt discussion around outcomes and indicators.
Administration guidance (plus any link to manuals or methodology)	The Community Participatory Evaluation Tool (CPET) uses visuals such as charts, community maps and problem/solution matrices in focus groups as part of a participatory method for the design and M&E of child-focused programmes in emergency contexts. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Limitations	
Resources for further guidance	Bragin M. The Community Participatory Evaluation Tool for Psychosocial Programs: A guide to implementation. Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict, 2005; 3(1), 3–24. United Nations High Commissioner for Refugees. Listen and Learn: Participatory Assessment with Children and Adolescents. Geneva: UNHCR; 2012.

MoV full name	<u>Classic focus group discussions</u>
Qualitative MoV categories	Focus group discussions (FGDs)
Relevant for age ranges	6 years and older
Summary of MoV	Classic FGDs involve engaging group members in open-ended or semi-structured conversations about topics of interest, such as projects, interventions, outcomes or indicators.
Administration guidance (plus any link to manuals or methodology)	For administration guidance, see Chapters 3 and 16 in: International Organization for Migration. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. Geneva: IOM; 2019. Link to guidance: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Limitations	Social pressures to respond in an accepted manner can be common in these groups. Additionally, FGDs can exacerbate existing power imbalances within a community. As a result, it is best that data are triangulated with other approaches to ensure validity. Limitations for FGDs with children and youth: FGDs can feel overly formal, pressured, intimidating or adult-controlled and youth may feel unable to share their views. Younger children may also be more comfortable in communicating in other ways (for example, drawing, stories, play) and so FGDs may only be partially informative.
Resources for further guidance	Ventevogel P, Jordans M, Reis R and De Jong J. Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. Conflict and Health, 2013; 7(1), 3. doi:10.1186/1752-1505-7-3 For guidance with children and adolescents: United Nations High Commissioner for Refugees. Listen and Learn: Participatory Assessment with Children and Adolescents. Geneva: UNHCR; 2012.

MoV full name	<u>Diary entries</u>
Qualitative MoV categories	Creative data-generating methods
Relevant for age ranges	12 years and older
Summary of MoV	Diary entries ask participants to document their experiences in a diary that can later be analysed.
Administration guidance (plus any link to manuals or methodology)	
Limitations	Participants may share extensive personal information in diaries. As a result, approaches to ensuring confidentiality and other ethical concerns should be implemented when using this approach, such as creating anonymised entries with names and details disguised. Participants should also be carefully informed about the potential risk involved if they were to lose a diary containing sensitive information. Additionally, diary entries can be a stressful process for people faced with adversity. Therefore, it is important to ensure that clear prompts are given and concrete goals are established for the exercise.
Resources for further guidance	

MoV full name	Documentation analysis
Qualitative MoV categories	Observation and documentation
Relevant for age ranges	All ages
Summary of MoV	Documentation analysis involves the review of project data or information to evaluate impact.
Administration guidance (plus any link to manuals or methodology)	<p>For administration guidance, see Tool 1 in: IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. IASC Reference Group Mental Health and Psychosocial Support Assessment Guide. IASC RG MHPSS; 2012.</p> <p>Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>
Limitations	Documentation analysis greatly benefits from the involvement of national researchers and national practitioners drawn from the community or country affected by the emergency. They often have access to grey literature and informal sources of information that international practitioners do not, and they also have the cultural and linguistic understanding to analyse and interpret documents and reports.
Resources for further guidance	<p>International Organization for Migration. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. Geneva: IOM; 2019. https://www.iom.int/mhpsed</p> <p>World Health Organization and United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: WHO; 2012. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>

MoV full name	Free listing
Qualitative MoV categories	Focus group discussions; interviews
Relevant for age ranges	12 years and older
Summary of MoV	Free listing asks groups to identify the issues that affect them.
Administration guidance (plus any link to manuals or methodology)	<p>For administration guidance, see Tool 2 in: IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. IASC Reference Group Mental Health and Psychosocial Support Assessment Guide. IASC RG MHPSS; 2012.</p> <p>Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>
Limitations	<p>Social pressures to respond in an accepted manner can be common in these groups. Additionally, FGDs can exacerbate existing power imbalances within a community. As a result, data should be triangulated with other approaches to ensure validity.</p> <p>Additionally, free listing is likely to be most useful when used with either individuals or homogenous groups. As a result, group composition may be best defined in part by gender and age to ensure accuracy of information and the safety of participants.</p>
Resources for further guidance	<p>World Health Organization and United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: WHO; 2012. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>

MoV full name	Key informant interviews
Qualitative MoV categories	Interviews
Relevant for age ranges	12 years and older
Summary of MoV	Key informant interviews (KIIs) can be conducted after an MHPSS activity to assess outcomes.
Administration guidance (plus any link to manuals or methodology)	<p>For administration guidance, see Tool 3 in: IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. IASC Reference Group Mental Health and Psychosocial Support Assessment Guide. IASC RG MHPSS; 2012.</p> <p>Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>
Limitations	<p>Interviewers must be trained in interviewing skills to avoid influencing informant responses.</p> <p>Additionally, it is essential that a representative sample be identified to take part in KIIs. However, identifying an appropriately representative sample can be difficult. Those who are often excluded include people living with a disability, older adults and females in more traditional societies.</p>
Resources for further guidance	<p>International Organization for Migration. Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return. Geneva: IOM; 2009. https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p> <p>World Health Organization and United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: WHO; 2012. https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>

MoV full name	Lifeline
Qualitative MoV categories	Mapping; focus group discussions
Relevant for age ranges	12 years and older
Summary of MoV	Lifeline activities ask individuals or group members to create a lifeline of important events and to discuss the impact of MHPSS actions. Lifeline activity discussions may also focus on how individuals have overcome similar adversity in the past when reviewing events (for example, in communities with frequent/cyclical natural disasters or facing climate change or conflict).
Administration guidance (plus any link to manuals or methodology)	For administration guidance, see: NGO-Ideas. Tiny tools: Guide to use “Lifeline”. 2012. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Limitations	It is essential that people are not forced to participate if they do not wish to. Participation should be entirely voluntary and participants must be free to share as much or as little as they wish. Additionally, lifeline requires a truly participatory approach. Results should be interpreted in the context of other triangulated approaches to ensure validity of the data gathered.
Resources for further guidance	

MoV full name	Most significant change (MSC)
Qualitative MoV categories	Interviews
Relevant for age ranges	12 years and older
Summary of MoV	The “most significant change” technique is a qualitative and participatory form of M&E that can be used with individuals, families or specific population groups. It is based on the collection, systematic selection and analysis of stories of significant changes attributed to an intervention.
Administration guidance (plus any link to manuals or methodology)	For administration guidance, see: Davies R and Dart J. The ‘Most Significant Change’ (MSC) Technique: A Guide to Its Use. 2005. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit Link to guidance: This guidance and other available resources to support implementation of the MSC method are available at: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Limitations	It is essential that people are not forced to participate if they do not wish to. Participation should be entirely voluntary and participants must be free to share as much or as little as they wish. Additionally, MSC requires a truly participatory approach. Results should be interpreted in the context of other triangulated approaches to ensure validity of the data gathered.
Resources for further guidance	Dart J and Davies R. A dialogical, story-based evaluation tool: The most significant change technique. American Journal of Evaluation, 2003; 2.4(2), 137-155. doi:10.1177/109821400302400202

MoV full name	Observation
Qualitative MoV categories	Observation and documentation
Relevant for age ranges	All ages
Summary of MoV	Observation during sessions of an MHPSS activity can be used to assess relevant outcomes. Observation in the community can also be used to evaluate relevant outcomes.
Administration guidance (plus any link to manuals or methodology)	For administration guidance, see Tools 4 and 5 in: World Health Organization and United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: WHO; 2012. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Limitations	
Resources for further guidance	International Organization for Migration. Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return. Geneva: IOM; 2009. https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit

MoV full name	Photovoice
Qualitative MoV categories	Creative data-generating methods
Relevant for age ranges	12 years and older
Summary of MoV	Photovoice involves asking participants to document their lives through pictures captured over time.
Administration guidance (plus any link to manuals or methodology)	For administration guidance, see: Sutton-Brown CA. Photovoice: A methodological guide. Photography and Culture, 2014; 7(2), 169-185. doi:10.2752/175145214X13999922103165 Link to guidance: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Limitations	Photovoice approaches yield rich and complex data. As a result, multiple methods should be used to triangulate data and ensure valid interpretations. Additionally, photovoice approaches require access to specific resources (for example, cameras, film, ability to print photos) that may not be available in many contexts.
Resources for further guidance	Save the Children Bangladesh. Photovoice Guidance: 10 simple steps to involve children in needs assessments. Save the Children; 2014. http://bit.ly/1pHeVwK Wang C and Burris MA. Photovoice: Concept, methodology, and use for participatory needs assessment. Health Education & Behavior, 1997; 24(3), 369-387. doi:10.1177/109019819702400309

MoV full name	Psychological Outcome Profiles (PSYCHLOPS) KIDS
Qualitative MoV categories	Interviews
Relevant for age ranges	6–11 years
Summary of MoV	PSYCHLOPS KIDS is a mixed quantitative and qualitative measure designed to assess client-generated outcomes before, during and after therapeutic intervention. It consists of four questions that measure three domains: problems, function and well-being.
Administration guidance (plus any link to manuals or methodology)	Link to guidance: http://psychlops.org.uk/versions
Limitations	While self-reported data have many advantages, they must be considered in the context of individual biases.
Resources for further guidance	Authors: Mark Ashworth mark.ashworth@kcl.ac.uk Maria Kordowicz maria.kordowicz@kcl.ac.uk

MoV full name	Psychological Outcomes Profile (PSYCHLOPS) TEEN
Qualitative MoV categories	Interviews
Relevant for age ranges	12–17 years
Summary of MoV	PSYCHLOPS is a mixed quantitative and qualitative measure designed to assess client-generated outcomes before, during and after therapeutic intervention. It consists of four questions that measure three domains: problems, function and well-being.
Administration guidance (plus any link to manuals or methodology)	Link to guidance: http://psychlops.org.uk/versions
Limitations	While self-reported data have many advantages, they must be considered in the context of individual biases.
Resources for further guidance	Authors: Mark Ashworth mark.ashworth@kcl.ac.uk Maria Kordowicz maria.kordowicz@kcl.ac.uk

MoV full name	Ranking
Qualitative MoV categories	Focus group discussions; interviews
Relevant for age ranges	12 years and older
Summary of MoV	Ranking activities ask groups to rank issues, problems and resources or coping strategies by priority.
Administration guidance (plus any link to manuals or methodology)	<p>For administration guidance, see Tool 2 in: IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. IASC Reference Group Mental Health and Psychosocial Support Assessment Guide. IASC RG MHPSS; 2012.</p> <p>Link to guidance: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>
Limitations	Participatory ranking is useful for capturing a particular snapshot in time. However, the priorities of communities, families and individuals change over time during the phases of an emergency or in protracted settings. Checking the prioritisation of problems can be done at several intervals over the course of a project/programme to ensure accurate understanding of the situation.
Resources for further guidance	<p>Ager A, Stark L and Potts A. Participatory Ranking Methodology: A Brief Guide (Version 1.1, February 2010). Program on Forced Migration & Health, Mailman School of Public Health, Columbia University, New York; 2009. https://www.alnap.org/system/files/content/resource/files/main/prmmanual-v1-1.pdf</p> <p>CARE Malawi. The Community Score Card (CSC): A generic guide for implementing CARE's CSC process to improve quality of services. Cooperative for Assistance and Relief Everywhere, Inc.; 2013. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>

MoV full name	Risk and resource mapping
Qualitative MoV categories	Mapping
Relevant for age ranges	6–17 years
Summary of MoV	Risk and resource mapping asks participants to create maps of risks and resources in their community.
Administration guidance (plus any link to manuals or methodology)	For administration guidance, see Chapters 3 and 16 in: International Organization for Migration. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. Geneva: IOM; 2019. Link to guidance: https://www.iom.int/mhpsed
Limitations	Additional safety considerations must be taken into account when assessing risks and resources with women and girls. For further guidance, refer to the Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming, Standard 9: Safety and Risk Mitigation. This document also provides references for additional tools available to support risk and resource mapping with women and girls.
Resources for further guidance	See: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit

MoV full name	Social mapping
Qualitative MoV categories	Mapping
Relevant for age ranges	6–17 years
Summary of MoV	Social mapping is a participatory approach that asks participants to map their social relationships with various people in their lives or communities.
Administration guidance (plus any link to manuals or methodology)	For administration guidance, see Section 2, FGD2 in: World Vision International. A Toolkit for Integrating Gender Equality and Social Inclusion in Design, Monitoring and Evaluation. 2020. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit
Limitations	Social mapping has the potential to elicit disclosures of abuse, and should thus be conducted by facilitators who have training in local protection referral pathways and procedures.
Resources for further guidance	World Vision International Guidance for Integrated Programming. Community Engagement Tools: Social Mapping. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit

MoV full name	Storytelling
Qualitative MoV categories	Creative data-generating methods
Relevant for age ranges	All ages
Summary of MoV	Storytelling/crafting asks participants to tell a story about their experience.
Administration guidance (plus any link to manuals or methodology)	<p>For administration guidance, please note that there are many methods and techniques for implementing storytelling or narrative approaches and analysing narrative data. A brief overview of narrative inquiry and a demonstration of multi-method narrative analysis can be found in: Nasheeda A, Abdullah HB, Krauss SE and Ahmed NB. Transforming transcripts into stories: A multimethod approach to narrative analysis. International Journal of Qualitative Methods, 2019; 18, doi:10.1177/1609406919856797</p> <p>Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>
Limitations	There is no single method of storytelling or narrative analysis. Approaches to collecting and analysing storytelling data can be intensive and can require expertise in qualitative methods.
Resources for further guidance	Clandinin DJ and Connelly FM. Narrative inquiry: Experience and story in qualitative research. San Francisco, CA: Wiley; 2000.

MoV full name	Transect walks
Qualitative MoV categories	Mapping
Relevant for age ranges	6 years and older
Summary of MoV	Transect walks involve walking with participants through their location to identify areas of importance.
Administration guidance (plus any link to manuals or methodology)	<p>For administration guidance, see: IFRC. Outreach walk: Improving protection and psychosocial support through outreach. Copenhagen, Denmark: IFRC Reference Centre for Psychosocial Support; 2019.</p> <p>Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit</p>
Limitations	Transect walks may pose potential risks to participants if not properly planned. This approach should be carried out with both men and women and across age ranges and groups, to the extent possible, to avoid placing specific groups at risk. Inclusive adaptations should be arranged to ensure that individuals with disabilities are able to participate fully in this M&E activity.
Resources for further guidance	Annex 15 in Gender-Based Violence Area of Responsibility (GBV AoR). Handbook for Coordinating Gender-based Violence Interventions in Emergencies. Global Protection Cluster; 2019. Available from: https://www.mhpss.net/toolkit/mhpss-m-and-e-mov-toolkit

Sample adaptation/ translation monitoring form*



* van Ommeren M, Sharma B, Thapa S, Makaju R, Prasain D, Bhattarai R and de Jong J. Preparing instruments for transcultural research: use of the translation monitoring form with Nepali-speaking Bhutanese refugees. *Transcultural Psychiatry*, 1999; 36(3), 285-301. doi:10.1177/136346159903600304

Item:	Item:
Lexical back-translation:	
Comprehensibility (semantic equivalence) Is this translation understandable in the language known to the local population? Please comment on any difficulties.	
Translators' views:	
Professionals' views:	
Focus group results:	
Acceptability and other response issues (technical equivalence) Would certain respondents be uncomfortable about responding honestly to this question? Please explain.	
Translators' views:	
Professionals' views:	
Focus group results:	
Relevance (content equivalence) Is this question relevant in the local culture? If not, please explain.	
Translators' views:	
Professionals' views:	
Focus group results:	
Completeness (semantic, criterion and conceptual equivalence) Would the back-translation relate back to the same concepts and ideas as the original? If not, please explain.	
Translators' views:	
Professionals' views:	
Focus group results:	
Comments (if necessary, use other side of the page):	

Glossary of terms used in monitoring and evaluation

Adaptation	The process of developing a new version of a tool or intervention to make it more suitable to the culture and/or context where it will be used.
Indicators <i>Impact indicators</i> <i>Outcome indicators</i> <i>Output indicators</i>	<p>A unit of measurement that specifies what is to be measured; indicators are intended to answer whether or not the desired impact, outcomes or outputs have been achieved. Indicators may be quantitative (for example, percentages or numbers of people) or qualitative (such as perceptions, quality, type, knowledge, capacity).</p> <p>Impact indicators reflect the result (or impact) of actions on a broader social, institutional (or organisational) scale.</p> <p>Outcome indicators reflect the changes for individuals or groups of people that have occurred as a consequence of a particular MHPSS programme or intervention.</p> <p>Output indicators are aligned with the activity plan and aim to reflect on whether the planned activity was carried out as intended (note that this common framework does not include output-level indicators).</p>
Informed consent	Informed consent is the permission that participants give before agreeing to share information or have it documented (including electronically, via photographs or recordings).
Means of verification	The tool(s) and/or data sources used to measure the indicator. It might also be called a “measure”, “measurement” or “assessment” tool. An MoV may result in quantitative or qualitative data.
Mental health and psychosocial support (MHPSS)	Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders.
Monitoring and evaluation (M&E)	<p>Monitoring refers to the visits, observations and questions we ask while a programme is being implemented to see if it is progressing as expected. One of the key issues, for example, in monitoring MHPSS programmes is to ensure that the programme is doing no harm. Monitoring can help to assess this.</p> <p>Evaluation refers to examining a programme at the beginning, middle (if timing allows) and after it has been completed to see if it has achieved the desired results. Obviously, it is important to know what the desired results are in order to evaluate them.</p>
Outcome	The changes that occur as a consequence of a specific project's activities. Results at this level are commonly referred to as project outcomes. Example: People with mental health and psychosocial problems use appropriate focused care.
Qualitative data	Qualitative data provide descriptive information.
Quantitative data	Numerical data that can be computed or analysed.

Reliability <i>Internal reliability (internal consistency)</i> <i>Test/re-test reliability</i> <i>Inter-rater reliability</i>	<p>The overall consistency of an MoV. A measure is said to have high reliability if it produces similar results under consistent conditions.</p> <p>The extent to which items that propose to measure the same general construct produce similar results.</p> <p>The extent to which responses are likely to be consistent/similar over time (that is, at different time points under similar conditions).</p> <p>The extent to which different people responding to an MoV give consistent/similar answers for the same behaviour or presentation of symptoms.</p>
Sample <i>Probability or representative sampling</i> <i>Non-probability sampling</i>	<p>Individuals or groups included in the collection of data.</p> <p>A randomly selected sample where all people in a population have an equal chance of selection.</p> <p>A sample that is not randomly selected.</p>
Validity <i>Face validity</i> <i>Construct validity</i> <i>Content validity</i> <i>Criterion validity</i>	<p>The overall validity of a measure. A measure is considered to be valid if it measures what it is intended to measure.</p> <p>The extent to which the items of a measure are seen to be assessing the overall construct.</p> <p>The extent to which a measure assesses the theoretical construct it is intended to measure (for example, if a measure of hope correctly identifies a person with hope).</p> <p>The extent to which the MoV's content represents the concept(s) to be measured.</p> <p>The strength of a relationship between an MoV and a measurable external criterion.</p>

ANNEX 12

Quantitative measurement gaps and limitations warranting further research

Overall, the widest and most robust selection of measures identified and included during the review process were those corresponding to the “disabling distress/symptoms” indicator. Relative to other indicators, far fewer measures were identified to assess functioning and social connectedness. The relatively low numbers of measures of “functioning” included in this framework may reflect the practice of developing measures of functional impairment locally to reflect relevant day-to-day practice according to culture and context (and these may not have been selected because they would be unlikely to have met inclusion criteria, but are locally appropriate nonetheless). While measures specific to early and mid-childhood, adolescence and adulthood were identified, measures specific to young, middle or older adulthood were not among those included.

Gaps corresponding to particular age groups and impact indicators included coping, social behaviour and social connectedness among adolescents aged 12–17 years. Another gap was tools to assess coping and subjective well-being among children of less than five years – although the importance of this gap might be debated with reference to whether assessments of “coping” and/or “subjective well-being” are relevant constructs for children in this age range, or variations of it.

An important limitation to identify in the selection of quantitative MoV included in this framework is their original development and use. The majority of measures that were identified as meeting inclusion criteria for this framework and subsequently were selected for inclusion originated in high-income countries and often outside of emergency contexts. While these measures have all been carefully assessed for meeting the criteria to be included in this framework (that is, translated into different languages, rigorously used and evaluated in multiple contexts, available, relevant, feasible and appropriate), they did not originate specifically for use in low-resource settings or emergencies. This emphasises the importance of using the MoV recommended in this framework with a degree of caution and careful consideration. Further, it demonstrates a need for greater investment in MHPSS measurement tools for emergency contexts, as well as to cover some of the gaps mentioned above where measures for certain areas of MHPSS and age groups are still lacking. Acknowledging these gaps and limitations may support advocacy efforts for the future development of assessment tools in MHPSS in emergencies.

References

1. Inter-Agency Standing Committee, IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC; 2007.
2. Tol WA et al. Research Priorities for Mental Health and Psychosocial Support in Humanitarian Settings, PLoS Medicine, 2011; vol. 8, no. 9, e1001096.
3. Johns Hopkins University Bloomberg School of Public Health, Department of Mental Health. Developing a Common Framework for Monitoring and Evaluation of Mental Health and Psychosocial Support Programmes in Humanitarian Settings: Report on review, phase 1: Review of common practices in monitoring and evaluation of MHPSS in emergencies. Unpublished report, 2014.
4. Johns Hopkins University Bloomberg School of Public Health, Department of Mental Health. Developing a Common Framework for Monitoring and Evaluation of Mental Health and Psychosocial Support Programmes in Humanitarian Settings: Report on review, phase 2: Selection of indicators and means of verification. Unpublished report, 2015.
5. Charities Evaluation Services. About Monitoring and Evaluation. London: The National Council for Voluntary Organisations.
6. Phillips C. What is Cost-Effectiveness? Second edition in the What is...? series on health economics, Hayward Medical Communications, a division of Hayward Group Ltd., UK; 2009.
7. United Nations Development Group. UNSDG Results-Based Management Handbook: Harmonizing RBM concepts and approaches for improved development results at country level. New York: UNDG; 2011.
8. Kleinman A, Das V and Lock M, eds. Social Suffering. University of California Press, Berkeley; 1997.
9. Oxford Dictionaries. Definition of “suffering” (www.oxforddictionaries.com/definition/english/suffering).
10. World Health Organization. Mental Health: Strengthening our response. Fact sheet. Geneva: WHO; updated in 2016.
11. The Sphere Project. Humanitarian Charter and Minimum Standards in Humanitarian Response, 2018 edition. eBook, UK: Practical Action Publishing; 2018.
12. Diener E. Guidelines for National Indicators of Subjective Well-Being and Ill-Being. Journal of Happiness Studies, vol. 7, no. 4, November 2006, pp.397-404.
13. Minnesota Department of Health, Social Connectedness. Evaluating the Healthy People 2020 Framework: The Minnesota Project, 2010, p.13.
14. Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H and Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. The Lancet, 2019; 394(10194), pp.240-248. doi:10.1016/S0140-6736(19)30934-1
15. Fazel M, Wheeler J and Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. The Lancet, 2005; 365(9467), pp.1309-1314. doi:10.1016/S0140-6736(05)61027-6

16. Steel Z, Chey T, Silove D, Marnane C, Bryant RA and van Ommeren M. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA*, 2009; 302(5), pp.537-549. doi:10.1001/jama.2009.1132
17. United Nations Development Programme. What is Human Development? New York: UNDP; 2015.
18. Cook P, Ensor M, Blanchet-Cohen N. Participatory Action Research on Community Mechanisms Linking Child Protection with Social Cohesion: Interim Report, Burundi/Chad. International Institute for Child Rights and Development (IICRD); 2015.
19. Bolton P, Tol WA and Bass, J. Combining qualitative and quantitative research methods to support psychosocial and mental health programmes in complex emergencies. *Intervention*, 2009; 7(3), 181-186. doi:10.1097/WTF.0b013e32833462f9
20. Bolton P. Cross-cultural validity and reliability testing of a standard psychiatric assessment instrument without a gold standard. *Journal of Nervous and Mental Disease*, 2001; 189(4), 238-242. doi:10.1097/00005053-2001040000-00005
21. Weaver LJ and Kaiser BN. Developing and testing locally derived mental health scales: Examples from North India and Haiti. *Field Methods*, 2015; 27(2), 115-130. doi:10.1177/1525822X14547191
22. Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings. Geneva: IASC; 2014.
23. Purgato M, Gastaldon C, Papola D, van Ommeren M, Barbui C and Tol WA. Psychological therapies for the treatment of mental disorders in low- and middle-income countries affected by humanitarian crises. *Cochrane Database of Systematic Reviews*, 2018; 7(7), CD011849. doi:10.1002/14651858.CD011849.pub2
24. Haroz E, Nguyen A, Lee C, Tol W, Fine S and Bolton P. What works in psychosocial programming in humanitarian contexts in low- and middle-income countries: a systematic review of the evidence. *Intervention*, 2020; 18(1), 3-17. doi:10.4103/intv.Intv_6_19
25. Bangpan M, Chiumento A, Dickson K and Felix L. The impact of mental health and psychosocial support interventions on people affected by humanitarian emergencies: a systematic review. 2017.
26. Gadeberg AK, Montgomery E, Frederiksen HW and Norredam M. Assessing trauma and mental health in refugee children and youth: a systematic review of validated screening and measurement tools. *European Journal of Public Health*, 2017; 27(3), 439-446. doi:10.1093/eurpub/ckx034
27. Siriwardhana C, Ali SS, Roberts B and Stewart R. A systematic review of resilience and mental health outcomes of conflict-driven adult forced migrants. *Conflict and Health*, 2014; 8(1), 13. doi:10.1186/1752-1505-8-13
28. Crotty M. The foundations of social research: meaning and perspective in the research process. London; Thousand Oaks, Calif.: Sage Publications; 2003.

Goal: Reduced suffering and improved mental health and psychosocial well-being

Outcomes:

Community-focused	1. Emergency responses do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable	2. People are safe and protected, and human rights violations are addressed	3. Family, community and social structures promote the well-being and development of all their members
	4. Communities and families support people with mental health and psychosocial problems	5. People with mental health and psychosocial problems use appropriate focused care	
Person-focused			

Underlying core principles:

1. Human rights and equity; 2. Participation; 3. Do no harm; 4. Integrated services and supports; 5. Building on available resources and capacities; 6. Multilayered supports